PATIENT INFORMATION SHEET (Please Print)

NAME:____DOB:__________________FEMALE or MALE
Last First (legal) Middle Initial (Circle One)

ADDRESS:___________________________UNIT#:_____ CITY/ZIP:_________________SSN:_____________

HOME PHONE: ______________________WORK:______________________CELL:____________________

Circle your preferred phone number. Is it okay to leave a message at this number? **Y** / **N** Is it okay to call with appointment reminders? **Y** / **N**

EMAIL: __________________________*FOR ACCESS TO HEALTH INFORMATION PORTAL AND PRACTICE INFORMATION. WE WILL NOT SELL THIS INFORMATION.

EMPLOYER: ______________________________CITY__________OCCUPATION:______________________

MARITAL STATUS: ☐Married ☐Single ☐Widowed ☐Divorced SPOUSES LEGAL NAME:____________________

How did you hear about us?____

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:__________________________

HOME PHONE: __________________CELL:____________________EMAIL:____________________________

EMPLOYER:____WORK:______________________

FATHER'S NAME: ____DOB:___________SSN:_____________
Last First (legal) Middle Initial

HOME ADDRESS: ____CITY/ZIP:__________________________

HOME PHONE: ____________________CELL:__________________EMAIL:____________________________

EMPLOYER:____WORK:______________________

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 require x-rays, hearing tests, labs or other procedures, which may be billed by other entities. 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 on 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 prepayment is expected prior to seeing the doctor and most likely will 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) a return 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 billing) 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 acknowledge reading and complying by above statements.

Signature of Self/Parent/Guardian:____ Date:________________

Printed Full Name:____