Center for Ear, Nose, Throat & Allergy, P.C.

Patient Registration *Office Use Only: Pt#*

PATIENT INFORMATION: Date:

Last Name:	Sex: Birthdate: Age:
First Name: Initial:	Marital Status:
Address:	Social Security No:
City/State/Zip:	Occupation: ☐ Fulltime ☐ Part-time
Home Phone:	Employer:
Cell Phone:	Address:
Email Address:	Work Phone:

PERSON RESPONSIBLE FOR PAYMENT: (For minors, person presenting patient for treatment.)

Name:	Relationship to Patient:
Address:	Social Security No.: Birthdate:
City/State/Zip:	Phone: Home Work
Cell Phone:	Email Address:

ALTERNATIVE CONTACT (For minors, please list other parent)

Name:	Relationship to Patient:
Address:	Phone:
City: State: Zip:	Work Phone:
Cell Phone:	Email Address:

REFERRING INFORMATION: How did you learn about us?

Referring Dr:	Family Doctor:
Address:	Address:
City/State/Zip:	City/State/Zip:
Phone:	Phone:
Other: ☐ Insurance Co. ☐ Yellow Pages ☐ Physician Referral Service ☐ Friend/Family ☐ Other:	

PRIMARY INSURANCE COMPANY:	***SECONDARY INSURANCE COMPANY:***
Insur Co:	Insur Co:
Address:	Address:
City/State/Zip:	City/State/Zip:
Plan Info:	Plan Info:
Policy Holder:	Policy Holder:
Sex: Birthdate:	Sex: Birthdate:
Policy Holder Soc Sec No:	Policy Holder Soc Sec No:
Employer:	Employer:
Policy No &/or Group No .:	Policy No &/or Group No.:
Patient Relationship:	Patient Relationship:

AUTHORIZATION & ASSIGNMENT:

I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services or any other insurance company and its agents, any information needed to determine these benefits or benefits for related services. I further request that payment of authorized Medicare, Medigap, or any other insurance company benefits be made on my behalf directly to Center for Ear, Nose, Throat & Allergy, for any services furnished to me by my physician. I acknowledge responsibility for payment of any deductibles, co-insurance, and non-covered services. This authorization is valid until revoked by me or my legal representative. A photocopy of this authorization shall be considered as valid as the original. If for any reason the account should become delinquent, I agree to pay for all collection and legal fees.

Patient or Legal Representative Signature: ____ Date: _________________

********PLEASE SEE REVERSE SIDE ********

CENTER FOR EAR, NOSE, THROAT & ALLERGY, P.C.
Scheduling Phone Numbers 317-926-1056 or toll free 800-283-1056

NO-SHOW POLICY

We ask that you notify our office by 2:00 pm one working day before your appointment if you need to cancel. In the event you cannot keep an appointment for a PET scan, please call Meridian North Imaging Center by 2:00 pm one working day prior to your appointment. We understand that there will be situations that involve medical emergencies or that are weather related. Failure to do so will result in the following charges applied to your account. These fees cannot be billed to your insurance carrier and must be paid before any new appointments can be made for you. Continued no-show/no-call events may result in your dismissal from our practice. Medical care will not be withheld in the event of an emergency.

- $25.00 - Office visit No-Show
- $50.00 - Office procedure No-Show
- $50.00 – Hearing Aid Evaluation No-Show
- $250.00 - PET Scan No-Show scheduled at Meridian North Imaging Center (aka Northwest Radiology). *The reason for this higher fee is that there is a special injection given for PET Scans. The chemical given in the injection must be specially ordered for each test and lasts only one (1) day and cannot be returned. The fee covers the cost of the chemical.*

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been offered a copy of Center for Ear, Nose, Throat & Allergy Notice of Privacy Practices.

FINANCIAL POLICY

I hereby acknowledge that I have reviewed the Center for Ear, Nose, Throat & Allergy Financial Policy and agree to its terms.

RELEASE OF MEDICAL INFORMATION

It may be necessary in the course of your medical evaluation and treatment for your physician to review the results of diagnostic tests or procedures, such as lab work or x-rays, ordered by other physicians. In this era of heightened concern about the confidentiality of medical information, we are being asked more frequently for a written authorization from the patient before this information will be released to us. Therefore, by signing below, you are giving a hospital, clinical laboratory, radiology facility, or other medical provider who has information pertinent to the diagnosis and treatment of the condition for which you have consulted our physicians, permission to release that information to Center for Ear, Nose, Throat & Allergy.

FINANCIAL INTEREST DISCLOSURE

The Physicians of Center for Ear, Nose, Throat & Allergy P.C. have financial interests in the following entities: Surgery Center of Indianapolis, Surgery Center of Carmel, Naab Rd. Surgery Center, Indianapolis Regional P.E.T. Scan and Meridian North Imaging Center. As a patient of the Center for Ear, Nose, Throat & Allergy P.C you may be referred to these facilities to received medical services. You may however, choose to be referred to another health care facility to receive these services.

IDENTITY THEFT PREVENTION AND ACTION POLICY

CENTA strives to prevent the intentional or inadvertent misuse of patients' names, identities, indentifying information, and medical records. CENTA will report any criminal activity relating to identity theft and theft of services to appropriate authorities and will take steps to correct and/or prevent further harm to any person whose name or other indentifying information is used unlawfully or inappropriately.

ACKNOWLEDGEMENT AND AUTHORIZATRION

By signing below, I am stating that I have read, understand and agree to the above listed policies and notifications.
A photocopy of this authorization shall be considered as valid as the original

Relationship to patient: _____ Same _____ Parent _____ Legal Guardian

Print patient name ____ Patient Date of Birth__________________

Signature X____ Date ______________________
Patient and/or Responsible Party

(REVISED 7.13.09)