ENT Associates, Inc.

A division of SOUNDHEALTH SERVICES

PATIENT INFORMATION

Last Name: ______________________ First Name: ______________________ MI: __________

Date of Birth: ____________ Sex: ________ SS Number: ______________ Marital Status: S M D W

Language: English, Bosnian, French, German, Mandarin, Spanish, Vietnamese, Italian, Decline

Race: African American, American Indian, Caucasian, Chinese, Filipino, Hispanic, Japanese, Multiracial, Native American, Declined

Ethnicity: Hispanic or Latino, Non-Hispanic or Latino, Declined

Home Number: ______________ Work Number: ______________ Mobile Number: ______________

Preferred Phone Contact: Home, Mobile, Work OK to Receive Text Messages: Yes or No

Email Address: ____

Home Address: ____

City: ______________________ State: __________ Zip Code: ____________

Preferred Local Pharmacy: ______________________ Phone Number: ____________

Referring Physician: ______________________ Primary Care Physician: ______________________

INSURANCE INFORMATION

Primary Insurance: ______________________ Subscriber/Policy Number: ______________________

Last Name: ______________________ First Name: ______________________ MI: __________

Date of Birth: ____________ Sex: ____________ Relationship to Patient: ______________________

Billing Address (if different from above): ____

Home Number: ______________________ Mobile Number: ______________________

Secondary Insurance: ______________________ Subscriber/Policy Number: ______________________

Last Name: ______________________ First Name: ______________________ MI: __________

Date of Birth: ____________ Sex: ____________ Relationship to Patient: ______________________

Billing Address (if different from above): ____

Home Number: ______________________ Mobile Number: ______________________

FINANCIALLY RESPONSIBLE PARTY (Person Bringing Child In)

Last Name: ______________________ First Name: ______________________ MI: __________

Date of Birth: ____________ Sex: ____________ Relationship to Patient: ______________________

Billing Address (if different from above) ____

Home Number: ______________________ Mobile Number: ______________________

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes to the above information. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to the physician unless my account has been paid in full. **I have received Sound Health Services, P.C. notice of privacy practice.**

Responsible Party Signature: ______________________________ **Date:** ____________

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FINANCIAL AGREEMENT

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. WE WILL REQUEST TO PHOTOCOPY YOUR INSURANCE CARD(S) AND A PHOTO I.D. FOR YOUR FILE.

- **APPOINTMENTS –** 24 hours notice must be provided in the event you cannot keep an appointment. Should you not provide this notice, a cancellation fee up to $35 may then be added to your account. Cancellations for Ancillary Services will have a higher fee.
- **REFERRALS –** If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral, YOU WILL BE REQUESTED TO SIGN A FINANCIAL WAIVER to be set up as a "Self-Pay" patient. It is then your responsibility to provide us with the referral within 48 hours or you will be personally responsible for that day's services.
- **CO-PAYMENTS –** By law we MUST collect your carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit. Should you not pay at the time of service, and we subsequently send you a statement, an administrative fee of $5 may be added to your account. Any procedure performed in this office could be deemed surgical by your insurance company and all copays and deductibles will apply.
- **FMLA AND/OR WORKMAN COMP –** There is a $25.00 charge for completion of Workman Comp or FMLA forms.
- **SURGERY DEPOSITS –** If you and your physician determine that your course of care requires surgery, a surgical deposit will be collected at time of scheduling. Our scheduling coordinators will work with you to determine estimated insurance payment and estimated patient responsibility.
- **OUT OF NETWORK PLANS –** You will be responsible for any balance your plan indicates as due on their explanation of benefits form. We will adjust the charges to coincide with your plan's UCR (Usual, Customary and Reasonable) charges. All patients will be responsible for their co-insurance and deductible. If we do not "participate" with your plan, we will send a courtesy bill to that carrier on your behalf. However, should they not pay your claim within 45 days, you will be responsible for the full amount due. Should you receive payment from your insurance carrier, please forward it to the physician's office.

> Private Insurance Authorization for Assignment of Benefits/Information Release: I, the undersigned, authorize payment of medical benefits to Sound Health Services, P.C. for any services furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize any holder of medical information about me to release to my insurance company (or the agent) information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

- **SELF-PAY PATIENTS –** Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.
- **MEDICARE –** We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one.

> Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits to be made on my behalf to Sound Health Services, P.C. for any services furnished to me. I authorize any holder of medical information about me to release to the CMS (and it agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluation and administering claims of benefits.

- **DIVORCED/SEPARATED PARENTS OF MINOR PATIENTS –** The parent who consents to the treatment of a minor child is responsible for payment of services rendered, Sound Health Services, P.C. will not be involved with separation or divorce disputes.
- **INSUFFICIENT FUND CHECKS –** A $25.00 fee will be charged to patient's account for checks returned due to non sufficient funds
- You are responsible for the timely payment of your account. Should it become necessary for us to use an outside agency to collect payment from you, you will be obligated to pay to us, to cover the costs of using a collection agency, an additional amount equal to 30% of your total unpaid balance at the time a collection agency is brought in to collect your account. WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, AMERICAN EXPRESS, DISCOVER OR CARE CREDIT. THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share with us special concerns.

Patient's Name: ______________________________ DOB: ______________

Responsible Party Signature: ______________________________ Date: ______________

Revised 04/01/2018