TUSCALOOSA EAR NOSE AND THROAT CENTER, P.C. Account #: _____

Name of Doctor seeing today: _____ **Date:** _____

PATIENT INFORMATION

First Name _____ **MI** ____ **Last Name** _____ **Age:** _____

***Preferred Name:**_____

Address: _____ **[ ] Male [ ] Female Birth date:** ____/____/____

City, State, Zip: _____ **Social Security #:** _____

Home#: (_____) _____ **Marital Status: [ ] Married [ ] Single**

Cell#: (_____) _____ **[ ] Employed [ ] Retired [ ] Unemployed**

Work #: (_____) _____ **Employer:** _____

Other#: (_____) _____ **Referring Physician:** _____

EMAIL Address: _____ **Primary Physician:** _____

Preferred Language: English / Spanish / Other _____ **Pharmacy:** _____

Race (Please circle one): Caucasian / African American / Hispanic / Other _____

Ethnicity (Please circle one): Hispanic or Latino / Non Hispanic or Latino / Other _____

PARENT/LEGAL GUARDIAN **Patient relationship to Responsible Party** _____

First Name _____ **MI** ____ **Last Name** _____

Address: _____ **[ ] Male [ ] Female Birth date:** ____/____/____

City, State, Zip: _____ **Social Security #:** _____

Home #: (_____) _____ **Marital Status: [ ] Married [ ] Single**

Work #: (_____) _____ **[ ] Employed [ ] Retired [ ] Unemployed**

Cell #: (_____) _____ **Employer:** _____

PRIMARY INSURANCE COMPANY :_____

Policyholder: [ ] Patient [ ] Responsible Party [ ] Other

Contract #: _____
Group#: _____ **If other:** **Name:** _____
Copayment: _____ **SSN:** _____
DOB: _____
Patient relationship to Policyholder: _____ **Employer:** _____

SECONDARY INSURANCE COMPANY :_____

Policyholder: [ ] Patient [ ] Responsible Party [ ] Other

Contract #: _____
Group#: _____ **If other:** **Name:** _____
Copayment: _____ **SSN:** _____
DOB: _____
Patient relationship to Policyholder: _____ **Employer:** _____

I consent to treatment necessary for the care of the above named patient. I authorize the release of any prescription records from my pharmacy for the purpose of treatment. I authorize the release of all medical records to the referring and primary physicians and to my insurance company, if applicable. I allow fax transmittal of my records if necessary.

Signature: _____ **Date:** _____

*****SEE OTHER SIDE*****

Notice of Privacy Practices

It is a breach of patient confidentiality for a physician and/or their staff to release any information regarding you and your medical condition to anyone without your permission. This includes your medical condition, prognosis, appointment times, insurance information, billing and demographic information. Therefore, if you anticipate the need for anyone else to have access to this information, please complete the information below.

I(we), the undersigned patient and/or responsible party, hereby authorize Tuscaloosa Ear, Nose & Throat Center, P.C. and Allergy Clinic, its physicians, agents, employees or representatives to discuss or release any or all patient information about me including but not limited to past and current medical information, billing information, appointment scheduling, prescriptions, etc., to the person or persons indicated below.

Please list ANY PERSON information may be released to below: (i.e. parent, guardian, spouse, children)

_____ _____

_____ _____

Financial and Office Policies
(Please read and initial each line)

_____ **Payment for all professional services rendered is the responsibility of the patient unless these services are covered benefits with an insurance carrier in which Tuscaloosa ENT is currently a contracted provider. It is the patient's responsibility to know his insurance benefits and whether Tuscaloosa ENT is, or is not, a preferred provider. Certain routine procedures may not be covered by insurance and payment for these services is the responsibility of the patient.**

_____ **We will bill your insurance AS A COURTESY if you provide ALL necessary information (insurance cards, correct billing address, etc.) and obtain authorization from your primary care provider or insurance when required.**

_____ **All copayments, deductibles, balances and non-covered charges are due at the time of service, regardless of who brings the patient in for his/her visit. We take cash, checks and credit cards for your convenience.**

_____ **If you do not have medical insurance we will collect $50.00 before your appointment and apply it toward the actual charge for that date of service.**

_____ **There is a $15.00 fee on any returned checks.**

_____ **All lab work will be billed by the reference lab that performs the testing.**

_____ **In order to release medical records, we must have a release signed by a parent or guardian on file. Please allow 24-48 hours to process any request for records.**

Agreement to Accept Financial Responsibility, Insurance Authorization and Assignment of Benefits

I acknowledge full financial responsibility for services rendered by Tuscaloosa Ear, Nose & Throat Center, P.C.
I understand that payment of copayments and/or charges incurred is due at the time of service unless other financial arrangements have been made prior to treatment. I also understand that if I fail to comply with this agreement, or if my account becomes more than 90 days past due, it may be turned over to a collection agency, an attorney, or small claims court for collection. I agree to pay all costs of collection including attorney's fees, court costs and other reasonable costs of collection. I authorize and request that insurance payment be made directly to Tuscaloosa Ear, Nose and Throat Center, P.C. should they elect to receive such payment.

Signature: _____ Date: _____