BAY AREA ENT SPECIALISTS

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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.**

WE DO NOT ACCEPT WORKERS COMPENSATION OR THIRD PARTY INSURANCE.
WE DO NOT OFFER TREATMENT FOR INJURIES RELATED TO A LAWSUIT OR MOTOR VEHICLE ACCIDENTS.

PATIENT RESPONSIBILITY:
Providing proof of insurance and 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, you will be responsible for your balance in full.

PAYMENT OPTIONS: NO CASH ACCEPTED
We accept Check or Credit/Debit Card. There is a $35 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 collection fee for delinquent accounts.**

MEDICARE:
We accept assignment of Medicare benefits and will file with your secondary or supplemental insurance. If you do not have supplemental insurance you will be responsible for any portion of the deductible or copay at the time of your visit. Any remaining balance that your supplemental insurance does not pay is the patient's responsibility.

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 APPOINTMENTS:
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 hour notice or 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_____

HEARING AIDS:
Coastal Audiology is a separate entity from Bay Area ENT Specialists, LLP and does not have contracts with any health insurance companies and are considered **OUT OF NETWORK**.
There is a fee to see the Audiologists for anything Hearing Aid related, the cost will vary by services performed and will be collected at the time of service.
Initial here_____

OUTSIDE LABS OR FACILITIES:
Services rendered by outside labs or facilities may incur an additional fee. Labs, Cultures, Tissue Samples, and any other services related to your appointment or procedure may incur additional fees that will be billed to you or your insurance.
****Outside labs or facilities may be out of network with your insurance, we cannot guarantee network status****
Bills received from outside labs or facilities are patient responsibility, no adjustments can be made by our office.
Initial here_____

ADDITIONAL FEES:
Any paperwork to be completed by the Physician or Physician Delegate at the request of the patient is additional fee of $50 which is due at the time the forms are dropped off. Payment must be made prior to completion of the forms. The standard turnaround time for forms to be completed is 5-7 business days. Please make sure the patient sections of the forms are complete prior to us receiving them, incomplete forms will cause delays. A $50 fee is required for any subsequent forms that need to be completed.

Initial here_____

MEDICAL RECORDS:
Medical records require a completed Authorization and Disclosure of Medical Records form to be completed before they can be released. There is a $25 fee for Medical Records released to the patient via fax or printed ***WE CANNOT EMAIL RECORDS***. You can obtain your visit summaries online via our Patient portal at no charge. Record sent to or requested by another Physician are sent at no charge as long as an authorization to release records is received or on file.
CT Scans done in our office can be printed to a disk for a $25 fee, please allow 2 business days.

Initial here_____

MEDICAL SUPPLIES
Ex: Ear plugs, ear molds, ear insufflators, ear bandit, cervical collar ect... will not be billed to your insurance and is the patient's responsibility to pay at time of check out.

CONSENT FOR TREATMENT & AKNOWLEDGEMENT OF PRIVACY PRACTICES

MINOR/PARENTAL CONSENT FORM: **(Please list anyone whom may bring your child)**
Minors accompanied by an adult other than a parent must have a parental consent form signed by the parent prior to treatment.

Consent Form: I being the parent or legal guardian authorize unexpected medical, surgical care, hospitalization and financial fees for the minor during the period of my absence.

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Parent signature:_____ **Date:**_____

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.

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 (insurance company), any information acquired in the course of my or the below named patient's examination and treatment. I authorize Bay Area ENT Specialists, LLP to appeal any insurance claims on my behalf, to stand in the shoes of the beneficiary and demand the protections allowed by law to call healthcare consumers.
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. I agree to see the physician assistant at my request and will be notified when scheduling an appointment. I understand that I can see the physician at my request.

Initial here_____

CONSENT FOR PROTECTED HEALTH INFORMATION:

I further authorize Bay Area ENT Specialists, LLP to contact or call on my behalf to discuss my personal health information with: (family member or other physician) *If the person is not listed below we **CANNOT** speak to them for any reason*

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 Practice. (HIPAA) **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 Specialists, 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 and the full and entire amount to 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:_____

Please be aware that your physicians have a financial interest in Houston Physicians Hospital, Houston Physicians Surgery Center and Argentum Toxicology * Please be aware that some of the diagnostics and surgery facilities may be out of network with your insurance

