

PATIENT INFORMATION SHEET (Please Print)

NAME: _____ DOB _____ F or M
Last First (legal) Middle Initial

ADDRESS: _____ UNIT#: _____ CITY/ZIP _____ SSN: _____

How did you hear about us? _____

Circle preferred phone number, is okay to leave message at preferred number? **Y / N** Is it okay to call with appointment reminders? **Y / N**

HOME PHONE: _____ WORK: _____ CELL: _____

EMAIL: _____ *GIVES PATIENTS ACCESS TO HEALTH INFORMATION PORTAL AND PRACTICE INFORMATION. WE WILL NOT SELL TO OUTSIDE ORGANIZATIONS.

EMPLOYER: _____ OCCUPATION: _____ CITY/ZIP: _____

MARTIAL STATUS: M S W D SPOUSES LEGAL NAME _____

EMERGENCY NOTIFICATION:

NAME: _____ RELATIONSHIP: _____
Last First (legal) Middle Initial

HOME PHONE: _____ WORK: _____ CELL: _____

PERSON RESPONSIBLE (ONLY for patients under 18 years of age):

MOTHER'S NAME: _____ DOB: _____ SSN: _____
Last First (legal) Middle Initial

HOME ADDRESS: _____ CITY/ZIP: _____ EMPLOYER: _____ CITY/ZIP _____

HOME PHONE: _____ WORK: _____ CELL: _____

FATHER'S NAME: _____ DOB: _____ SSN: _____
Last First (legal) Middle Initial

HOME ADDRESS: _____ CITY/ZIP: _____ EMPLOYER: _____ CITY/ZIP _____

HOME PHONE: _____ WORK: _____ CELL: _____

INSURANCE – Only fill out if you do not have cards, please give cards to receptionists so we can make copies and submit to insurance.

PRIMARY INSURANCE: _____ DOB: _____ POLICYHOLDERS NAME: _____

SSN: _____ POLICY NUMBER: _____ GROUP NUMBER: _____

SECONDARY INSURANCE: _____ DOB: _____ POLICYHOLDERS NAME: _____

SSN: _____ POLICY NUMBER: _____ GROUP NUMBER: _____

PRESCRIPTION PLAN: _____ POLICYHOLDERS NAME: _____ SSN: _____ PLAN CODE: _____

WORKMANS COMPENSATION – injured while on the job – your employer will have given you paperwork for us

DATE / TIME OF INJURY: _____ / _____ WORK RELATED? Y / N CAUSE: _____

REFERRED BY: _____ WORKMANS COMP. CARRIER: _____ CLAIM# _____

**AUTHORIZATION FOR TREATMENT / ACCIDENTAL EXPOSURE /
FINANCIAL POLICY & ASSIGNMENT OF BENEFITS / WAIVER FOR NO REFERRAL**

1) - I hereby apply for treatment by the health care providers at Plains Ear, Nose, Throat & Facial Plastic Surgery (Plains ENT). Such treatments may include x-rays, hearing tests, and such other procedures as they deem necessary. I further understand that it is my responsibility to be familiar with the Notice of Privacy Practices (NPP) which spells out how my protected health information may be used. This NPP is available for review and the written acknowledgement form will be kept in your record.

Additionally, if health care workers accidentally expose themselves to my body fluids, I agree to have my blood tested for infectious diseases that can be transmitted by exposure to blood and/or body fluids at Plains ENT expense.

2) - **Financial Policy:** I understand that my insurance policy is a contract between me and my insurance carrier and those co-payments and deductibles that have not been satisfied are the responsibility of the patient/guardian. **Copays** are required at the time of service, and failure to pay may result in a \$20 administrative fee on your next statement. Prepayment may be requested for certain procedures. If your plan requires a **REFERRAL** from your primary care physician it is **your responsibility** to obtain it prior to appointment. If no referral has been obtained your insurance may deny all charges resulting in 100% patient responsibility. For **self-pay**, a standardized payment formula will be used for office visits and procedures conducted in the office. A minimum of **\$150** is expected prior to seeing the doctor and may not cover all office charges. The parent/guardian who consents to the treatment of a minor child is responsible for payment of services rendered. Plains ENT will not get involved in separation/divorce disputes. A statement fee of \$5 may be applied to the account following the first statement, and thereafter. In the event of non-sufficient funds (NSF) return a fee of \$40 may be applied. In the event of default; I agree to pay the balance and all reasonable costs of collections, including agency and/or attorney fees.

3) - **Assignment of Benefits:** I request that payment of authorized benefits made on my behalf to Plains ENT for services provided by Plains ENT physicians and health care providers, and I assign my right to receive these payments to Plains ENT. I authorize Plains ENT to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my health insurance plan will not direct payment to Plains ENT, I agree to forward all health insurance payments to Plains ENT for services provided by Plains ENT providers. I authorize Plains ENT or any holder of medical information about me or the patient to release to my health insurance plan such information required to determine these benefits payable for related services.

4) - **Medical and Financial Information Authorization and release:** complete this to allow us to better serve and protect your private information. We appreciate your attention to this sensitive matter. Please be specific when designating your choices.

I authorize the staff of Plains ENT to release FINANCIAL INFORMATION (including the procedure charges associated with bill) to the following people:

Spouse: _____
 Partner: _____
 Parent/guardian: _____
 Other: _____

I authorize the staff of Plains ENT to release MEDICAL INFORMATION to the following people:

Spouse: _____
 Partner: _____
 Parent/ guardian: _____
 Other: _____

By signing below, you acknowledgement reading and complying by above statements.

Signature of Self/Parent/guardian: _____

Date: _____

Printed Full Name: _____

Witness: _____

Date: _____