Albany ENT

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Patient's Name: _____ **SS #:** _____
First Name MI Last Name

Date of Birth: _____ Male __ Female __ Single __Married __Widowed __ Divorced __ Separated __

Street Address: _____ **City/State/Zip Code:** _____

Home Phone#: _____ **Cell Phone#**: _____

Employer: _____ **Work Phone w/Area Code:** _____

If patient is a minor, are parents __Married __Divorced **If parents are divorced, who does the child live with?** _____

Mom's name: _____ **Cell Phone#:** _____ **Work Phone#:** _____

Father's name: _____ **Cell Phone#:** _____ **Work Phone#:** _____

Guarantor (Financial Responsible Party): _____

Guarantor address and phone # (if different from patient) _____

Relationship to patient: _____ **Guarantor DOB:** _____

In case of emergency, contact (not living with you): _____

Phone Number w/Area Code: _____ **Relationship to Patient:** _____

Pharmacy name and location: _____ **Primary Care Physician**: _____

Referring Physician's Name & Phone Number:_____

PLEASE PRESENT INSURANCE CARD(S) & PHOTO ID FOR COPYING

- **I hereby authorize the payment of medical benefits to Albany Ear Nose Throat Sinus and Allergy Clinic LLC for services rendered. I understand that I am financially responsible for any services not covered by my insurance carrier.**
- **I further agree to pay all collections costs, attorney fees, and other collections costs that may be incurred to enforce the collection of any amounts outstanding.**
- **I hereby authorize Albany Ear Nose Throat Sinus and Allergy Clinic LLC to release any medical information necessary to complete and process my insurance claims.**
- **I authorize the providers at Albany Ear Nose Throat Sinus and Allergy Clinic LLC to treat me and use my personal health information for healthcare operations**.

>>_____ _____
>>*Patient's Signature* (OR parent if patient is a minor) Date

Financial Policy

The following sets forth the general billing policy of Albany Ear Nose Throat Sinus and Allergy Clinic, LLC. Please review this information and sign where indicated.

- I understand that it is my responsibility to provide the office with current and accurate billing information at the time of check in and to notify office staff of any changes in this information.

- I understand that it is my responsibility to know my specialist co-pay (which can be different than my Primary Care co-payment) and to pay it prior to services being rendered. I understand that this is a contractual agreement that I have with my health plan and that the clinic also has a contractual agreement with my health plan to collect co-pays at the time of service, and they are required to report to the carrier any enrollees failing to pay the co-pay.

- I understand that if I present an insufficient funds check (NSF check) for payment on my account that I will be charged a $35 NSF fee. I further understand that to rectify my account, I will be required to pay with either cash, a money order, cashier's check, or credit card.

- I understand that the office will verify my insurance eligibility, deductible amounts, and coinsurance amounts prior to any elective surgery that I may have. I further understand that it is the policy to collect the deductible and/or coinsurance prior to scheduling my elective surgery. I further understand that THE FEE I AM QUOTED IS AN ESTIMATE based on 1) anticipated surgery to be performed and 2) current information provided to clinic by my insurance carrier.

- I understand that I will be billed for any amounts due by me (co-payments/coinsurance amounts/ deductibles) and that I have a financial responsibility to pay these amounts. I understand that I will be provided with two (2) statements for any balance due after insurance payment. I further understand that if I have not made payment prior to the second statement being mailed, that the second statement will be marked as "Final Notice" and may be sent to an outside collection service if I do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest or legal expenses associated with the collection efforts.

- I understand that the clinic will obtain the necessary prior authorizations prior to rendering treatment. I further understand that prior authorization is not a guarantee of payment, and that I am responsible for any bills not paid by my insurance carrier.

My signature below confirms that I have read these billing policies and my financial obligation as pertains to the providers of **Albany Ear Nose Throat Sinus and Allergy Clinic LLC.**

_____ _____

Legal Signature Date

_____

Relationship to Patient