METRO ENT & FACIAL PLASTIC SURGERY
division of Centers for Advanced ENT Care, LLC
Annette M. Pham, M.D.

PLEASE PRINT CLEARLY

■ Patient Information

Name (Last, First, Middle) _____ Today's Date _____

Birthdate _____ Soc. Sec. # _____ Home Phone _____

Email address _____ Cell Phone _____

Address _____ Work Phone _____

City _____ State _____ Zip _____ Sex: ☐ M ☐ F

☐ Check if Minor (less than18) Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

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 _____ Soc. Sec. # _____ **Birthdate** _____

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 _____ Soc. Sec. # _____ **Birthdate** _____

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. I authorize the use of my signature on all insurance submissions. I authorize a copy of this document to be used in place 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: _____

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. Our billing process works better if you provide social security numbers as well.

Health Insurance Cards: Upon scheduling each appointment, we will ask to verify your insurance information, and will ask to see your insurance card upon check-in at each appointment. Please bring your card to every appointment, and notify the office at your first appointment after if 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 $20 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 your 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 our staff determines 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, and 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, even should our staff 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 our staff determine that your plan requires a referral, you do not have one, and you reschedule instead of signing a waiver, you may be charged $20 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 bill you for any portion of your treatment that your health insurance carrier assigns to your responsibility. 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 35% if your unpaid balance for the cost 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 21 days before scheduled surgery date. 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 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 division of Centers for Advanced ENT Care, 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.

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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 division of Centers for Advanced ENT Care.

**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: _____

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