

South Tulsa Ear Nose & Throat Center, PC

Personal Information

Today's Date: _____ Account #: _____ SSN: _____

First Name: _____ MI: _____ Last Name: _____

Address: _____

Zip Code: _____ City: _____ State: _____

Date of Birth: _____ Age: _____ Marital Status: _____

Sex: _____ May we leave information on your answering machine or voicemail? Yes No

Primary Phone: (number you wish to be reached at) _____ Other #: _____

Occupation: _____ Work No: _____

Employer: _____ Full Time Student: Yes No

In the event of an emergency please contact:

Name: _____ Relationship: _____ Phone No: _____

Minor Patients: Name of Parent/Guardian _____

Parent/Guardian DOB: _____ Parent/Guardian SSN: _____

Referring Physician's Name: _____ Phone No: _____

Address: _____

Insurance Information:

Please present your insurance card(s) to the receptionist. Please give complete information.

Primary Insurance: _____ Insured's Name: _____

Patient's Relationship to Insured: Self Spouse Child Other

Policy #: _____ Group#: _____

Employer: _____ SSN: _____ DOB: _____

Secondary Insurance: _____ Insured's Name: _____

Patient's Relationship to Insured: Self Spouse Child Other

Policy #: _____ Group #: _____

Employer: _____ SSN: _____ DOB: _____

NOTICE REGARDING INSURANCE CLAIMS/PAYMENTS:

If we are filing insurance for your visit, we must have complete information and any required referral at the time of the visit. If you cannot provide the information, we will be unable to file your insurance, and payment in full will be required.

Payment of your charges cannot be determined until the claim is submitted to your insurance company. Payment will be based on your individual health plan, and the amount applied to your plan deductible and/or coinsurance will be your responsibility. Procedures which are excluded from coverage, based on your plan's determination of medical necessity, will also be your responsibility. Your office visit co-pay is due at the time of the visit and, in many cases, covers only the office visit charge. Any procedures performed will be considered surgery by your insurance company, and deductibles and coinsurance may apply.

For all other patients, payment is required at the time of service. We will provide you with the necessary documentation to file for reimbursement upon your request.

I have read the above information and understand that I am responsible for payment for services I receive.

Patient/Guardian Signature: _____ Date: _____



South Tulsa Ear Nose & Throat Center, PC

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enttulsa.com

Financial Policy and Receipt of Notice of Privacy Practices

- 1.) Payment is due at the time of service for cash patients. Insurance co-payment or percentage is also due at the time services are rendered for patients with insurance.
- 2.) As a courtesy to the patient, we will file the insurance. Please remember your insurance coverage is a contract between you and your insurance company; therefore, you are responsible for full payment of your account when due.
- 3.) Many otolaryngology office procedures are commonly classified as surgical in the CPT guidelines required by your insurance company. As such, your insurance company may apply a surgical co-insurance responsibility or deductible in addition to your office visit co-payment. These procedures may include cerumen removal, Laryngoscopy, Nasopharyngoscopy, Chemical cautery, Biopsy, Nasal/Sinus Endoscopy with polypectomy or debridement.
- 4.) A \$40 No Show fee will be charged for cancellations or rescheduled appointments without 24 hours notice given.
- 5.) Due to increased postage, printing costs, and staff time...we will only send you three statements prior to referring your account to a collection agency. We would much rather work with you, so please be prompt in paying your bill or contacting us if you need to make payment arrangements. If we must refer your account to a collection agency we will add a 30% surcharge.

I understand the above financial policy and agree to adhere to the conditions set forth in above.

Name of Patient

Date of Birth

Patient/Guardian Signature

Date

Notice of Privacy: My signature on this form indicates that I have reviewed a Notice of Privacy Practices available at the office or on our website enttulsa.com. If you have any questions, please contact the Privacy Officer at the office.

I authorize South Tulsa Ear Nose & Throat to disclose my protected health information to the following:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

This authorization is valid for one year unless otherwise revoked in writing.

Patient/Guardian Signature

Date