Ear Nose and Throat Consultants of East Tennessee, P.C
Patient Information Sheet

Date: _____

First Name: _____ M.I. ___ Last: _____

Address: _____

City: _____ ST: _____ Zip: _____

Sex: M/F Marital Status: M S D W

Home Phone: (___) _____ Cell: (___) _____ Work: (___) _____

Birth Date: _____ Age: ___ **Social Security Number:** _____

Employer: _____

Position: _____ Student: Y/N

Is patient's condition related to: Employment? (Current or Previous) Y/N

Auto accident? Y/N (date of accident): _____

Other accident? Y/N (please describe): _____

Referring Physician: First: _____ Last: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Spouse/Guardian Name: _____ Relationship: _____

Address: _____ Phone: _____

Employer: _____ Work Phone: _____

Primary Insurance Name _____

Insured Person (if not self): _____

Relationship: _____

Insured address (if different from patient): _____

City: _____ State: ____ Zip: _____

Birth Date: _____ Social Security number: _____

Insured Employer: _____

Secondary Insurance Name _____

Insured Person (if not self): _____

Relationship: _____

Insured address (if different from patient): _____

City: _____ State: ____ Zip: _____

Birth Date: _____ Social Security number: _____

Insured Employer: _____

Turn Page Over

Medical Records Release, Financial Policy and Receipt of Privacy Notice

I authorize the release of any medical or other information necessary to process a claim for medical related services provided to patient. I also request payment of all medical benefits, including government benefits, to the attending physician. I understand that I am financially responsible to the physician for charges not covered by the patient's insurance. All copayments, coinsurance, and payment for services not covered by patient's insurance policies are expected at the time of service. Please allow receptionist to copy all insurance cards for our files.

Please bring your insurance card(s) with you to every appointment. It is your responsibility to inform the front desk of any changes in insurance coverage or when the claim should be billed to a Medpay (auto insurance), liability insurance company or worker's compensation company rather than your regular primary insurance due to cause for treatment. We will file your insurance claims for you, unless you instruct us otherwise.

All copayments, deductibles, coinsurance, and payment for services not covered by patient's insurance policies are the responsibility of the patient and may be expected at the time of service. If you have Medicare and you receive a service that Medicare may deem as "medically unnecessary" according to HCFA payment guidelines, you will be required to sign a waiver (advanced beneficiary notice) prior to treatment and will be responsible for payment at the time of service.

We are obligated under many of the managed care contracts to report patients who repeatedly refuse to pay copays and deductibles at the time of service or who repeatedly "no show" for appointments. Please know that if you are reported, you could possibly lose your health care benefits. You may contact your employer's human resources department for further clarification of your benefits and obligations.

If you make an overpayment on your account for a particular service, a refund will only be issued if there are no other outstanding debts on your account or on any other account containing the same guarantor or financially responsible party. Patient balances unforeseen at the time of service will be billed to the address you have provided for billing purposes. It is your responsibility to inform us of any change in address, phone or employment. All balances are due in full within 14 days of the billing date. If you cannot pay the balance in full within 14 days, please contact our office to see if you qualify for any special payment arrangement options. Once an account has been turned to a collection agency, we are not at liberty to arrange a payment plan with you.

Failure to meet your financial obligations may result in reporting you to the credit bureau, filing for a judgment in small claims court or other collection action against you. You may also be terminated as a patient of ENTCET. All attorney fees, court costs and other expenses related to collecting your account will be added to your outstanding balance. A $25.00 service charge may be added for each returned check.

I acknowledge that ENTCET made available to me its Notice of Privacy Practices dated 9/23/13

I have read, understand and will comply with ENTCET's Financial Policy above.

Signature: _____

Print Name: _____

Date: _____