NORTHEAST EAR, NOSE & THROAT CENTER

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

Social Security _____ Date of Birth _____ ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

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

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Mailing Address _____

City _____ State _____ Zip _____

Email Address _____ Employer _____

Home Phone _____ Cell Phone _____Work Phone _____

EMERGENCY CONTACT INFORMATION	**INSURANCE POLICY HOLDER INFORMATION**
Spouse/Parent_____	Policy Holder Name_____
Home Phone_____	Policy Holder Date of Birth_____
Cell Phone_____Work _____	Policy Holder SS#_____
Primary Care Physician _____	Policy Holder Employer_____

DEDUCTIBLE AND CO-PAYS ARE DUE AND PAYABLE AT TIME OF SERVICE. THIS ALSO INCLUDES SURGERY CHARGES. If we are not contracted with your insurance company, full payment is due at time of service. As a courtesy, we will file your insurance claim for your reimbursement. Patients with no insurance may receive a 30% discount and are expected to pay in full at each visit. If your account is over 60 days old with no payment activity, you will be sent a 30-day notice to pay in full or set up payment plan. At the end of 30 days, if no arrangements have been made, the account will be turned over to a Collection Agency. I understand and agree *that I am ultimately responsible for the balance of my account for any professional services rendered.*

MEDICARE PATIENTS: Deductible and co-pay due at time of service unless you can show your deductible has been met and you have supplemental insurance coverage.
MEDICAID PATIENTS: You must present a copy of your current card in order to be seen. Co-pays must be paid at the time of service. Carolina Access requires we have a referral from your PCP prior to being seen.
WORKERS COMPENSATION: You must present a claim number and employers phone number. We will call your employer to validate your claim. If it is not authorized, you must pay for office visit**.**

Signed (Patient)_____ Date_____

IF PATIENT IS A MINOR: I, _____, Custodial Parent/Legal Guardian of _____ do hereby give my permission for NorthEast Ear, Nose & Throat Center to treat him/her. I accept financial responsibility for such treatments.

Signed (Custodial Parent/Legal Guardian)_____ Date_____

AUTHORIZATION TO RELEASE INFORMATION TO INSURANCE COMPANY: (In order to file your insurance, you must sign and date this authorization.) I authorize NorthEast Ear, Nose & Throat Center to release any medical and other information necessary to process my insurance claims in compliance with HIPAA privacy rules. I further authorize payment of medical benefits to NorthEast Ear, Nose & Throat Center for my services. I understand this authorization allows the release of all information in my file, including information regarding any chemical dependency and/or treatment and HIV testing. I further understand that I may revoke this authorization in writing at any time**.**

Signed_____ Date_____
(Patient OR Custodial Parent/Legal Guardian)