EAR, NOSE & THROAT ASSOCIATES

DRS. DIEHN, KUNAR, KAPLAN, DUBIN, FLETCHER, WOOD & HAHN

Date: **PATIENT INFORMATION** **Acct #**

First MI Last	Home #	Work #	Cell # / Email
Address	City	State	Zip
Social Security #	Date of Birth	Male/Female	Marital Status

PRIMARY CARE PHYSICIAN

Physician's Name		Telephone	Fax
Address	City	State	Zip

REFERRING PHYSICIAN (complete only if referred by Physician or Nursing Practitioner)

Physician's Name		Telephone	Fax
Address	City	State	Zip

PRIMARY INSURANCE

Insurance Co. Name	Policy #	Group #	Effective Date
Policyholder's Name	Address (if different from above)	Home #	Work #
Policyholder's Employer	SSN	Date of Birth	Relationship to Patient

SECONDARY INSURANCE

Insurance Co. Name	Policy #	Group #	Effective Date
Policyholder's Name	Address (if different from above)	Home #	Work #
Policyholder's Employer	SSN	Date of Birth	Relationship to Patient

RESPONSIBLE PARTY/EMERGENCY CONTACT

Name	Home	Work	Cell
Address	City	State	Zip

ALL FEES ARE DUE AT THE TIME OF SERVICE **FINANCIAL AGREEMENT ON BACK**

PATIENT AGREEMENT AND CONSENT TO DISCLOSE HEALTH CARE INFORMATION

I the undersigned agree that I am financially responsible for all services rendered to me/my dependent by Ear, Nose & Throat Associates; this includes non-covered services, co-payments, co-insurance amounts, and/or deductibles. It is also my responsibility to bring referrals, claim forms, etc. that are required by my insurance company for payment; otherwise I will be responsible for payment or will have to reschedule the appointment. **Your insurance carrier may process some procedures performed (i.e. endoscopy) as requiring multiple copays or additional payments towards your deductible that you may be responsible for.** I authorize payment directly to Ear, Nose & Throat Associates from my health insurance company; including auto carriers, worker's comp, and any third-party payments by any person, employer, or insurance company that satisfies a balance owed by the patient. There is a $25 fee for all checks returned from the bank for non-sufficient funds. If the account is made delinquent we reserve the right to submit the balance to an outside collection agency and you will be responsible to satisfy this debt with the collection agency, your credit may be affected. Our policy for missed/cancelled appointments with less than 24 hours notice is $25.00.

I authorize Ear, Nose & Throat Associates to disclose any health information needed for treatment and/or payment of services received. I also authorize release of health care information to other health care providers for continuing care and treatment.

I certify the information stated on the front of this patient information form is correct to the best of my knowledge. This consent is valid for one year and I will need to provide current information on an annual basis.

Ear, Nose & Throat Associates may refuse to render treatment to you if you do not sign this form. A Notice of Privacy Practices Act is available to view upon request. I hereby give permission for Ear, Nose & Throat Associates to contact me via the phone numbers provided on the front sheet unless otherwise stated; leaving messages re: matters that directly involve me or my dependent and Ear, Nose & Throat Associates.

I have read and understand this consent and I am the patient or am authorized to act on behalf of the patient to sign this document.

______________________________ Patient Name

______________________________ Today's Date

______________________________ Patient/Guarantor Signature

______________________________ Relationship to patient