

METRO ENT & FACIAL PLASTIC SURGERY
a division of Centers for Advanced ENT Care, LLC

Annette M. Pham, M.D.

PLEASE PRINT CLEARLY

■ **Patient Information**

Today's Date: _____

Name (Last, First, Middle) _____

Sex: M F

Birth Date _____ Occupation _____

Home Phone _____

Email address _____

Cell Phone _____

Address _____

Work Phone _____

City _____ State _____ Zip _____

Last 4 digits of Social Security #: _____

Check if Minor (less than 18) Marital Status: Single Married Partner Divorced Widowed Separated

Emergency Contact _____ Relationship _____ Phone _____

Who Referred You to Our Office? _____ If this is your Primary Care Physician, please
give address: _____ Phone _____

If not, your Primary Care Physician is _____ Address _____

Have you seen an ENT in the past 3 years? _____ If so, who? _____

Preferred Pharmacy Name _____ City & State _____

■ **Primary Insurance**

Insurance Company _____

Insurance ID # _____ Group # _____

Please enter the policyholder's information below. If you are the policyholder yourself, check this box and skip to the next section.

Policyholder's Name (Last, First, Middle) _____

Relationship to Patient _____ Birth Date _____

Address _____ Home Phone _____

Employer _____ Work Phone _____

■ **Secondary Insurance** *(If not applicable, please cross out section. If you have tertiary insurance, please ask the receptionist for another page.)*

Insurance Company _____

Insurance ID # _____ Group # _____

Please enter the policyholder's information below. If you are the policyholder yourself, check this box and skip to the next section.

Policyholder's Name (Last, First, Middle) _____

Relationship to Patient _____ Birth Date _____

Address _____ Home Phone _____

Employer _____ Work Phone _____

■ **Assignment and Release**

I hereby authorize payment directly to Metro ENT & Facial Plastic Surgery division of Centers for Advanced ENT Care of all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered for me or for my dependents. I authorize the doctors and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits, to my insurance company, or to the Maryland Insurance Commissioner. In addition, I also authorize the use of this signature on all my insurance submissions. I also agree that a photocopy of this form may be used in lieu of the original. I have read and agreed to the above.

Signature: _____ Date: _____

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above, and fill in the information below.

Parent/Guardian Name (print): _____ Relationship to Patient: _____

Print Name: _____

Date of birth: _____

RACE

- American Indian or Alaska Native
- Asian
- Native Hawaiian or Other Pacific Islander
- Black or African American
- White
- Hispanic
- Other Race _____
- Refused to Report

LANGUAGE

- English
- Spanish
- Chinese
- Vietnamese
- Russian
- Other _____

ETHNICITY

- Hispanic or Latino
- Not Hispanic or Latino
- Refused to Report

METRO ENT & FACIAL PLASTIC SURGERY
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BILLING and COLLECTION POLICIES

Our goal is to provide you with high-quality and efficient care. There are many details involved in the process of payment for the services that you receive. In order for this process to flow smoothly, it is essential that you understand what information we must share with each other and with health insurance companies, and what both our responsibilities are.

Upon scheduling and registration we require you to provide your medical insurance card (if you have coverage), photo identification, your address, date of birth, and phone number. If you receive health benefits through a spouse, partner or parent, we require you to provide that person's address, date of birth, and phone number as well.

Health Insurance Cards: Upon scheduling each appointment, our team will ask to verify your insurance information, and will ask for your insurance card upon check-in at each appointment. Please bring your card to every appointment, and notify the office if there are any changes. Intentionally failing to notify us of changes to your insurance coverage may constitute fraud, and we may be obliged to report such behavior to the authorities. We will not engage in any fraudulent practices under any circumstances.

Keeping Appointments: Should you not arrive for a scheduled appointment, unless that appointment has been cancelled at least 1 full business day in advance, you may be charged \$25 for each no-show occurrence. Should this occur more than three times within a 12 month period, you may be dismissed from the practice. By signing below, you accept this policy.

Health Insurance Plans: It is your responsibility to understand the provisions of your health insurance plan and coverage. As helpful as we like to be, we cannot be expected to know the details of your particular plan. As a courtesy, we want to inform you that your insurance policy may have a separate deductible and/or co-payment for certain in-office procedures (listed as surgery on you explanation of benefits (EOB) or hearing related testing. If this applies to your insurance policy you will be responsible for these charges.

