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FELLOW AMERICAN ACADEMY OF OTOLARYNGOLOGY

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FLORIDA ENT ADULT & PEDIATRIC, INC.

OTOLARYNGOLOGY – HEAD & NECK SURGERY – EAR & SINUS SURGERY – FACIAL PLASTIC & SKIN CANCER SURGERY – THYROID SURGERY

DATE_____ **PLEASE PRINT**

P A T I E N T I N F O R M A T I O N

Name (*if patients name appears on card please enter it as it appears on card)*	Sex	Age	Date of birth	Social security #
Last First MI	[ ] M [ ] F		/ /	– –

Mailing Address	Home phone	Cell phone
No. & Street City State Zip		

PHARMACY (Name and Phone Number)	**EMAIL ADDRESS** **Prefered Language:** _____ **Ethnicity:** [ ] Hispanic [ ] Non- Hispanic **Race:** Black White Hispanic Asia Other: _____

F I N A N C I A L I N F O R M A T I O N

Occupation	Marital Status	Emergency Contact	Phone no.
	[]Single []Married []Widow []Separated		( )

Employer Name	Employers address	Business phone
	No. & Street City State Zip	( )

Financially responsible party	Responsible Party if Other Than You		
	Name	Address	Phone Number
[]Self []spouse []Parent []Child []Parent []Other			

P R I M A R Y I N S U R A N C E C O V E R A G E - - - P O L I C Y H O L D E R S I N F O P L E A S E

Policy Holders Information	Policy Number	Date of Birth	Social Security #
Name		/ /	– –

Insurance Company name	Phone Number	Policy Effective Date
	( )	/ /

S E C O N D A R Y I N S U R A N C E C O V E R A G E - - - P O L I C Y H O L D E R S I N F O P L E A S E

Policy Holders Information	Policy Number	Date of Birth	Social Security #
Name		/ /	– –

Insurance Company name & Phone Number	Policy Effective Date
	/ /

So that we may show appreciation - Please indicate how you were referred to this office (provide name where appropriate)

[ ]Doctor_____ [ ]Friend_____

[ ]Advertisement_____ [ ]Phone Book []Your Insurance Company

Name of Physician who requested you to consult us		Name of Family physician	
Name		Name	
Address	Phone	Address	Phone

Please turn this form over … read and sign at the bottom where indicated

When returning this and other paper work to the front desk, please have your Insurance cards and photo ID ready for us to make copies.

Payment of Co/Pays, Co/Insurance are due at the time services are rendered.

We gladly accept Cash, check, Visa, MasterCard, Discover and American Express. There is a $35.00 fee for all returned checks AND credit cards that declined in payment plans

PLEASE READ CAREFULLY BEFORE SIGNING

CANCELLATION FEES

I understand that if I don't cancel my appointment within 24 hours, I will be charged a $25.00 fee for a follow up appointment, a $50.00 for any procedure, and a $100.00 for any surgery. This is for courtesy of other patients trying to make appointments.

FOR OUR HEARING IMPAIRED PATIENTS NEEDING A SIGN LANGUAGE INTERPRETER

If an interpreter is not covered by your insurance, Florida ENT will, at our expense provide an interpreter for your visit. If you must cancel your appointment it is your responsibility to advise us 48 hours before the appointment so that we can cancel the interpreter service. If you do not give notice of cancellation with 48 hours notice you will be billed $90 to offset the cost of the interpreter. This rule is strictly enforced, so BE sure that you talk to a staff member to cancel your appointment.

RELEASE OF MEDICAL RECORDS

I hereby authorize the release of Medical, Psychiatric, alcohol, HIV, testing and/or drug abuse information for insurance carriers or continuing patient care. Any of the classifications above may be crossed off if that information is not to be released.

FEES FOR MEDICAL RECORDS

Florida ENT Adult and Pediatric PA will charge patients for medical records ($5.00 minimum) in the amount of $1.00 per page for the first 25 pages and $.25 for each additional page given to patient or sent on their behalf. (Florida Administration Code, Rule, 64B8-10.003).

INSURANCE ASSIGNMENT

I hereby authorize my insurance benefits to be paid directly to Florida ENT, Adult and Pediatric, PA. I understand and agree that regardless of my insurance status I am ultimately responsible for the balance of my account for any professional services rendered. I understand that any balance of $5.00 or less shall remain as a credit for any future appointments, unless I request a refund in writing.

RESPONSIBILITY FOR INSURANCE CARRIER

I have been informed that it is my responsibility to confirm with my insurance carrier which laboratory or diagnostic facility is approved by them. I also understand that if I have diagnostic testing done at an unapproved laboratory or diagnostic facility, I will be responsible for payments of any charges not covered by my insurance.

CONSENT FOR EVALUATION OR TREATMENT

The undersigned hereby consents to whatever evaluation or treatment the assigned physician may deem necessary to the patient name. I understand it is my responsibility to follow-up as directed by Dr Fadhli, in order to obtain any results of any test ordered by this office.

MEDICARE PART B SIGNATURE AUTHORIZATION – LIFETIME

This paragraph applies to Medicare patients only:

I certify that the information given by me in applying for payment under title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of the intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original. I request that payment of the authorized benefits are made on my behalf. I assign the benefit payable for physician services to submit a claim to Medicare for payment to me.

TO FACILITATE MY TREATMENT

I consent, Florida ENT Adult & Pediatric to obtain Electronic Health Information (eEHx) and Electronic External Prescription Information (EPI) to be imported and exported for my records.

AUTHORIZATION

I hereby authorize any physician or hospital that has treated me in the past to release a copy of my records to Florida ENT Adult & Pediatrics, PA . I also authorize Florida ENT Adult & Pediatrics, PA to release any information in the course of my treatment to (insurance companies, Diagnostic Facilities, Laboratory Facilities, and Other Physicians).

I agree and understand all of the above statements.

X _____

Signature of Patient, Parent, Legal Guardian or Authorized Representative Date