Ear, Nose and Throat and Facial Plastic Surgery, P.A.

Referring Doctor____________________ **Today's Date**_________________

PATIENT REGISTRATION

PATIENT:

First Name____________________ Middle Name____________________ Last Name____________________

Preferred Name to be called (Nickname)____

Mailing Address____________________________ Street Address____________________________

City________________ State________________ Zip Code ______________ County________________

Home Phone (   )____________________ Date of Birth____________ Soc. Sec. #____________________

Cellular Phone (   )____________________ Age____________ Marital Status____________ Sex____________

Employer____________________________________ Occupation____________________________

Employer Address________________________________ Work Phone (   )____________________

PATIENT'S SPOUSE:

Name________________________ Soc. Sec. #____________________________ Date of Birth____________

Employer's Name________________________________ Work Phone (   )____________________

Employer's Address__________________________ City____________ State____________ Zip____________

****EMERGENCY INFORMATION:**
Name of someone not living with you (in case of emergency).

Name____ Phone (   )____________________

Address____ Relationship____________________

- ***PLEASE COMPLETE SECTION BELOW IF PATIENT IS MINOR OR STUDENT***

PATIENT'S FATHER:

Father's Name____________________________________ Father's Date of Birth____________________

Father's Home Address____

Father's Home Phone (   )__________ Father's Work Phone (   )__________ Father's Soc. Sec. #________________

Father's Employer____

Father's Employer's Address______________________ City____________ State____________ Zip____________

Occupation____

PATIENT'S MOTHER:

Mother's Name____ Mother's Date of Birth____________

Mother's Home Address____

Mother's Home Phone (   )_________ Mother's Work Phone (   )_________ Mother's Soc. Sec. #______________

Mother's Employer____

Mother's Employer's Address______________________ City____________ State____________ Zip____________

Occupation____

CLINIC POLICY:

I authorize the Physicians of Ear, Nose and Throat & Facial Plastic Surgery, P.A. (Practice) and its designees to provide treatment and use my Health information for treatment, payment, and healthcare operations (TPO), which includes submitting information to my insurance company for the purpose of processing claims. I further authorize non-Practice labs and radiology centers and Pathologists and Radiologists who may interpret and/or report on diagnostic test ordered by Practice to provide such treatment and use my Health information for billing and payment. I am responsible for payment of services rendered to me by Practice. If I am 18, parent/guardian requesting treatment assumes responsibility. Full payment is due at the time of service unless I am covered by an accepted insurance or third party coverage plan. I understand that if my account should ever require action by a collection agency or attorney in order to collect the balance owed, fees charged by these agents may be added to my balance due on my account.

I hereby acknowledge and agree to accept the policies stated above.

Signature____ Dated:____________________

(Signature is required for all patient or responsible parties)

AUTHORIZATION

Insurance and/or Medigap ☐

I, the undersigned, authorize payment of medical benefits to this physician, South Mississippi Anesthesia Associates and Hubcare Pathology for any services furnished to me by the physician. I understand I am financially responsible for any amount not covered by my insurance policy. I also authorize you to release to my insurance company information concerning health care advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

Date__________________________ Signed__________________________ *Lifetime Signature

Medicare ☐

I, the undersigned, understand that this clinic accepts assignment of Medicare. I agree to be responsible for my deductible and/or any uncovered charges as well as 20% of the allowance of covered services. I request that payment of authorized Medicare benefits be made either to me or on my behalf to this clinic, South Mississippi Anesthesia Associates, Hubcare Pathology for any services furnished me by the clinic, South Mississippi Anesthesia Associates and Hubcare Pathology. I authorize any holder of medical information about me to release to The Health Care Financing Administration and its agents any information needed to determine these benefits or benefits payable for related services.

Date__________________________ Signed__________________________ *Lifetime Signature

Medicaid ☐

I agree to be responsible for any service not covered by Medicaid. I request that payment of authorized Medicaid benefits be made on my behalf to this clinic, South Mississippi Anesthesia Associates, Hubcare Pathology for any services furnished me by the clinic, South Mississippi Anesthesia Associates and Hubcare Pathology. I authorize any holder of medical or other information about me to release to the Division of Medicaid or its Fiscal Agent any information needed to determine these benefits or the benefits payable for related services.

Date__________________________ Signed__________________________ *Lifetime Signature

I assume full responsibility for the bill incurred. I understand that payment is due at the time services are rendered. I further understand that in the event of returned check, a $30.00 fee will be assessed. I also understand and agree if this account goes into default I will be responsible for all court costs, attorney fees and collection fees, which will total 35% of the balance of the account at the time of default.

I have read the financial policy. I understand and agree to the terms above.

______________________________ ______________________

Signature of patient or responsible party Date

I hereby acknowledge that I have received and had an opportunity to ask questions in regards to Ear, Nose and Throat & Facial Plastic Surgery, P.A.'s Notice of Privacy Practices.

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Signature of patient or responsible party Date

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Relationship to patient, if not patient

I gave patient the NPP form. ______________ Employee's Initial