BAY AREA ENT SPECIALISTS

REGISTRATION FORM

****ONLY THE PARENT OR LEGAL/GUARDIAN CAN BRING A MINOR TO THE APPOINTMENT****

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

Name (Last):_____(First):_____M_____

Sex: M F Date of Birth: _____ Age: _____ Marital Status: S M Other_____

Street Address:_____ City:_____ State_____ Zip_____

Billing Address:_____ City_____ State_____ Zip_____

Home Phone:_____ Work:_____ Cell_____

Email:_____ Employer:_____

Family Doctor:_____ Referring Doctor:_____

Pharmacy:_____ Location:_____ Phone:_____

Emergency Contact Name_____ Phone_____ Relationship_____

Primary Insurance:_____ Subscriber name:_____ DOB:_____

Relationship to Patient:_____SS#_____ Employer Name:_____

Secondary Insurance:_____ Subscriber Name;_____ DOB:_____

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_____

IF PATIENT IS A MINOR: PARENTAL /LEGAL GUARDIAN INFORMATION

Name (Last):_____ (First)_____ Relationship:_____

Address:_____ City_____ State_____ Zip_____

Home Phone:_____ Work_____ Cell_____

Employer/Phone:_____

Sign:_____ **Date:**_____

BAY AREA ENT SPECIALISTS MEDICAL HISTORY FORM

Patient Name: _____ DOB: _____

Please circle Yes ONLY!

Have you had any of the following within the **last two weeks**?

CONSTITUTIONAL

Recreational Drug use	Yes	No
Fever	Yes	No
Weight Loss	Yes	No
Loss of Appetite	Yes	No
Fatigue	Yes	No

Have you **ever** had or do you **currently** have any of these problems?

ENT

Hearing Loss	Yes	No
Dizziness	Yes	No
Infections	Yes	No
Ear Discharge	Yes	No
Nose Trauma	Yes	No
Nose Obstruction	Yes	No
Snoring	Yes	No
Nasal discharge	Yes	No
Bleeding	Yes	No
Post Nasal Drip	Yes	No
Ringing in the ears	Yes	No
Soreness	Yes	No
Difficulty Swallowing	Yes	No
Tonsillitis	Yes	No
Voice Change	Yes	No
Hoarseness	Yes	No
Sinus Pain	Yes	No
Sinus Swelling	Yes	No
Sinus Pressure	Yes	No
Frequent Sinus Infections	Yes	No
Crowns	Yes	No
Root Canal	Yes	No
TMJ	Yes	No
Dental Trauma	Yes	No

OPTHALMOLOGY

Blurring Vision	Yes	No
Double Vision	Yes	No
Decreased Visual Acuity	Yes	No

RESPIRATORY

Coughing up blood	Yes	No
Tuberculosis	Yes	No
Shortness of Breath	Yes	No
Wheezing	Yes	No

CARDIOLOGY

Chest Pain	Yes	No
Rheumatic Fever	Yes	No
Heart Attack	Yes	No
High Cholesterol	Yes	No
High Blood Pressure	Yes	No
Leg Edema	Yes	No
Murmur	Yes	No
Palpitations	Yes	No

UROLOGY

Kidney Stones	Yes	No
Infections	Yes	No
Tumor	Yes	No
Recurrent UTI	Yes	No
Urinary retention	Yes	No
Urinary incontinence	Yes	No

BAY AREA ENT SPECIALISTS MEDICAL HISTORY FORM

Patient Name: _____ DOB: _____

Please circle Yes ONLY!

Have you ever had or do you currently have any of these problems?

ENDOCRINOLOGY

Thyroid Disease	Yes	No
Weight Loss	Yes	No
Weight Gain	Yes	No
Diabetes	Yes	No
Heat/Cold Intolerance	Yes	No

NEUROLOGY

Stroke	Yes	No
Epilepsy	Yes	No
Seizures	Yes	No
Migraines	Yes	No

PSYCHOLOGY

Depression	Yes	No
Anxiety	Yes	No
Mental Illness	Yes	No
Alcoholism	Yes	No
Drug dependency	Yes	No
ADHD	Yes	No

GASTROENTEROLOGY

Jaundice	Yes	No
Liver Disease	Yes	No
Abdominal Pain	Yes	No
Constipation	Yes	No
Diarrhea	Yes	No
Reflux	Yes	No
Ulcers	Yes	No

MUSCULOSKELETAL

Arthritis	Yes	No
Back Pain	Yes	No
Neck Pain	Yes	No

ALLERGY

Asthma	Yes	No
Hay Fever	Yes	No
Hives	Yes	No
Eczema	Yes	No
Scratchy Throat	Yes	No
AIDS	Yes	No
HIV Positive	Yes	No
Immune Deficiency	Yes	No

DERMATOLOGY

Rash	Yes	No
Dry/Sensitive skin	Yes	No
Hives	Yes	No
Skin Cancer	Yes	No

HEMOTOLOGY

Easy Bruising	Yes	No
Hep C	Yes	No
Swollen Glands	Yes	No