TEXAS ENT CENTER

Physician: (Checkmark) ☐ Stephen White, M.D. ☐ Brandon Christianson, M.D. ☐ Caitlin Oetken, PA ☐ Abigayle Neel, PA

Audiologist: (Checkmark) ☐ Kristin Schmidt, Au.D. ☐ Akhila James, Au.D. ☐ Robyn Culpepper, Au.D.

PERSONAL INFORMATION

Patient First Name: _____ MI: ____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Marital Status: _____ Sex: (Checkmark) ☐ M ☐ F

Primary Phone: _____ (Number you wish to be reached at) _____

Email: _____

May we text you appointment reminders? (Checkmark) ☐ Yes ☐ No If yes, please provide the number: _____

May we leave information, including test results, on your answering machine or voicemail? (Checkmark) ☐ Yes ☐ No

Parent/Guardian Name: _____ Phone No: _____

INSURANCE INFORMATION (THIS INFORMATION MUST BE COMPLETED, EVEN IF WE HAVE YOUR CARD)

Insurance Co: _____ Phone No: _____

ID No: _____ Group No: _____

Claims Address: _____

Name of Policy Holder: _____ Policy Holder Date of Birth: _____

Primary Physician (REQUIRED IF YOU HAVE MEDICARE): _____

Phone No: _____

PHARMACY

Pharmacy Name: _____ Phone No: _____

IN THE EVENT OF AN EMERGENCY, PLEASE CONTACT:

Name: _____ Relationship: _____ Phone No: _____

Who referred you? (Checkmark) ☐ Physician ☐ Family ☐ Friend ☐ Internet ☐ Insurance Co. ☐ Other: _____

Referring Physician's Name: _____ Phone No: _____

MEDICAL AUTHORIZATION

Authorization to disclose protected health information

I authorize Texas ENT Center, PLLC physicians and their staff to disclose my health information to:

_____ _____

Name of Person (e.g., spouse, parent, child, grandparent) Printed Name of Patient

_____ _____

Signature of Patient or Guardian Date

1. Authorization to Release Information:

I authorize Texas ENT Center, PLLC (TENTC) to furnish requested information from the patient's medical and other records to (1) any insurance company or third-party payor for the purpose of obtaining payment on account of TENTC, (2) any other person(s) or entities financially responsible for the patient's care or treatment and (3) representatives of local, state or federal agencies in accordance with law. Such information may include, but is not limited to, information concerning communicable diseases such as acquired immune deficiency syndrome ("AIDS"). I authorize the release of information from or the review of the patient's records for purposes of conducting medical audits, utilization reviews or quality assurance reviews.

2. Assignment of Benefits:

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **It is your responsibility to pay any copay, deductible amount, coinsurance or any other balance not paid for you by your insurance company at the time of your visit.**

IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS AND OFFICE PROCEDURES BE PAID AT THE TIME OF EACH VISIT.

If this account is assigned to an attorney for collection or suit, the prevailing party shall be entitled to reasonable attorney's fees for the costs of collection.

I understand that I am responsible for providing all insurance information at the time of registration to allow for verification of benefits and that regardless of my assigned insurance benefits, I am responsible for the total charges for services rendered.

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and other health plans, to TENTC. This assignment will remain in effect until I revoke it in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges, whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

3. Medicare Assignment of Benefits:

I certify that the information I provided when applying for payment under Title XVII of the Social Security Act is correct. I authorize the release of information concerning me to the Social Security Administration or its intermediaries or carriers, as well as any information needed to file a Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign benefits payable for services to the physician or organization submitting a claim to Medicare for me.

4. Surgery/Procedure Deposit Requirements:

If and when this is needed, I understand that I am responsible for paying a $250.00 surgery deposit to be put on the surgery schedule. I also acknowledge that this is a nonrefundable deposit unless (1) the surgery is performed and (2) all claims are processed appropriately through insurance. If I choose to remove myself from the surgery schedule, I understand that the $250.00 is nonrefundable unless I reschedule within seven days prior to the surgery date and within a 365-day time frame from the pay date.

NO-SHOW POLICY

Our office requires a 24-hour cancellation notice. There is a $50.00 charge for not showing up for scheduled appointments. Repeated cancellations or missed appointments will result in the loss of future appointment privileges.

_____ ☐ Patient under 18 years of age

Printed Name of Patient

_____ _____

Signature (and relationship if not the patient) Date

_____ _____

Translator (Print Name) Translator Signature

_____

Witness