PATIENT INFORMATION

Date _______________ **Referring M.D.**___________________________

Last Name: ___________________________________ First Name: _________________________ MI __________

Address: ____________________________________City _______________________ State: _____ Zip___________

Patient's Home # (_____)___________________________ Patient's Work # (____)____________________________

Patient's Birthdate __________________ Age ___________ SS# ___________________________________

Patient is: Male Female Minor Single Married Divorced Widowed (PLEASE CIRCLE)

RESPONSIBLE PARTY/INSURANCE HOLDERS INFORMATION

Responsible For Account? Last name: ________________First_________ Relationship to Patient: _____________

Do you have Insurance? [ ] NO [ ]YES, If yes,

[ ] MEDICARE #________________________________

[ ] MEDICAID Recipient #__________________________ County of ________________________________

<u>Guarantor and/ or Insurance Holder</u>: Last Name: __________________________ First Name: ____________________

Address: ___________________________________City ________________________ State: _______ Zip____________

Responsible Party Home # (______)______________________ Work # (______)______________________________

CELL PHONE # ___________________________________ EMERGENCY PHONE #____________________________

Insurance Holder's Birthdate: ________________Insurance Holders SS# ___________________________________

Insurance Co.: ______________________________ Group # ________________Member #_______________________

Address: _____________________________________ City _____________________State _____ Zip ________________

Employer: ____

Second Insurance Yes [ ] No [ ] Insurance Holder ____

Insurance Holder's Birthdate: ________________Insurance Holders SS# _______________________________________

Insurance Co. _______________________________ Group # ________________Member #_______________________

Employer _________________________________**Second Insurance billed on surgeries & allergy testing only. (Copy of Card required)**

ASSIGNMENT & RELEASE: I, the undersigned, have insurance coverage with __________________________ and assign directly to Midwest Ear, Nose & Throat Consultants, Ltd. all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

___________________________________ ____________________

Patient/Guarantor Signature Date

MEDICARE AUTHORIZATION: I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. ___________________________ for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurance or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

__________________________________ ______________________

Beneficiary Signature Date

MEDICAID: I, the undersigned, understand that claims for services provided will be submitted to Medicaid. In Medicaid assigned cases, the physician or supplier agrees to accept the charge determination of Medicaid as the full charge. The patient/guardian is responsible for charges if Medicaid is terminated, a spend-down has to be met, or charge is a non-covered service.

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Signature of Insured/Guardian Date