BAY AREA ENT SPECIALISTS
REGISTRATION FORM

PATIENT INFORMATION

Name(Last)_____ (First)_____

Sex:__M__F Date of Birth:_____ Age:_____ SS#_____

Marital Stauts: S__M__Other_____ Emergency Contact_____

Street Address_____City_____State____Zip_____

Billing Address_____City_____State____Zip_____

Home Phone_____Work Phone_____Cell Phone_____

Email Address_____Employer_____

Family Doctor(Full Name)_____Referring Doctor_____

Pharmacy:_____Location_____Phone_____

PRIMARY Insurance: _____Subscribers Name_____

Subscribers Date of Birth_____ Relationship to Patient_____

SS#_____ Employer_____Employers Phone_____

SECONDARY Insurance:_____Subcribers Name_____

INFORMATION REQUESTED BY THE FEDERAL GOVERNMENT

Language:_____ **Ethnicity:**_____Hispanic_____Not Hispanic_____Refuse to Report

Race_____American Indian_____Asian_____Black or African American_____Hispanic

_____Other Pacific Islander_____White_____Refuse to report

Parent/Legal Guardian (For children under age 18)

Name(Last)_____(First)_____(MI)_____

Address:_____City_____State_____Zip_____

Home Phone:_____Work Phone_____Cell Phone_____

Employer:_____Employer Phone:_____

*****Note: THE PARENT WHO BRINGS A CHILD TO THE OFFICE FOR MEDICAL TREATMENT IS RESPONSIBLE AT THE TIME OF SERVICE FOR CO-PAYMENTS, CO INSURANCE, DEDUCTIBLES AND ACCOUNT BALANCES.**

BAY AREA ENT SPECIALISTS, LLP
Deborah Miller, MD* Chester Strunk MD
Shauna McLaughlin, PA-C* Lori Jones, PA-C

FINANCIAL POLICY

The physicians and staff at Bay Area ENT Specialists, LLP appreciate the confidence you have shown in choosing us to provide for your health care needs and are committed to providing you with quality care.
Please feel free to ask any questions about our fees and / or our financial policy.

PATIENTS RESPONSIBILITY:

- Obtaining a referral if necessary. Without a referral, you will be responsible for the charges in full at time of service.
- Payment of deductible/co-insurance, co payments and any non covered charges as designated by your insurance. If your insurance claim is denied or your insurance is terminated, you will be responsible for your balance in full.

PAYMENT OPTIONS:

- Cash, Check, Credit/Debit Card. There is a $35.00 per check fee if your check is returned by the bank**.**
- If your account becomes past due, Bay Area ENT Specialists, LLP will take the necessary steps to collect the debt, including but not limited to collection agency, lawyers, and reporting to Credit Bureau where you agree to pay all of the collection costs incurred. **We will charge an additional $150.00 collection fee for** delinquent **accounts.**

MEDICARE:

- We accept assignment of Medicare benefits and will file with your secondary or supplemental insurance.

WE DO NOT ACCEPT WORKERS COMPENSATION OR THIRD PARTY INSURERS

MINORS/ UNACCOMPANIED MINORS:

- Unaccompanied minors must have authorization for medical treatment signed by his/her parent or legal guardian and is responsible for providing current insurance information and any necessary payment at the time of service.

DIVORCED PARENTS:

- The parent **accompanying** a child of a divorced family will be responsible for payment of charges incurred for the date of service regardless of insurance or divorce decree status at the time of visit.

SELF PAY PATIENTS:

I do not have health insurance and I will be responsible for all medical services rendered at Bay Area ENT Specialists, LLP. I will be offered a discount and I agree to pay Bay Area ENT Specialists, LLP the balance of these charges related to the office visit and any treatment/procedure rendered to me or to the above named patient at the time of each visit.
Initial here_____

CANCELLATIONS & MISSED APPTOINTMENTS:

We request that at least **24 hour** advance notice be given to the office if you will be unable to keep your scheduled appointment. All cancellations with less than 24 hours notice and missed appointments will be billed $50.00 per occurrence. Patients will be expected to pay the $ 50.00 fee before scheduling future appointments.
Initial here_____

Please be aware that your physicians have a financial interest in Houston Physicians Hospital, Houston Physicians Surgery Center and Premier Sleep Center

MEDICAL SUPPLIES:
Ex: ear plugs, cervical collars, will not be billed to your insurance and is the patients responsibility to pay at time of check out.

