

PATIENT INFORMATION (please print)

TODAY'S DATE _____

Legal Name _____ Birthdate _____ Age _____

Marital Status: (circle) S M W D Sep Social Security # _____ - _____ - _____ Sex: M / F

Address _____ City/State _____ Zip _____

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

Occupation _____ Employer's Name/Address _____

Spouse's Name _____ Birthdate _____ Soc Sec # _____

Work Phone (____) _____ Cell Phone (____) _____ Occupation _____

Employer's Name _____ Employer's Address _____

PARENT INFORMATION –complete if patient is a minor or dependent student

Father's Name _____ Soc Sec # _____ Birthdate _____

Address _____ City/State _____ Zip _____

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

Occupation _____ Employer's Name/Location _____

Mother's Name _____ Soc Sec # _____ Birthdate _____

Address _____ City, State _____ Zip _____

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

Occupation _____ Employer's Name/Location _____

INSURANCE INFORMATION–please give your insurance card(s) to the receptionist for copying

Primary Insurance _____ Secondary _____

Work-related Injury? Y N Related to auto accident? Y N Date of Injury _____

Primary care(family) doctor _____ Address _____

Date of your last visit to your Primary Care Doctor _____

Doctor who sent you to this office: _____

Emergency Contact: Name _____ Phone _____

Has an immediate family member ever been a patient here? Y N Who? _____

How did you hear about our office? Family _____ Friend _____ Doctor _____ Website _____ Radio _____

Please continue on other side)

I authorize Ear, Nose & Throat Center, P.C.(formerly Western Michigan Otolaryngology Associate, P.C.) to release medical information to:

- My (or my minor child's) primary care physician.
- The physician requesting consultation.
- My health insurance carrier, when necessary to process my medical claim.

A copy of this authorization may be used in place of the original.

Date: _____ Signature: _____

I authorize the Ear, Nose & Throat Center, P.C. to give the following people any information on my care when requested by the individual.

I certify that the health insurance information provided to the Ear, Nose & Throat Center, P.C. by myself is valid coverage for this patient. I will be financially responsible for all services provided including:

- All deductibles and copayments assigned by my health insurance.
- Services that are not a benefit of my health insurance plan.
- Services not authorized by my managed care insurance plan (or primary care physicians).
- Any amounts in excess of my insurance payment, in instances where the Ear, Nose & Throat Center, P.C. does not have a contractual, "participating", agreement with my insurance.

A copy of this authorization may be used in place of the original.

Date _____ Signature _____

ENT CENTER HIPPA ACKNOWLEDGEMENT:

I hereby acknowledge that I am aware of HIPPA: (Patient Rights to Privacy Act)
(IF NOT, A BROCHURE WILL BE GIVEN TO ME UPON REQUEST)

Print Patient Name

Sign Patient name or Parent's name if a minor

Date

MEDICARE Notice to Beneficiary

Medicare Part B pays only for services that are determined to be reasonable and necessary under section 1862 (a)(1) of the Medicare law. If a particular service is not reasonable and necessary under Medicare standards, although it would otherwise be covered, Medicare Part B denies payment for that service. We believe that, in your case, Medicare Part B is likely to deny payment for **HEARING TESTS** (audiogram and/or tympanogram), **FACIAL NERVE FUNCTION STUDIES**(Hilger tests), **EARPLUGS** or **HEADBANDS** because Medicare does not pay for these services or supplies.

I have been notified by my physician that, in my care, Medicare Part B is likely to deny payment for the services or supplies identified above, for the reason stated. If Medicare Part B denies payment, I agree to be personally and fully responsible for payment.

Date _____ Signature _____