BAY AREA ENT SPECIALIST
REGISTRATION FORM

Date:

Dr:

*****ONLY THE PARENT OR LEGAL/GUARDIAN CAN BRING A MINOR TO THE APPOINTMENT*****

*****NOTE: THE PARENT WHO BRINGS A CHILD TO THE OFFICE FOR MEDICAL TREATMENT IS RESPONSIBLE AT THE TIME OF SERVICE FOR CO-PAYMENT. CO INSURANCE, DEDUCTIBLES AND ACCOUNT BALANCES*****

PATIENT REGISTRATION

Name (Last):_____(First): _____ (M)_____

Sex: M F Date of Birth:_____ Age: _____ SS#_____

Marital Status: S M Other:_____

Street Address:_____ City:_____State_____Zip_____

Billing Address:_____ City:_____State_____Zip_____

Home Phone:_____ Work:_____Cell:_____

Email:_____ Employer:_____

Family Doctor:_____ Referring Doctor:_____

Pharmacy:_____ Location:_____ Phone:_____

Emergency Contact Name:_____ Phone: _____Relationship:_____

Primary Insurance:_____ Subscriber name:_____DOB:_____

Relationship to Patient:_____SS#_____Employer Name:_____

Secondary Insurance:_____Subscriber name:_____DOB:_____

INFORMATION REQUESTED BY THE FEDERAL GOVERNMENT

Language:_____ Ethnicity: Hispanic _____ Not Hispanic _____ Refuse to Report___

Race: American Indian_____ Asian_____ Black or African American _____ Hispanic _____

Other Pacific Islander_____ White _____ Refuse to Report _____

IF PATIENT IS A MINOR

PARENTAL/LEGAL GUARDIAN INFORMATION

Name (Last):_____ (First)_____ Relationship:_____

Address:_____ City:_____State_____Zip_____

Home Phone:_____ Work:_____Cell:_____

Employer/Phone:_____

Sign:_____ Date:_____

Patient Name: _____ Date of Birth: _____

BAY AREA ENT SPECIALISTS, LLP
DEBORAH MILLER, MD* CHESTER STRUNK, MD* CHRISTOPHER TRAN, MD,
SHAUNA MCLAUGHLIN, PA-C

The physicians and staff at Bay Area ENT Specialist, LLP appreciate the confidence you have shown in choosing us to provide for your health care needs and are committed to providing you with quality care. **Please feel free to ask any questions about our fees and/or our financial policy.**

PATIENT RESPONSIBILITY:
Obtaining a referral if necessary. Without a referral, you will be responsible for the charges in full at time of service. Payment of deductible/co-insurance, co-payments and any non-covered charges as designated by your insurance. If your insurance claim is denied or your insurance is terminated, you will be responsible for you balance in full.

PAYMENT OPTIONS:
Cash, Check, Credit/Debit Card. There is a $35 per check fee if your check is returned by the bank.
If your account becomes past due, Bay Are ENT Specialists. LLP will take the necessary steps to collect the debt, including but not limited to collection agency, lawyers, and reporting to Credit Bureau where you free to pay all of the collection costs incurred. **We will charge an additional $150 collection fee for delinquent accounts.**

MEDICARE:
We accept assignment of Medicare benefits and will file with your secondary or supplemental insurance.

MINOR/PARENTAL CONSENT FORM: (Please list anyone whom may bring your child)
Minors accompanied by an adult other than a parent must have a parental consent form signed by the parent.

Consent Form: I being the parent or legal guardian authorize unexpected medical, surgical care, hospitalization and financial fees for the minor during the period of my absence.
Name:_____ Relationship: _____
Name:_____ Relationship: _____
Parent signature: _____ Date:_____

DIVORCED PARENTS:
The parents **accompanying** a child of a divorced family will be responsible for payment of charges incurred for the date of service regardless of insurance or divorce decree status at the time of visit.

SELF PAY PATIENTS:
I do not have health insurance and I will be responsible for all medical services rendered at Bay Area ENT Specialists, LLP. I will be offered a discount and I agree to pay Bay Area ENT Specialists, LLP the balance of these charges related to the office visit and any treatment/procedure rendered to me or to the above-named patient at the time of each visit.
Initial here_____

CANCELLATIONS & MISSED APPOINTMENTS:
We request that at least **24-hour** advance notice be given to the office if you will be unable to keep your scheduled appointment. All cancellations with less than 24 hours notice and missed appointments will be billed $50.00 per occurrence. Patient will be expected to pay $50.00 fee before scheduling future appointments.
Initial here_____

***** Please be aware that your physicians have financial interest in Houston Physicians Hospital, Houston Physicians Surgery Center and Argentum Toxicology* Please be aware that some of the diagnostics and surgery facilities may be out of network with your insurance*****

MEDICAL SUPPLIES

Ex: Ear plugs, ear molds, ear insufflators, ear bandit, cervical collar etc… will not be billed to your insurance and is the patient's responsibility to pay at the time of check out.

HEARING AIDS:

Coastal Audiology is a separate entity from Bay Area ENT Specialists, LLP and does not have contracts with any health insurance companies. **OUT OF NETWORK**

CONSENT FOR TREATMENT/ AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Bay Area ENT Specialists, LLP through its appropriate personnel, to perform or have performed upon me, or the above-named patient, appropriate diagnostic and treatment procedures.
I further authorize Bay Area ENT Specialists, LLP to release to appropriate agencies (insurance company), any information acquired in the course of my or the below named patient's examination and treatment.
I authorize Bay Area ENT Specialists, LLP to appeal any insurance claims on my behalf, to stand in the shoes of the beneficiary and demand the protections allowed by law to call healthcare consumers.
Initial here_____

CONSENT FOR TREATMENT BY PHYSICIAN ASSISTANT:

Physician Assistants are health care professionals licensed to practice medicine. They are trained in in tensive education programs accredited by the accreditation review commission and graduation they are licensed with the state.
I understand that the physician assistant and the physician work together as a team to provide my medical care. I agree to see the physician assistant at my request and will be notified when scheduling an appointment. I understand that I can see the physician at my request.
Initial here_____

CONSENT FOR PROTECTED HEALTH INFORMATION:

I further authorize Bay Area ENT Specialists, LLP to contact or call in my behalf to discuss my personal health information with: (family member or another physician)
Name: _____ Relationship:_____
Name: _____ Relationship:_____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have reviewed or been given the opportunity to receive a copy of Bay Area ENT Specialists Notice of Privacy Practice. (HIPAA) **Initial Here** _____
I have read the above policy regarding my financial responsibility to Bay Area ENT Specialists, LLP for providing medical services to me or the above-named patient. I certify that the information I provide to Bay Area ENT Specialists, LLP to the best of my knowledge is current, true and accurate. I authorize my insurer to pay any benefits directly to Bay Area ENT Specialists, LLP or other providers the full and entire amount to bill incurred by me or the above-named patient; or if applicable any amount due after payment has been made by my insurance carrier. I here by agree to all the terms of this financial policy.
Patient Signature: _____ **Date:**_____
Guarantor Signature: _____ **Date:**_____