HEARING AIDS:
Coastal Audiology is a separate entity from Bay Area ENT Specialists and does not have contracts with any health insurance companies. If you have out-of-network benefits for hearing aids, as a courtesy to our patients, our office will file a claim to your insurance company on your behalf.

CONSENT FOR TREATMENT/AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Bay Area ENT Specialists, LLP through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate diagnostic and treatment procedures.

I further authorize Bay Area ENT Specialists, LLP to release to appropriate agencies, any information acquired in the course of my or the below named patient's examination and treatment. I authorize Bay Area ENT, LLP to appeal any insurance claims on my behalf.
Initial here_____

CONSENT FOR TREATMENT BY PHYSICIAN ASSISTANT

Physician Assistants are health care professionals licensed to practice medicine. They are trained in intensive education programs accredited by the accreditation review commission and upon graduation they are licensed with the state.

I understand that the physician assistant and the physician work together as a team to provide my medical care and I agree
to be seen by the physician assistant. I understand I can always see the physician at my request.
Initial here_____

CONSENT FOR PROTECTED HEALTH INFORMATION

I further authorize Bay Area ENT Specialists, LLP to contact, discuss my personal health information with:

Name:_____ Relationship_____

Name:_____ Relationship_____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have reviewed or been given the opportunity to receive a copy of Bay Area ENT Specialists Notice of Privacy Practices.
Initial here_____

I have read the above policy regarding my financial responsibility to Bay Area ENT Specialists, LLP for providing medical services to me or the above named patient. I certify that the information I provide to Bay Area ENT Specialist, LLP to the best of my knowledge is current, true and accurate. I authorize my insurer to pay any benefits directly to Bay Area ENT Specialists, LLP or other providers the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.
I hereby agree to all the terms of this financial policy.

Patient Signature _____ **Date** _____

Guarantor Signature _____ **Date** _____
(If guarantor is not the patient)

DISCLOSURE AND CONSENT OF IN OFFICE PROCEDURES

As we are a surgical practice please be aware that certain procedures performed in our office are not included in the standard office visit. These procedures are billed separately from the office visit charges.
Most insurance carriers classify these procedures as "Surgery" because of their invasive nature and apply the charges to deductible amounts. **In such cases, payment for the procedure will be due from the patient**. Be assured that we are following accepted billing and coding guidelines and that all procedures are performed in the best interest of patient care.

EXAMPLES OF IN OFFICE PROCEDURES INCLUDE:

Flexible Laryngoscopy: This procedure involves passing a long thin flexible fiber optic scope through the nasal cavity and into the throat. The fiber optic scope enables the physician to visualize areas of the throat not readily seen using the laryngeal mirrors.

Rigid Nasal endoscopy: This procedure uses the rigid scope attached to a light source to view areas of the nasal cavities that cannot be viewed by the physician using the standard nasal speculum and head mirror.

Nasal endoscopy with debridement or biopsy: This is the same procedure as above with removal of crusting or tissue.

Nasal Cauterization: For control of nosebleeds.

Myringotomy /Tympanostomy: Incision in the ear drum to relieve fluid pressure build up and/or to insert ventilation tube to provide drainage to help reduce middle ear infections.

Transtympanic Injection: For treatment of hearing loss.

Cerumen Removal: Removal of impacted ear wax using either: cerumen spoon, forceps and/or suction.

CT SCANS AND VNG TESTING: Although not considered invasive, these office procedures may apply to your deductible/co insurance or have a higher co pay amount in addition to the office visit.

Please speak with our office staff if you have any questions.

I understand that the procedures listed above may be considered by my insurance company as surgical procedures or advanced radiology (CT)and therefore may fall under my deductible, co insurance or a higher co pay.

I agree to pay for my portion of the procedure in full at the time the service is rendered.

Print _____ **Sign** _____

Patient/ Legal Guardian Name Patient/Legal Guardian Name

_____

Witness Signature

Date: _____ Submit by Email