THE CENTER FOR ENT
Sinus + Allergy + Hearing

# Patient Registration Form

| Patient Information | | | | | |
|---|---|---|---|---|---|
| Last name, First name, MI | | | Referring Physician: | Marital Status:<br>☐Single ☐Mar ☐Div ☐Sep ☐Wid | |
| DOB: | Age: | Drivers Lic.#: | Primary Language: | Gender: | Race: |
| Address: | | | City: | State: | Zip Code: |
| Home phone: | Mobile Phone: | | Email: | | |
| Employer: | | | Phone: | Fax: | |
| Address: | | | City: | State: | Zip Code: |
| Emergency Contact: | | | Phone: | Relation: | |
| Primary Care Physician: | | | Phone: | Fax: | |
| Other Contacts: (List other people who we may inform about your health information) | | | | | |

| Primary Insurance | | Secondary Insurance | |
|---|---|---|---|
| Primary Insurance: | | Secondary Insurance: | |
| Subscriber Name: | DOB: | Subscriber Name: | DOB: |
| Policy #: | Group #: | Policy #: | Group #: |
| Employer: | | Employer: | |

## Medical History

| Last name, First name, MI | | | Date: |
|---|---|---|---|
| Reason for appointment: | Height: | Weight: | Pregnant? ☐No ☐Yes<br>Breastfeeding? ☐No ☐Yes |
| Current Medications: | | | |
| | | | |
| Medication Allergies? ☐No ☐Yes (list medication and reaction) | | | |
| | | | |
| Pharmacy Name/Location: | Phone: | | Fax: |

**Medical History**

| | | | |
|---|---|---|---|
| ☐ Sinusitis | ☐ Bleeding Disorder | ☐ Gastric Reflux (GERD) | ☐ Stroke |
| ☐ Allergy/Asthma | ☐ Cancer | ☐ Heart Disease | ☐ Thyroid Disorder |
| ☐ Hearing Loss | ☐ Diabetes | ☐ Hypertension | ☐ Other |

Explanation:

**Surgeries** (include year)

**Family History** (Serious Illnesses)

| Mother: | Sibling: |
|---|---|
| Father: | Child: |

**Social History**

| Occupation: | Tobacco Use: ☐No ☐Yes<br>____packs/day ____years | Alcohol Use: ☐No ☐Yes<br>_____drinks/week |
|---|---|---|

| **Currently**, which symptoms do you have? | | ☐ skin rash | ☐ sinus congestion | ☐ muscle/joint pain |
|---|---|---|---|---|
| ☐ seasonal allergies | ☐ shortness of breath | ☐ sensitivity to cold | ☐ heartburn | ☐ headache |
| ☐ cough | ☐ fever | ☐ hearing loss | ☐ bruise easily | ☐ blurred vision |

THE CENTER FOR ENT
Sinus + Allergy + Hearing

## Financial Policy

**Insurance:** We participate in most insurance plans. Please provide a photo identification and current insurance card so that we may verify your insurance policy. Coverage may vary if you are using out-of-network benefits. Co-pays, which apply to office visits, are due at the time of the visit. Any additional tests or procedures performed during the visit may apply to your deductible. We will submit your claim and assist you in any way to complete the processing of your claim. Most services are covered by your insurance policy; however, some services may be considered as non-covered. It is important that you know your insurance benefits. You authorize assignment of benefits to the Center for ENT until cancelled in writing. You will be responsible for deductibles, non-covered services and any remaining balances.
**Medicare**: We are participating providers with Medicare. We will also file with your secondary or supplementary policy.
**Self-Pay:** For patients not using insurance, a $200 deposit will be due at check-in. This deposit will be applied towards the actual charges at check-out. Any remaining balance will be due at check-out; overages will be refunded.
**Contracted Managed Health Care:** (HMO's, PPO's, EPO's) It is your responsibility to make sure that the Physician(s) you will see is currently enrolled with your plan. All necessary referrals must be obtained prior to each visit. If a referral is not completed or obtained prior to your appointment, it may result in a delay or possibly rescheduled.
**Worker's Compensation:** We do NOT accept Worker's Compensation as of 07-01-2002.
**Minors/Unaccompanied Minors:** The parent accompanying a child of a divorced family will be responsible for payment of charges incurred for the date of service regardless of insurance or divorce decree status.

### Additional Policies

**Surgery Scheduling:** A $100 scheduling deposit is required to reserve a procedure/surgery. This will be applied to your final balance. If surgery is cancelled within 7 days of the surgery, the fee is non-refundable.
**Allergy Testing**: A $25 scheduling deposit is required to reserve your time for allergy testing. This will be applied to your final balance. If your allergy test is cancelled within 3 days of the testing, the fee is non-refundable.
**Missed Appointments:** Please contact the office 24 hours in advance of any cancellation. If you arrive >20 minutes late for an appointment, we may have to reschedule your appointment. Missed appointments will incur a $25 fee.
**Form Fees:** Additional paperwork beyond of the completion of the medical record, including forms such as FMLA, disability and immigration, will be completed for $25. Copies of your medical record will be provided to you for $25.
**Collection Fees, Bank Fees, and Credit Reporting:** Accounts more than 90 days old are subject to a 40% collection fee. Uncleared checks are subject to any bank fees with a minimum charge of $50.

### Physician Disclosure of Financial Interest

Center for ENT physicians may refer you to one or more ancillary services including, but not limited to, Apnix Sleep Diagnostic, Memorial Herman Surgery Center Kirby, OakBend Surgery Center River Oaks ("ancillary services"). You are advised that your physician may have an indirect ownership interest in such ancillary service and therefore will receive, directly or indirectly, remuneration as a result of such referral. This information is being provided to help you make an informed decision about your health care. Should your physician at any time refer you to any of the above referenced ancillary services and you prefer to use a different health care provider, you will be advised of alternative health care providers that you may choose. You will not be treated differently by your physician or the physician's staff if you choose to use a different health care provider.

## Notice of Privacy Practices and Non-Discrimination

You have been provided a copy the Notice of Privacy Practices for The Center for ENT and its Physicians. This notice describes your legal rights regarding your protected health information (PHI) and will inform you of the legal duties and privacy practices. In order to provide effective healthcare, The Center for ENT may contact you via Home Phone or Mobile Phone. Secure Email and Portal eMessages may be used to respond to non-urgent matters. You authorize your PHI to be released to your primary and referring physician. For questions, contact our Practice Administrator. The Center for ENT complies with applicable Federal civil rights laws, does not discriminate on the basis of race, color, national origin, age, disability, or sex, and does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

I consent to the medical treatment for myself, my child or named dependent, for which I am legally responsible. There may be scribes, observers, or others who accompany the doctor. Please notify our team if you are uncomfortable with these people.

**I have read and understood the Center for ENT Policies, Disclosures and Privacy Practices.**

_____ _____
Signature Date