TEXAS ENT CENTER, LLC

PERSONAL INFORMATION

Physician: (please circle) Stephen White, M.D. Brandon Christianson, M.D. Hailey Baird, PA-C

Audiologist: Elizabeth Kehrwald, AUD Kristin Horan, AUD

First Name: ___________________________________ MI: _________ Last Name: ____

Address: ____ Email Address: ____

Zip Code: ________________________City:____ State: _______________

Date of Birth: ________________________Age:_____________ Marital Status: ___________________ SEX: M F

Primary Phone: (number you wish to be reached at) ___________________________________Other:_________________________

May we text you appointment reminders? Yes No If yes, please provide number _________________________________

May we leave information including test results on your answering machine or voicemail? Yes No

Parent/Guardian Name: _______________________________________Phone No: ____

Address: ____

Zip Code: ____________________________City:____ State: ________________

INSURANCE INFORMATION

Insurance Co:____ Phone No:____

ID No:____ Group No:____

Claims Address:____

Name of Policy Holder: ____ Date of Birth: ________________________

PHARMACY

Pharmacy Name:____ Phone No:________________________________

IN THE EVENT OF AN EMERGENCY PLEASE CONTACT:

Name: ____Relationship:____________________Phone No: ___________________

Who referred you? 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, LLC physicians and staff to disclose my health information to:

____

Name of person (*i.e. spouse, parent, child, grandparent*)

____

Printed Name of patient

____ _________________________

Signature of patient Date

Texas ENT Center, LLC

Stephen J. White, M.D.   Brandon L. Christianson, M.D.   Hailey Baird, PA-C
Elizabeth Kehrwald, AUD   Kristin Horan, AUD

4601 Heritage Trace Pkwy
Ft. Worth, Texas 76244

Phone 817-431-7985
Fax 817-431-5031

1. Authorization to Release Information:

I authorize Texas ENT Center, LLC (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 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.

INITIAL ________________

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

I understand that I am responsible for providing TENTC 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/or 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 revoked by me 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:

a. I certify that the information given by me in 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 for filing 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.

INITIAL________________

NO SHOW POLICY

Our office requires a 24 hour cancellation notice. *There is a $50 charge for not showing up for scheduled appointments*.

Repeated cancellations or missed appointments will result in loss of future appointment privileges. **INITIAL ________________**

____
SIGNATURE (AND RELATIONSHIP IF NOT PATIENT)

____
DATE

____
WITNESS

[ ] Patient under 18 years of age

____
Translator (Print Name)

____
Translator (Signature)