Family Ear, Nose & Throat, LLC

Patient Name:_____DOB:_____

Mailing Address:_____City:_____State:____Zip Code:_____

Physical Address(If different from mailing):_____

Home Phone:_____Cell:_____Work:_____

Occupation:_____

Can we send information via email? YES NO Email:_____
Do we have permission to leave messages on your answering machine or with others who may answer your phone? YES NO

Contact Persons: If the person is someone, we can discuss medical information with please list.
Otherwise, we will ***NOT*** be able to discuss any information with them.
Authorization will only expire with written revocation from the patient

Name:_____Phone #:_____Relationship:_____

Name:_____Phone #:_____Relationship:_____

Primary Care Physician/Provider: _____State:_____

Other Physician/Providers you would like to receive office notes:

Physician/Provider:_____State:_____Physician/Provider:_____State:____

Physician/Provider:_____State:_____Physician/Provider:_____State:____

Parent/Guardian #1Name:_____ Relationship:_____

Mailing Address:_____City:_____State:_____Zip Code:_____

Physical Address(If different from Mailing Address):_____

Home Phone:_____Cell:_____Work:_____

Parent/Guardian #2 Name:_____Relationship:_____

Mailing Address:_____City:_____State:_____Zip Code:_____

Physical Address(If different from Mailing Address):_____

Home Phone:_____Cell:_____Work:_____

Insurance-**Primary** Carrier:_____

Subscriber Name:_____DOB:_____

Insurance-**Seconday** Carrier:_____

Subscriber Name:_____DOB:_____

By signing below, you are authorizing and validating all the above information.

Patient signature or responsible party:_____ Date:_____

Financial Policy

Healthcare is expensive and a universal concern for employers, patient families and medical providers. As a small, independent practice, we are committed to continue to support patient families by providing caring medical care and services. To do this, we will maintain a firm financial policy. So that expectations are clear between practice and the patient family, the following represents the obligations of the patient.

- The **co-pay** is due at the time of service and $5 processing fee will be applied to all co-pays made afterwards.
- **Coinsurance** and **deductible** amounts, to be paid by the patient, are due upon receipt of the statement. If that balance is more than $100, we can arrange a payment plan to extend over a set number of months.
- Patients paying for services should be prepared to pay full amount at the time of service or arrange a payment plan. Payments made beyond the agreed number of months will be subject to $10 processing fee for each month a balance remains.
- **Returned checks** will be subject to a $35 processing fee.
- Appointments cancelled with less than one business day notice and any **no-shows**, will be charged a $20 fee.
- It is the patient's responsibility to resolve all insurance denials directly with the insurance company when the denial is through no fault of our practice.
- If an account remains unpaid without an agreement in place, it will be sent to a collection agency.

Please sign below to indicate you have read and understand these policies. Thank you.

Patient Signature or Responsible Party:_____Date:_____

Please circle response:

- Would you like access to patient portal? YES NO *This will give access to send messages only.*

- Would you like a reminder: Call#:_____Text #:_____ or NO