THE CENTERS FOR ADVANCED ENT CARE
CENTRAL ENT CONSULTANTS

PATIENT INFORMATION			
First:	M.I.	Last:	Gender: M / F
Legal Guardian or Guarantor Information:			
First:	M.I.	Last:	Gender: M / F
Address:	City:	State:	Zip:
DOB: / /	SS#:	Marital Status:	
Cell Phone:	Home Phone:	Email:	
Employer Name:	Employer Phone:		
Occupation:	Full Time Student:		
Emergency Contact:	Phone:	Relationship:	
INSURANCE INFORMATION			
Primary Insurance:	ID/Policy #:	Group #:	
Subscriber Name:	Subscriber DOB:		
Relationship to Patient:	Subscriber Gender: M / F		
Secondary Insurance:	ID/Policy #:	Group #:	
Subscriber Name:	Subscriber DOB:		
Relationship to Patient:	Subscriber Gender: M / F		

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 and Cash are accepted as forms of payment. Checks returned for insufficient funds will be assessed a $40 fee. As always, we will continue to make a second deposit of the check for clearance. However, if the check fails to clear a second time, there will be a second fee of $ 50.00 assigned.

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. Any appointment cancelled with less than 24-hours notice or if you do not show for your appointment, you will be considered a No Show appointment and will be subject to a $50 No Show fee. Our office does have a 15 minute late policy. If you present to the office 15 minutes or greater after your scheduled appointment time, you may be subject to a fee and your appointment may be rescheduled. Copies of records are available and are subject to a printing fee to be determined by the office at the time of the request. This also applies to paperwork for disability/FMLA/etc. As a specialist, part of your ENT exam may include specialized diagnostic tools and/or minor procedures on you. Your insurance company may apply a surgical copayment or coinsurance responsibility, or the procedure may apply to any outstanding deductible. Please be assured that we have correctly performed and documented the services as required by the CPT coding guidelines.

I have read the above information and understand that I am responsible for payment for services I receive. By signing below you are acknowledging that you have read and understand the financial policies for Central ENT Consultants and will abide by the policies mentioned above.

Patient/Guardian Signature

Date

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Patient Name: **DOB: / /** **Pharmacy:**

In order for us to obtain a complete medical history, it is important for you to fill out this form completely.

Please choose Yes or No if you have had any of the following conditions:

Acid reflux:	Y	N	Mouth breathing:	Y	N	Nasal congestion:	Y	N
Heart disease:	Y	N	Snoring:	Y	N	Cough:	Y	N
Asthma:	Y	N	Swollen Glands:	Y	N	Running nose:	Y	N
Sleep Apnea:	Y	N	Von Willebrand Disease:	Y	N	Sneezing:	Y	N
AIDS/HIV:	Y	N	Broken Nose:	Y	N	Watery Eyes:	Y	N
Diabetes	Y	N	Decreased Smell/Taste:	Y	N	Seasonal Allergies:	Y	N
Cancer, basal cell:	Y	N	Deviated Septum:	Y	N	Drink Alcohol:	Y	N
Cancer, larynx:	Y	N	Recurring Sinusitis:	Y	N	Tobacco use:	Y	N
Cancer, esophageal:	Y	N	Nosebleeds:	Y	N	Smoke Marijuana:	Y	N
Meniere's syndrome:	Y	N	Sinus/Facial Pain:	Y	N	Use/d drugs:	Y	N
Fatigue:	Y	N	Nasal Polyps:	Y	N	FAMILY HISTORY		
Lightheadedness:	Y	N	Dry Mouth:	Y	N	Hearing Loss:	Y	N
Headaches:	Y	N	Sore Throat:	Y	N	Cancer:	Y	N
Sleep Disturbance:	Y	N	Weight gain/loss:	Y	N	Diabetes:	Y	N
Blocked Ear:	Y	N	Difficulty sleeping:	Y	N	Asthma	Y	N
Decreased Hearing:	Y	N	Dizziness:	Y	N	Heart Disease:	Y	N
Ear Pain:	Y	N	Thyroid problems:	Y	N	Thyroid Problems:	Y	N
Ear Ringing/Tinnitus:	Y	N	Goiter:	Y	N	Bleeding Disorders:	Y	N
Difficulty swallowing:	Y	N	Grave's Disease:	Y	N	Multiple sclerosis:	Y	N

Primary Care Physician: _____ Phone: _____

Please list all medications/supplements you are taking, including dosage and frequency:

_____

_____

_____

_____

Please list previous surgeries or medical procedures with dates or any disorders not listed above:

_____

_____

_____

_____

Please list all medication allergies and any reactions: _____

_____

_____

_____

_____

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HIPAA / PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that my written permission is necessary for protected health information to be released to anyone including family or friends who may be involved in my treatment or care except as permitted or required by law.

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.
Please see the front desk for a copy of our Private Practices

_____ _____ / _____ / _____
Printed Name DOB

_____ _____ / _____ / _____
Patient/Guardian Signature Date

Acceptable Method of Contact : ____Home ____Cell ____Work ____Email

Do you give permission for us to leave a message: _____Yes _____ No

CONSENT TO RELEASE INFORMATION

I hereby authorize The Centers for Advanced ENT Care, Central ENT Consultants and any of its affiliates permission to discuss my financial account and/or my treatment with the following individuals other than myself:

Name: _____ Relationship: _____ Phone No: _____

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CANCELLATION & NO SHOW

Any appointment cancelled with less than 24-hours notice or if you do not show for your appointment, you will be considered a no show appoitment and will be subject to a $50 no show fee. Our office does have a 15 minutelate policy. If you present 15 minutes or greater after your scheduled appontment time, you, may be subject to a fee and your appointment may be rescheduled.

I hereby acknowledge that I have read and understand the above statement regarding the No Show/Cancellation Policy and Fee.

_____ _____ / _____ / _____
Patient/Guardian Signature Date