CENTRAL
ENT Consultants, 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: Cell# _____ E-mail address: _____

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 _____

Who Referred you? ☐Physician ☐Family ☐Friend ☐Phone Book ☐Insurance Co. ☐Other _____

Primary Care 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/FINANCIAL POLICY

I consent to treatment necessary for the above named patient. I authorize this office to apply for benefits on my behalf for services rendered by Central ENT Consultants. I request payment from my insurance company to be made directly to the Providers. I certify that the information I have reported with regard to my insurance coverage is correct and authorize the release of any necessary information, including medical information, for claims. I permit a copy of this authorization be used in place of the original. This authorization may be revoked by me at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided. Copayments, coinsurance, deductibles and non-covered services are due at the time of service. Visa, MC, Amex, Discover, Care Credit and Cash are accepted as forms of payment. Checks returned for insufficient funds will be assessed a $35 fee. Should Central ENT Consultants bill me in accordance with insurance response to claim submission, payment is due in full upon receipt of a statement. I understand that in the event my account is turned over to an outside collection service and/or attorney, an administration charge will be added to my account. I understand it is my responsibility to immediately notify the office of any changes in my insurance coverage as well as my personal information. I acknowledge that should my insurance change and I do not notify the office at the time of my visit, I will be responsible for any charges for that service, even if the office is a participating provider of the new insurance. I understand that it is my responsibility to determine if the Providers are participating providers for my insurance plan. **I understand that a $50 fee will be assessed for appointments not cancelled timely.** Fees apply for completion of FMLA, Disability and supplemental forms.

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

Patient/Guardian Signature: _____ **Date:** _____