

MIDWEST EAR, NOSE, & THROAT, P.A.
CENTER FOR FACIAL PLASTICS

ANNUAL INFO UPDATE: YR/INITIALS _____ / _____ / _____ / _____ / _____ / _____ DATE _____

FAMILY PHYSICIAN _____

REFERRED BY OR REQUEST FOR CONSULT BY _____

How did you hear of us? _____

PLEASE COMPLETE THIS FORM AND BRING IT TO THE REGISTRATION DESK ALONG WITH YOUR INSURANCE ID CARD AND REFERRALS

PATIENT NAME _____
FIRST MIDDLE LAST AGE DATE OF BIRTH

ADDRESS _____
STREET APT # CITY STATE ZIP CODE

ARE YOU CURRENTLY RESIDING IN A NURSING FACILITY? YES ___ NO ___ IF YES, WHAT FACILITY? _____

HOME PHONE(_____) _____ CELL PHONE(_____) _____ EMAIL ADDRESS _____

SS# _____ Drivers License _____ EXPIRES _____

EMPLOYER _____ WORK PHONE (_____) _____

OCCUPATION _____ SINGLE MARRIED WIDOWED DIVORCED MALE FEMALE

SPOUSE'S NAME _____ EMPLOYER _____ PHONE _____

NEAREST RELATIVE NOT LIVING IN YOUR HOME
NAME _____ ADDRESS _____ PHONE _____

(Complete this box ONLY if patient is a minor)
BILLING / RESPONSIBLE PARTY INFORMATION

FATHER'S NAME _____
ADDRESS _____

MOTHER'S NAME _____
ADDRESS _____

HOME PHONE _____
EMPLOYER _____

HOME PHONE _____
EMPLOYER _____

SS# / Date of Birth _____

SS# / Date of Birth _____

Drivers License # _____ Expires _____

Drivers License # _____ Expires _____

INSURANCE INFORMATION

PRIMARY INS _____

SECONARDY INS _____

NAME OF POLICY HOLDER _____

NAME OF POLICY HOLDER _____

Your health insurance program may have limits that will affect your charge at Midwest Ear, Nose & Throat, PA. Some insurance companies will not pay for certain tests or office visits and will be your responsibility. We accept assignment with numerous insurance carriers. Please check with our front desk to identify your insurance carrier. If you do not have insurance through one of these carriers, then you are responsible for submitting claims and payment will be due at the time of service.

I HAVE READ AND UNDERSTAND THE ABOVE, and hereby give my consent to any physician member of Midwest Ear, Nose & Throat, P.A. or designee to provide medical treatment to me encompassing diagnostic and therapeutic procedures.

Patient Signature/ Parent/ Guardian

Date

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**Midwest Ear Nose & Throat, P.A.
Center for Facial Plastics**

The following is a statement of our Financial Policy, which we would like you to read and sign prior to any services being rendered.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area.

SELF PAY

Balance due in full at conclusion of the visit unless other arrangements have been made prior to services.

PARTICIPATING INSURANCE PLANS

In order to properly bill your insurance company and avoid untimely delays, we require that you provide us with your insurance information and allow us to keep a copy of your insurance card on file. For those plans with which we are a participating provider, all co-pays and deductibles are due at the time of service. For those patients requiring a referral form from their primary care physician, please bring the completed and signed referral form at the time of your visit or before any surgical procedure.

NON-PARTICIPATING INSURANCE PLANS

We do require that payment be made at the time of service if you do not have an insurance plan where we are a provider. In addition to cash or check, we accept MasterCard and Visa. We will provide you with an itemized receipt of your charges. This can be used for any insurance claims you want to process after your visit.

SECONDARY INSURANCE

We would be happy to file your secondary insurance if you provide us with the necessary information. If you do not provide us with secondary insurance information, you will be responsible for filing any claims with that insurance.

Thank you for your understanding of this Financial Policy. Please let us know if you have any questions or concerns.

MEDICAL AUTHORIZATION:

I authorize Midwest Ear, Nose, & Throat, P.A. to furnish complete medical information to my insurance or its intermediaries regarding services rendered.

Patient Signature/Parent/Guardian

Date