ENT Associates
SOUTHWEST

PATIENT INFORMATION SHEET

NAME:_____ Preferred Name: _____
Last First Middle Initial

DOB:_____ FEMALE ☐ MALE ☐ S.S.N:_____

MAILING ADDRESS:_____ CITY:_____ ZIP:_____

STREET ADDRESS:_____ UNIT #:_____ CITY:_____ ZIP:_____

HOME PHONE:_____ WORK PHONE:_____ CELL:_____

EMAIL ADDRESS:_____ MARITAL STATUS: M ☐ S ☐ W ☐ D ☐
(By providing your email address, you are accepting electronic statements.)

EMPLOYER:_____ OCCUPATION:_____

RACE: [ ] American Indian or Alaskan Native [ ] Black or African American [ ] Asian [ ] White
[ ] Native Hawaiian or Other Pacific Islander

ETHNICITY: [ ] Hispanic or Latino [ ] Not Hispanic or Latino PREFERRED LANGUAGE: _____

PREFERRED METHOD OF NOTIFICATION: [ ] Postal Mail [ ] Phone [ ] Email Is this a work-related injury? Y N

SPOUSE/PARENT/GUARDIAN INFORMATION (please circle one):

NAME:_____
Last **First** **Middle Initial**

S.S.N:_____ DATE OF BIRTH:_____

EMPLOYER:_____ WORK PHONE:_____

EMERGENCY CONTACT INFORMATION:

NAME:_____ RELATIONSHIP:_____
Last **First**

HOME PHONE:_____ WORK PHONE:_____ CELL:_____

PRIMARY INSURANCE:_____ EFFECTIVE DATE:_____

POLICYHOLDER'S NAME:_____ DOB:_____ SSN:_____

POLICY NUMBER:_____ GROUP NUMBER:_____

SECONDARY INSURANCE: _____ EFFECTIVE DATE:_____

POLICYHOLDER'S NAME:_____ DOB:_____ SSN:_____

POLICY NUMBER:_____ GROUP NUMBER:_____

FAMILY PHYSICIAN (The doctor you see regularly)

FAMILY PHYSICIAN:_____ OFFICE PHONE:_____

REFERRING PHYSICIAN (The provider who sent you to us)

REFERRING PHYSICIAN:_____ OFFICE PHONE:_____

ARE YOU CURRENTLY LIVING AT HOME? IF NO, PLEASE TELL US WHERE YOU ARE CURRENTLY STAYING:

FACILITY NAME (if applicable) _____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____ PHONE: _____

_____ _____
SIGNATURE OF PATIENT (or parent/guardian, if minor) DATE

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PATIENT FINANCIAL RESPONSIBILITIES

CO-PAYS

Co-pays are to be paid at time of service. Co-pays will not be billed. If there are outstanding copays owing on my account and I am unable to pay today, my appointment will be rescheduled.

NSF CHECKS

A $40.00 charge will be charged for any check returned for insufficient funds or otherwise dishonored.

NO SHOW / CANCELLATIONS

Every effort will be made to give at least 24 hours notice when cancelling an appointment. I understand that I may be discharged from the practice if I have three or more "no show" appointments.

REFERRALS

I understand I am responsible for making sure my referral is in place *prior* to my appointment. If my referral is not in place when I present for my appointment, I may have to reschedule or pay privately for my service.

COSMETIC / NON COVERED SERVICES

Cosmetic and non-covered services are to be paid in **full** prior to the procedure being performed.

PRIVATE PAY

Payment is due at the time of treatment. We accept cash, check, Visa or MasterCard. A 10% discount will be given for payment in full at the time of treatment (with the exception of cosmetic procedures and hearing aids). Financial arrangements must be made in advance and agreed upon in writing.

THIRD PARTY INSURANCES

I understand that this office will **not** bill any third party insurance, i.e. automobile insurance, attorney, L&I and that I will be considered private pay. I understand it is my responsibility to submit bills to my third party insurance.

FINANCING

We accept financing through Care Credit. Please contact Care Credit at www.carecredit.com or 1-800-859-9975 to apply.

INSURANCE CARDS

If I arrive for my appointment without my insurance card, I will be given the option of either rescheduling my appointment or paying privately for my services. I understand it is not the responsibility of ENT Associates to obtain this information on my behalf.

INSURANCE COVERAGE

We will, as a courtesy, bill your insurance company from our office. **I agree to be personally and fully responsible for total payment of all procedures performed in this office, including but not limited to CT's, endoscopy examinations and ear cleanings, including any portion not paid by my insurance carrier for whatever reason**. I agree that my personal payments will not be delayed or withheld because of any insurance coverage, annual deductibles not yet met, or pending insurance claims I may have. I understand it is my responsibility to handle any delays or disputes involving my insurance claims. **I further understand it is my responsibility to provide this office with correct and updated insurance. Otherwise, I agree to bill any other insurance not provided to this office.** This office does not assume responsibility for the collection of insurance proceeds. I understand that is my responsibility to pay in full for hearing aids at the time of fitting. This office will bill insurance, as a courtesy, once payment in full is obtained for all hearing aid instruments. If benefits are allowed for hearing aids, this office will reimburse you for any payments made.

PATIENT STATEMENTS

Billing statements shall be promptly paid in full upon receipt. All charges shown on a billing statement are agreed to be correct and reasonable, unless disputed in writing within thirty (30) days after the billing date. In the event legal action should become necessary to collect an unpaid balance due for treatment rendered to me or my family, I agree to pay reasonable attorney's fees, court costs, and other such costs as the Court deems appropriate.

Patient Name: _____ Legal Guardian: _____
(please print) (relationship to patient)

Signature: _____ Date: _____