Alliance ENT & Hearing Center, S.C.

Registration Form

(Please Print)

Today's date:	Primary Care Doctor:
Pharmacy Name & Location:	

PATIENT INFORMATION

Patient's last name: First: Middle:	Marital status (circle one): Single / Married / Divorced / Widowed

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Driver's License #	Sex: ❑ M ❑ F

Street address:	Home phone no.: ( )	Cell phone no.: ( )

City:	State:	ZIP Code:	Email:

Occupation:	Employer or School:	Employer phone no.: ( )

Race: ❑ White / Caucasian ❑ African American ❑ Asian ❑ Hispanic ❑ Other:

Other family members seen here (name and date of birth):

INSURANCE INFORMATION

If patient is a child:

Father's Name:	Birth date: / /	Address (if different):	Cell phone no.: ( )
Mother's Name:	Birth date: / /	Address (if different):	Cell phone no.: ( )

(Please give insurance cards to receptionist)

Name of Primary insurance:	PO Box to submit medical claims (back of card):

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Policy no.:	Group no.:	Co-payment: $

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of Secondary insurance (if applicable):	Subscriber's Name & date of birth:	Policy no.:	Group no.:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY

Name of friend or relative:	Relationship to patient:	Home phone no.: ( )	Cell phone no.: ( )

All professional services rendered are payable by the patient. The patient is responsible for all fees, regardless of insurance coverage. I hereby authorized Alliance ENT & Hearing Center, SC to furnish insurance companies or their representatives information concerning by illness and treatments and I hereby assign Alliance ENT & Hearing Center, SC all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount my insurance does not pay. If I have Medicare, I request the payment of authorized Medicare benefits made on my behalf to Alliance ENT & Hearing Center, SC for any services furnished me by that provider. I authorize any holder of medical information about me to release to the healthcare financing administration and its agents any information needed to determine the benefits payable for related services. This authorization is in effect until I revoke it.

By signing this form, I acknowledge that I was afforded the opportunity to read and ask questions regarding the HIPAA Privacy Notice

I understand that my PHI (personal health information) will be used as needed for my medical treatment. I have the right to object to this disclosure at any time with a written refusal.

Patient/Guardian signature ***Date***

PATIENT FINANCIAL RESPONSIBILITY

I, _____ understand and agree that services have been rendered for which I am fully responsible, whether or not medical or other insurance should cover the cost of at least a portion of the services rendered. I further understand and agree that in the event that I default on any payments due and owing this doctor for such services, I will pay any and all costs of collection of such payments due and owing, including, without limitation, reasonable attorney's fees, third party collection agency fees, court costs, and any other such costs.

Agreed to as of the date first written below,

Patient/Guardian signature ***Date***

COMMUNICATION OF HEALTH INFORMATION AUTHORIZATION AND APPOINTMENT REMINDER

Patient Name: *Date of Birth:*

I authorize Alliance ENT & Hearing Center, S.C. to contact me via the following methods:
Please check the appropriate boxes – this gives us permission to leave health information (i.e. test results, prescription refills, appointment and billing information).

☐ **Home Phone:**

Leave message on machine? ☐ Yes ☐ No | Leave message with any person who answers the phone? ☐ Yes ☐ No

☐ **Cell Phone:**

Leave message on machine? ☐ Yes ☐ No | Leave message with any person who answers the phone? ☐ Yes ☐ No

☐ **Work Phone:**

Leave message on machine? ☐ Yes ☐ No | Leave message with any person who answers the phone? ☐ Yes ☐ No

❑ **Fax:**

❑ **By Mail (address):** _____

_____

_____

Unless otherwise requested, we may remind you of an upcoming appointment by letter, a telephone call, a message on your answering machine, or voicemail, or a message with the person who answers your telephone. Appointment reminders will include date and time of your appointment, the provider you are scheduled to see and the medical center location. I understand that this will also authorize the release of my information according to the manner stated above.
I understand a written notification is necessary to cancel this request

Patient/Guardian signature ***Date***

Note: Personal representative means the parent, guardian or legal custodian of a minor patient or adult patient.
If you have Durable Power of Attorney, documentation is required before release of information.