NORTHEAST EAR, NOSE & THROAT CENTER

Chart #

Patient Name ____
(Last) (First) (Middle) (Maiden)

Social Security _________-_________-__________ Date of Birth _______/_______/_______ ❿ Male ❿ Female

Marital Status: ❿ Single ❿ Married ❿ Widowed ❿ Divorced

Race: ❿ Asian ❿ Black ❿ Indian ❿ More than one race ❿ Native Hawaiian ❿ Other Pacific Islander ❿ White

Ethnicity: ❿ Hispanic or Latino ❿ Not Hispanic or Latino

Mailing Address ____Apt/Unit# ______________

City ____ State ___________ Zip ________________

Home Phone ________________Work _______________Cell _______________ Auth to Text? ☐ Y ☐N

Primary Care Doctor ____

Email Address ____

(If Patient is a MINOR - Parent/Guardian Information	**INSURANCE POLICY HOLDER INFORMATION**
Name ________________________________	Insurance Carrier___________________________
Relationship ____________________________	Policy Holder Name _________________________
Home Phone____________________________	Policy Holder DOB__________________________
Work _______________Cell _______________	Policy Holder SSN __________________________

Emergency Contact: Name ________________________________Relationship_________________

Home Phone ______________________________ Cell ___________________________________

FINANCIAL RESPONSIBILITY

By signing below, I understand and agree that I am ultimately responsible for the balance of my account for any professional services rendered. If we are not contracted with your insurance company, full payment is due at time of service. Patients with no insurance may receive a 30% discount when paying in full at each visit.
MEDICARE deductibles and/or co-insurance are due at time of service unless deductible has been met and you have supplemental insurance coverage. MEDICAID patients must present current card in order to be seen and co-pays must be paid at time of service. WORKERS COMP patients must present a claim number and employer's phone number. We will call to validate and if not authorized, you must pay for office visit.
ALL OTHER INSURANCE DEDUCTIBLES AND CO-PAYS ARE DUE AT TIME OF SERVICE. THIS ALSO INCLUDES SURGERY CHARGES AND PAST DUE BALANCES. If your account is over 60 days old with no payment activity, you will be sent a 10-day notice to pay in full or set up a payment plan. After 10 days, if no arrangements have been made, the account will be turned over to a Collection Agency.

I AUTHORIZE NorthEast Ear, Nose & Throat Center to release any medical or other information necessary to process my insurance claims in compliance with HIPAA privacy rules. I understand this authorization may include information regarding any chemical dependency, treatment or HIV testing. I understand I may revoke this authorization in writing at any time. **I FURTHER AUTHORIZE** payment of medical benefits directly to NorthEast Ear, Nose & Throat Center for all services rendered. **IF PATIENT IS A MINOR:** I hereby give my permission for NorthEast Ear, Nose & Throat Center to treat him/her. I accept financial responsibility for such treatments.

Signed (Patient or Parent/Legal Guardian)_________________________________ Date________________