Authorizations: You are responsible to obtain all necessary referrals, pre-certifications or other required documentation prior to your appointment. If we determine that your plan requires an authorization, and you do not provide such referral, authorization or certification, you may be required to sign a waiver in order to receive services. This waiver includes a credit card authorization, which permits us to charge you for the services rendered at that visit should your health insurance carrier deny payment due to lack of authorization. Additionally, should we fail to request such a waiver, you will nonetheless be responsible for all charges that are not paid by your insurance carrier due to lack of authorization. Should we determine that your plan requires a referral and you decide to reschedule your appointment instead of signing a waiver, you may be charged \$25 for a no-referral cancellation. By signing below, you accept these policies.

Copayments: It is our responsibility, as detailed by the terms of our contracts with health insurance companies, to collect any copayment amounts at the time of your appointment. It is your responsibility, as detailed by the terms of your health insurance coverage, to pay any copayment amounts at the time of your appointment. Please have your payment ready upon check-in. Please be aware that, should you not pay your copayment at the time of service, and should we need to invoice you for that payment, you will be responsible to pay an invoice fee in the amount of \$10 for each instance we send you an invoice for an unpaid copayment (except for Medicare beneficiaries), including multiple invoice instances for the same occurrence. By signing below, you accept these policies.

Previous balances and/or deductibles: It is our responsibility, as detailed by the terms of our contracts with health insurance companies we participate with, to collect any portion of your treatment that your health insurance carrier assigns to your responsibility. Co-insurance, deductibles, balances and any non-covered services are collected at the time of service. It is your responsibility, as detailed by the terms of your health insurance coverage, to pay any such portion. Understand that you are ultimately responsible to pay for services rendered, including reasonable attorney's fees and 35% of your unpaid balance for the costs of collection in the event of default. You may be dismissed as a patient by our practice for failure to meet your financial obligations. By signing below, you accept these policies.

Health insurance non-payment: Services that have not been paid by your health insurance carrier within 60 days of claim submission will become your responsibility to pay in full. Should your health insurance carrier later pay us for those services you paid for, you will be reimbursed within 30 days. By signing below, you accept this policy.

Self-pay patients: If you do not have health insurance, have coverage through a carrier with which we do not participate, or are receiving a known non-covered service, it is our policy that you must pay for your service in full before leaving the office. Some cosmetic services require a 50% deposit upon scheduling, which may be taken over the telephone and charged to a credit card, and are not refundable. Should your credit card subsequently be declined or charged back, you will still be responsible for the deposit amounts. By signing below, you accept these policies.

Form Completion Request: From time to time, various forms including, but not limited to disability and FMLA forms need to be filled out. There may be a service fee ranging from \$10.00 to \$50.00 to complete these forms.

I have read, fully understand, accept and agree to comply with all the above policies. I consent to the assignment of authorized health insurance benefits by my health insurer to Metro ENT & Facial Plastic Surgery for any services furnished to me or my dependents.

Signature of Patient: _____ Date: _____

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above, and indicate relationship to the patient.

**PRIVACY PRACTICES ACKNOWLEDGEMENT
AND CONSENT FORM**

◆ I have received your Notice of Privacy Practices and/or I have been provided an opportunity to review it.

◆ I agree that telephone messages regarding my appointments, prescription renewals, lab results, and all other Protected Health Information* ("PHI"), may be left for me on voicemail systems and answering machines at the following telephone numbers, in addition to any other numbers provided to you by me:

(___ ___) ___ ___ - ___ ___ Home / Office / Cell / Other: _____
(___ ___) ___ ___ - ___ ___ Home / Office / Cell / Other: _____
(___ ___) ___ ___ - ___ ___ Home / Office / Cell / Other: _____

[If we need to contact you with lab results, please place a check mark next to the preferred contact number, if any.]

◆ I agree that my PHI may be shared with my spouse. Yes No

◆ I agree that my PHI may be shared with the following other people:

◆ I understand that I can change any of the foregoing agreements, at any time, by giving written notice to Metro ENT & Facial Plastic Surgery.

**as defined in the Health Insurance Portability and Accountability Act of 1996 and its regulations, as may be amended from time-to-time ("HIPAA")*

Patient Name (print): _____

Signature: _____ Date: _____

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above, and fill in the information below.

Parent/Guardian Name (print): _____ Relationship to Patient: _____