ENT specialists
otolaryngology head & neck surgery

Personal Information:

Today's Date: _____ Account #: _____ SSN: _____

First Name: _____ MI: _____ Last Name: _____

Address: _____

Zip Code: _____ City: _____ State: _____

Date of Birth: _____ Age: _____ Sex: _____ Marital Status: _____

Primary Phone #: _____ Mobile #: _____ Work #: _____

Email: _____ Employer: _____

In the event of an emergency please contact:

Name: _____ Relationship: _____ Phone #: _____

Minor Patients: Name of Parent/Guardian _____

Who Referred you? ☐Physician ☐Family ☐Friend ☐Phone Book ☐Insurance Co. ☐Other _____

Referring Physician's Name: _____ Phone #: _____

Address: _____

Insurance Information:

Please present your insurance card(s) to the receptionist. Please give complete information.

Primary Insurance: _____ Insured's Name: _____

Patient's Relationship to Insured: ☐ Self ☐Spouse ☐Child ☐Other

Policy #: _____ Group#: _____

Employer: _____ SSN: _____ DOB: _____

Secondary Insurance: _____ Insured's Name: _____

Patient's Relationship to Insured: ☐ Self ☐Spouse ☐Child ☐Other

Policy #: _____ Group #: _____

Employer: _____ SSN: _____ DOB: _____

Release of Medical Information:

By signing below, I authorize the doctors and staff at ENT Specialists to disclose my protected health information, including but not limited to appointment times, office notes, diagnostic tests, and lab results, to the below-named persons (e.g., spouse or parent). This authorization shall be effective until I revoke it in writing.

Individual #1 _____ Individual #2 _____

Relationship to Patient _____ Relationship to Patient _____

Notice Regarding Insurance Claims/Payments:

I am responsible, regardless of insurance coverage, for payment of all rendered services. I am responsible for copayments, deductible amounts, co-insurance, non-covered services, or services deemed as "non-medically necessary" by my insurance carrier. **I understand co-payments are due at time of service**. I am responsible for providing correct/updated insurance information so this office can bill my insurance. I understand that interest will accrue on all amounts 30 days and older at the rate of 18% annually until paid in full. If any amounts are referred to a third party collection agency, I am responsible for a collection fee of up to 40% of the principal amounts owing as allowed by Utah Code Annotated, sec. 12-1-11 in addition to any other amounts, such as interest or court costs. **I understand that some medical services performed in the office (audiology tests, CT scans, scopes, etc.) are billed separately from the office visit.**

A 24 hour cancellation notice is needed to avoid a $25 "NO SHOW" charge.

By signing below, I acknowledge that I have read the Financial Policy above and agree to abide by its guidelines.

Patient/Guardian Signature: _____ **Date:** _____