

Date _____

Ear, Nose & Throat Associates
2801 Westhill Drive • Wausau WI 54401

SECTION I

PATIENT INFORMATION

Last Name _____ First Name _____ Initial _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Leave Message? Y N Cell Phone _____ Leave Message? Y N

Birthdate _____ Sex M F Social Security Number _____ Marital Status _____

Employer _____ Address _____

City _____ State _____ Zip _____ Phone _____ Ext. _____

Email Address _____

Referral Source _____ Family Physician _____

ALTERNATE CONTACT

Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____ State _____ Zip _____

Relationship to Patient Spouse Parent Child Friend Other _____

Home Phone _____ Leave Message? Y N

Other Phone _____ Leave Message? Y N

SECTION II

INSURANCE INFORMATION

*** PLEASE PRESENT ALL APPLICABLE INSURANCE CARDS TO THE FRONT DESK ***

****Primary Insurance**** _____ Address _____

City _____ State _____ Zip _____

Phone _____ Subscriber Name _____

Subscriber Birthdate _____ Subscriber SS# _____

Subscriber I.D.# _____ Group Number _____

Employer _____ Address _____

City _____ State _____ Zip _____ Phone _____ Ext. _____

****Secondary Insurance**** _____ Address _____

City _____ State _____ Zip _____

Phone _____ Subscriber Name _____

Subscriber Birthdate _____ Subscriber SS# _____

Subscriber I.D.# _____ Group Number _____

Employer _____ Address _____

City _____ State _____ Zip _____ Phone _____ Ext. _____

(Continued on side 2)

SECTION III

AUTHORIZATION AND POLICY INFORMATION

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize this office to release any information necessary to expedite all types of insurance (including Medicare) claims. I authorize payment (including Medicare benefits) to be made directly to the physician for any services or supplies furnished by that physician. I understand I am responsible for all charges regardless of insurance coverage (excluding Medicare and Medicaid).

PAYMENT POLICY

I understand Co-pays are due at the time of service. I understand that unmet deductibles (up to \$250) will be collected at the time of service and any amounts greater than \$250 will be billed to me or the responsible party. I understand that all uninsured patient services will be discounted 15% with an additional 5% bonus discount given to those paying the full balance at the time of service. I understand that a minimum of 50% of the estimated balance is due at the time of service. I understand payment plans are available for those with special circumstances and that rules and conditions apply. I understand that prior bad debts with ENT (sent to a collection agency) must be paid in full before further care will be provided.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

In accordance with HIPAA (Health Insurance Portability & Accountability Act), I have been provided and/or offered a copy of the Ear, Nose and Throat Associates Privacy Notice. I understand the notice may also be found on their website at www.entwausau.com

SIGNATURE

DATE

SECTION IV AUTHORIZATION TO RELEASE HEALTH INFORMATION

I understand that ENT Associates will not provide any Protected Health Information (PHI) to unauthorized individuals without the written consent of the patient (or the adult parent or guardian of a minor).

I understand that I must personally authorize the individuals or organizations I want to have access to my private medical and personal information.

(Place an "X" next to the information you want released to the individuals below)

___ I **authorize** release of **all PHI except** that which relates to **mental health, alcohol, drug abuse, developmental disability or HIV test results.**

___ I specifically **authorize** release of PHI relating to **mental health, alcohol, drug abuse or a developmental disability.**

___ I specifically **authorize** disclosure of **HIV test results.**

I authorize the following individuals to access my private medical and personal information:

1. _____ 2. _____ 3. _____
(name / relationship) (name / relationship) (name / relationship)

Patient Signature, Parent/Guardian Signature

Date