PATIENT INFORMATION (please print) **TODAY'S DATE**_____

Legal Name_____DOB_____

Social Security # _____-_____-_____ Sex: M F

Address_____City/State_____Zip_____

Home Phone: (___)_____Work Phone: (___)_____Cell Phone: (___)_____

Contact person e-mail address:_____

Occupation_____Employer_____

Spouse's Name_____DOB_____Soc Sec #_____-_____-_____

Work Phone: (___)_____Cell Phone: (___)_____Occupation_____

Employer_____

English speaking person contact name_____Phone: (____)_____

Interpreter needed? Y____ N_____ Language:_____

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

Father's Name_____Soc Sec #_____-_____-_____DOB_____

Address_____City/State_____Zip_____

Home Phone: (___)_____Work Phone: (___)_____Cell Phone: (___)_____

Occupation_____Employer:_____

Mother's Name_____Soc Sec #____-_____-_____ DOB_____

Address_____City/State_____Zip_____

Home Phone: (___)_____Work Phone: (___)_____Cell Phone: (___)_____

Occupation_____Employer:_____

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_____

Date of your last visit to your Primary Care Doctor _____

Doctor who sent you to this office:_____

Emergency Contact: Name_____ Phone:_____

Relationship:_____

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 HIPAA ACKNOWLEDGEMENT:
I hereby acknowledge that I am aware of HIPAA: (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_____