

New Patient Information

Please complete all fields. If any item does not apply, please write N/A.

<p>Patient Full Name: _____ Age _____ Date of Birth _____ Sex _____ SSN _____ Marital Status: _____ Home Address _____ City _____ State _____ Zip _____ Home Phone _____ Cell Phone _____</p>	<p>Referring Doctor's Name: _____ Phone () _____ ***** Primary Doctor's Name _____ Phone () _____</p>				
<p>Patient's Employer: _____ Address _____ City _____ State _____ Zip _____ Phone Number _____ Patient's Occupation _____</p>	<p><u>Complete only if patient is a minor or student</u> Mother's Name: _____ SSN _____ DOB: _____ Occupation _____ Employer _____ City _____ State _____ Phone Number _____ ext _____</p>				
<p>Patient's Spouse _____ Soc. Sec. Number _____ DOB _____ Employer _____ Work phone number: _____</p>					
<p>Emergency Contact: Name _____ Phone _____ Relationship to Patient _____</p>	<p>Father's Name: _____ SSN _____ DOB: _____ Occupation _____ Employer _____ City _____ State _____ Phone Number _____ ext _____</p>				
<p>Who is responsible for payment, if not Patient?</p> <table><tr><td>Name _____</td><td>Home Phone Number _____</td></tr><tr><td>Address _____</td><td>Work Phone Number _____</td></tr></table>		Name _____	Home Phone Number _____	Address _____	Work Phone Number _____
Name _____	Home Phone Number _____				
Address _____	Work Phone Number _____				
<p align="center"><u>Primary Insurance</u></p> <p>Insurance Company Name _____ Subscriber Name _____ SSN _____ Date of birth _____ Subscriber relation to Patient _____ Copay _____ Effective Date _____ Employer _____</p>	<p align="center"><u>Supplemental Insurance</u></p> <p>Insurance Company Name _____ Subscriber Name _____ SSN _____ Date of birth _____ Subscriber relation to patient _____ Copay _____ Effective Date _____ Employer _____</p>				
<p>Authorization: I hereby authorize Kentucky Ear, Nose & Throat to furnish information to insurance carriers concerning my illness/accident and treatment and I hereby assign Kentucky Ear, Nose and Throat all payments for medical services rendered to my dependents or myself. I understand that I am financially responsible for all charges whether or not covered by insurance.</p> <p>Signature of PATIENT or Guardian: _____ Date _____</p>					

Office Policies

We are committed to providing you with the best possible care. In order to better serve you, KENTUCKY EAR, NOSE & THROAT has adopted the following policies. Please read and familiarize yourself with these policies so that future misunderstandings can be avoided. If you have questions, please do not hesitate to speak with the practice administrator.

- 1) If we participate with your insurance plan and it requires a referral, you will be held responsible to obtain a referral prior to your visit. All co-payments will be collected at the time of service. Please refer to your insurance company's provider directory to see if we participate with your plan.

*Please remember. Your insurance policy is a contract between you, your employer and your insurance company. We are not a party to that contract. You are personally responsible for any bill, or portion thereof, not paid by a third party insurance carrier or Medicare. Note: Hearing tests are frequently not covered by Medicare and other carriers.

- 2) If we do not participate with your insurance plan, you will be required to pay in full at the time of service, unless payment arrangements have been made prior to your visit. Our encounter form will serve as a receipt to submit to your insurance carrier.
- 3) We will file all third party insurances for surgical procedures. However, we will require any insurance deductibles and/or co-payments up to 20% be paid prior to the date of surgery.
- 4) For elective procedures not covered by insurance, payment in full is required prior to surgery.
- 5) A service fee of \$25.00 will be assessed for each returned check. Past due accounts may also be subject to attorney's fees, court costs, and other costs of collection.
- 6) In the event of repeatedly missed or broken appointments, the practice reserves the right to discharge a patient from its care.
- 7) For hearing aids dispensed by this office, payment in full is required when you pick up the device. You are entitled to a full refund minus the non-refundable fitting fees for up to 30 days from the time you pick up the aid.
- 8) I will allow photographs to be taken and used at the discretion of Kentucky Ear, Nose & Throat for treatment and educational purposes.

PATIENT'S NAME: _____

I have read the policies above and understand my responsibilities in exchange for medical care provided by Kentucky Ear, Nose and Throat.

Signature: _____ Date: _____

I Have Received The Privacy And Procedures Notice From Kentucky Ear, Nose and Throat.

PATIENT'S NAME: _____ Date: _____

Parent/Guardian Signature: _____