ENT & FACIAL PLASTIC SURGERY SPECIALISTS
OF SHADY GROVE

PATIENT'S NAME (PLEASE PRINT) First, Middle, Last	PARENT SOCIAL SECURITY NUMBER	SEX	DATE OF BIRTH	AGE

HOME ADDRESS CITY, STATE, ZIP CODE	HOME PHONE FATHER CELL: MOTHER CELL:

RACE: American/Alaska Native Indian ( ) White ( ) Black-African American ( ) Hispanic ( ) Asian ( ) Other ( ) _____	**ETHNICITY:** Hispanic or Latin ( ) Not Hispanic ( )	**LANGUAGE:** English ( ) Spanish ( ) Other ( ) _____

EMERGENCY CONTACT	RELATIONSHIP	HOME PHONE	CELL PHONE	BUSINESS PHONE

REFERRING PHYSICIAN	PRIMARY CARE PHYSICIAN

PHARMACY NAME AND LOCATION

RESPONSIBLE PARENT/GUARDIAN EMAIL ADDRESS:

PRIMARY INSURANCE	POLICY ID NUMBER	GROUP NUMBER	EFFECTIVE DATE

POLICYHOLDER'S NAME	RELATIONSHIP TO PATIENT	SOCIAL SECURITY NUMBER	DATE OF BIRTH

EMPLOYER	OCCUPATION	BUSINESS PHONE	EXT

SECONDARY INSURANCE	POLICY ID NUMBER	GROUP NUMBER	EFFECTIVE DATE

POLICYHOLDER'S NAME	RELATIONSHIP TO PATIENT	SOCIAL SECURITY NUMBER	DATE OF BIRTH

EMPLOYER	OCCUPATION	BUSINESS PHONE	EXT

ENT & FACIAL PLASTIC™ SURGERY SPECIALISTS
OF SHADY GROVE

INSURANCE AUTHORIZATION, ASSIGNMENT & OFFICE POLICIES

I request that payment of authorized insurance benefits be made on my behalf directly to ENT & Allergy Specialists of Shady Grove and I authorize them to release to that company any information necessary to determine benefits for services rendered. I understand that I am responsible for charges not covered by this authorization. I permit a copy of this authorization to be used in place of the original.

AND/OR I request that payment of authorized Medicare benefits be made on my behalf directly to ENT & Allergy Specialists of Shady Grove and authorize them to release to the Health Care Financing Administration and its agents any information necessary to determine benefits for services rendered. I understand that I am responsible for charges not covered by this authorization.

I understand that I may be charged $50.00 for not keeping a scheduled appointment or failing to give a 24 hour notice. I understand that there is a charge of $35.00 for returned checks.

I understand that if my Insurance requires me to have a referral, I am responsible for providing a referral at the time of my appointment. If I do not provide a referral, I understand that I will be responsible for all charges billed.

I understand that if I have not met my deductible and co-insurance, I will be responsible for payment of any charges for my visit at the fee schedule rate of my insurance at the time of my visit.

This information is accurate and true to the best of my knowledge. I understand that I am ultimately responsible to pay for services rendered. I understand that I am responsible for charges not covered by this authorization, including reasonable attorney's fees and costs of collection in the event of default.

As a courtesy, we want to remind you that your insurance policy may have a separate deductible and/or coinsurance for certain in-office procedures which may be listed as surgery on your explanation of benefits (EOB), or hearing related testing. I understand that if this applies to my insurance policy I will be responsible for these charges.

By signing below, I am acknowledging that I have reviewed and updated all personal an insurance information. I understand that this review is required annually.

X_____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE