ESP
ENT SPECIALTY PARTNERS

PATIENT REGISTRATION

Patient Information

Last Name _____ **First Name** _____ **Middle** _____

Date of Birth _____ /_____ /_____ **Age:** _____ **Gender Assigned at Birth:** _____ **Marital Status:** _____

Social Security Number: _____ - _____ - _____ **Email** _____

Address _____ **APT #**_____ **City** _____ **State** _____ **Zip** _____

Cell # (primary) _____ - _____ - _____ Home # _____ - _____ - _____

Employer _____ Work Phone _____ - _____ - _____

Reminder Messages: We have an electronic system that can text, e-mail, or call you to remind you of your scheduled appointments. Messages may include billing reminders. Please select below your preferred reminder option:

☐ Text to mobile # _____ ☐ Email _____ ☐ Leave a Message at #_____

PCP Name: _____ **Referring Physician** _____

How did you hear about us? ☐ Referring Physician ☐ Family/Friends ☐ Social Media ☐ Google/Internet ☐ Other ☐ Insurance

Preferred Language: _____ **Ethnicity**: _____ (Hispanic/Latino or Non-Hispanic or Latino)

Race: ☐ Asian ☐ Black or African American ☐ American Indian ☐ White ☐ Other

Emergency Contact (primary) _____Relationship _____ Phone ____ - _____ - _____ Emergency

Contact _____Relationship _____ Phone ____ - _____ - _____

Pharmacy Name: _____ **Cross Streets** _____
Please note that prescriptions will be sent electronically to the pharmacy you provide. Please let us know if any changes need to be made.

Who are we authorized to speak with? I authorize ENT Specialty Partners, its affiliated physicians and affiliated practices, to release verbally, electronically, and/or in writing my confidential medical information for purposes of treatment, payment of charges, quality assurance and utilization review, transfer and follow-up procedures to my insurance carrier, employer (if treatment is related to employment), any other healthcare providers:

Name_____ Relation _____ Phone _____

Name_____ Relation _____ Phone _____

****Complete This Section ONLY if Patient is under 18 Years Old****

Parent/Guarantor Information (Complete if Patient is under 18 Years)

The parent/guardian accompanying the child to the visit is responsible for payment due at the time of service. Our office staff will not get involved in matters involving third party personal billing as the result of custody, court order, or personal circumstances.
Last Name _____ First Name _____ Date of Birth ____ /____ /_____

Address _____ APT #_____ City _____ State _____ Zip _____

Employer _____ Work Phone _____ - _____ - _____

Cell Phone _____ - _____ - _____ Home Phone _____ - _____ - _____

Relationship to Patient: ☐ Parent ☐ Guardian ☐ Spouse Email_____

****Complete This Section if You Have Medical Insurance****

Primary Medical Insurance

Policy Holder Name_____ | Group #_____

Carrier_____ | Policy Holder Date of Birth _____/ _____/ _____

Member ID #_____ | Relationship to Patient: ☐ Self ☐ Parent ☐ Guardian ☐ Spouse

Policy Holder Address (if different from patient's address) _____

Policy Holder Phone _____- _____ - _____

Secondary Medical Insurance

☐ Not Applicable

Policy Holder Name_____ | Group #_____

Carrier_____ | Policy Holder Date of Birth _____/ _____/ _____

Member ID #_____ | Relationship to Patient: ☐ Self ☐ Parent ☐ Guardian ☐ Spouse

Policy Holder Address (if different from patient's address) _____

Policy Holder Phone _____- _____ - _____

GUARANTEE OF PAYMENT: If insurance is filed on my behalf for charges associated with care provided by ENT Specialty Partners, its affiliated physicians and affiliated practices (ESP), I assign to the provider all payments from 1st party, 3rd party, medical, accident or any other insurance coverage responsible for payment. ESP may use and disclose my healthcare information to an insurance company, 1st party, 3rd party or accident insurance payor for the purposes of payment if a claim is filed on my behalf. I acknowledge that if ESP submits a claim to my insurance carrier, it is done so as a courtesy and that I am ultimately responsible for all charges incurred, unless both parties mutually agree otherwise. I agree that I will pay my estimated out of pocket based on the best available information of my current policy and understand this is only an estimate. While ESP makes every effort to verify my correct insurance information, I understand ESP cannot guarantee the accuracy of my bill until it has been fully processed by my insurance carrier. If insurance is filed on my behalf to a plan that is later discovered to be a limited benefit plan or one that restricts the provider's ability to collect from other sources, I understand and agree that the acceptance of that coverage will be rescinded, and the balance will be pursued from the other source. I understand that if paying by check and it is returned or if a credit card dispute is initiated by me or on my behalf, a processing fee will be assessed. The follow fees are provided by state: Texas- $30, Maryland - $35, District of Columbia - $25 and Virginia- $50. I attest that the information provided to ESP and written herein is true and accurate.

Disclosures

PRIVACY PRACTICES & PATIENT RIGHTS: By signing this form, I acknowledge that a copy of the company's Notice of Privacy Practices and Patient Bill of Rights has been provided to me for review and is available to take home at my request. I am aware the documents may be downloaded anytime on the company website.

ANCILLARY SERVICES: Your provider may recommend diagnostic laboratory tests and/or radiology exams to help aid in the treatment and diagnosis of your condition. Some of these services are not performed in our facility. Laboratory tests may be sent to an outside third-party lab for processing. Radiology exams may be read and interpreted by a third-party. These third-party services may be billed to you by the third-party company. ESP is not responsible for these ancillary charges if determined to be your responsibility.

CONSENT TO TREATMENT: By signing this consent form, I voluntarily consent to the administration, treatment and cost of medical services, surgical procedures, radiology procedures, medication, equipment/supplies, and other ancillary medical services for myself or my dependent. I understand that a copy of this consent form may be used with the same effectiveness as the original.

Patient or Guarantor Signature: _____ Date _____

If Guarantor, Relationship to Patient: _____ Date _____

Please read this Financial Agreement, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

Financial Agreement: I understand my insurance is a contract between myself and my insurance company and it is my responsibility to determine if providers are in network with my insurance. ENT Specialty Partners, its affiliated physicians and affiliated practices (ESP) will bill my insurance as a courtesy to me. I understand that I am responsible for deductibles, copays, noncovered services, coinsurance and items considered "not medically necessary" by my insurance company. I agree to pay copayments, coinsurances and/or deductibles at the time of service. ESP may verify my benefits; however, the final determination will be made by my insurance company at the time of payment. Therefore, any estimate for services will be considered an estimate only and any payment will be considered a partial payment only, until such time as the insurance company processes my claim and determines the final out-of-pocket balance that I will owe. The patient/guarantor is ultimately responsible for any balance on their account.

Insurance: We participate in most insurance plans. If the patient is not insured by a plan we are contracted with, payment in full is expected at each visit. If we discover after the visit that insurance did not pay, patient will be required to pay the balance. If insured by a plan we contract with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify active coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Non-covered services: Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. We will collect payment for these services in full at the time of the visit.

Proof of insurance: All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license (or other government issued identification) and current valid insurance to provide proof of insurance and identity. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly and it is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays your claim or denies coverage. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If do you not provide active insurance information within 45 days of your visit, the balance will be billed to you.

Forms Fee: Please allow 7 - 10 business days to complete all forms that require a physician signature and medical review (FMLA, Short-term Disability [STD], or any other leave of absence forms). The physician must review the form, your medical record and complete the form. A fee maybe charged and must be paid prior to the completion of the form. Medical Record requests are processed by our billing office staff and fees for the release will be addressed at the time the request is received.

_____ **No Show/Cancellation/Multiple Reschedule Fees:** We are committed to making your appointments at the earliest convenience; therefore, we require a
Initial
phone call if you are unable to keep your scheduled appointment. As a specialist, there are certain appointment types, inclusive of in-office procedures and surgeries, that if canceled less than a set number of days, cannot be rebooked due to the requirements for that appointment type. Multiple missed appointments may result in our request that you find another specialist. Depending on the appointment type, a fee may be incurred.

Nonpayment. If your account is past due and we have exhausted our standard collection efforts, you may receive a letter stating that you have 10 days to pay your account in full. Partial payments will not be accepted unless we have agreed to this arrangement. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you, and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Collection Fees and Returned Payments: If you fail to pay on time and we refer your account(s) to a third party for collection, a collection fee will be assessed and will be due at the time of the referral to the third party. The fee will be calculated at the maximum percentage permitted by applicable law. I understand that if paying by check and it is returned by the bank or by credit card and a dispute is initiated by the cardholder, a processing fee will be assessed depending upon state regulations. In Texas the fee would be $30, $50 in Virginia, $35 in Maryland, and $25 in the District of Columbia.

Collection Efforts: I agree to allow ESP and anyone who collects or communicates on ESP behalf to contact me about my account status, including past due or current charges, using prerecorded calls, text messages, email and calls or messages using live, artificial, or prerecorded voices delivered by an automatic telephone dialing system or any other computer-aided technologies to any landline phone, wireless phone number, other contact number or email address I have provided or that I obtain in the future. I further agree that ESP will treat any email address and phone numbers I provide as my private email or phone number that is not accessible by unauthorized third parties. Unless I notify ESP that my wireless service is based in a different time zone, calls will be made to my cellular device during permitted calling hours based upon the time zone affiliated with the mobile telephone number I provide.

Surgery Deposit: If surgery is scheduled, you will be required to pay the estimated surgeon fee no less than 48 hours prior to the surgery date. The estimated deductible and/or co-insurance is a partial payment until such time as the insurance company processes your claim and determines the full amount of patient responsibility. If the procedure includes nasal/sinus surgery, insurance typically assigns a "no post op period" to the procedure therefore any post-op visits may be applied to patient responsibility. If your surgery is canceled in an unreasonably close period to the surgery for a non-medical reason a fee may be assessed.

Referrals: If your medical insurance plan requires a referral for specialist services, you will need the referral from your Primary Care Physician prior to seeing our Specialist. If the referral is generated from the insurance company, you must contact your Primary Care Physician and ensure they contact your insurance to complete this requirement. As a Specialist, our staff cannot generate a referral on your behalf. If your referral is not received prior to your appointment, you will need to reschedule or you will be registered as self-pay and will be responsible for all charges. It is the responsibility of the patient to know if a referral is required by their plan and to assure one is approved prior to being seen.