

# EAR, NOSE & THROAT ASSOCIATES of GADSDEN, P.A.

## Patient Registration

(please print or type)

Whom may we thank for this referral: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ D O B \_\_\_\_\_  
(Last) (First) (Mi)

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Sex: \_\_\_\_\_ SS: \_\_\_\_\_ Race: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ D O B: \_\_\_\_\_

SS: \_\_\_\_\_ Phone: \_\_\_\_\_

Person to contact in an emergency (not living with you): \_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Relationship: \_\_\_\_\_

Whom may we notify of test results: \_\_\_\_\_ Phone: \_\_\_\_\_  
(if you are unavailable)

I understand that I am totally responsible for payment of all expenses incurred. I assign and authorize E.N.T. ASSOCIATES of GADSDEN payment of any and all benefits payable by Medicare or other Insurance, and the necessary release of medical information to ant entity needed to process any Medicare or Insurance claims. I permit a copy of this authorization to be used in place of the original. I further agree, in the event of non-payment, to bear the cost of collection and/or court costs and reasonable legal fees not to exceed 33 1/3 % of the unpaid balance. The undersigned waives the rights of exemption under the laws of the State of Alabama. **PAYMENT IS REQUESTED AT TIME OF SERVICE.**

**Patient or Responsible Party**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*As my patient, I want to provide you with the best care possible. There may be certain services that are not covered by your insurance. You will be expected to pay for those services in full. For example, I may order certain allergy tests that may not be covered by your insurance contract. Your contract could possible have "CONTACT MAXIMUMS" pertaining to any allergy testing and your extracts.*

Let me assure you that I will only order tests that I feel are necessary for your treatment and care.

I have read the above statement and agree to pay for services not covered by my insurance.

**Patient or Responsible Party**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**It is also important for our patients to know that we have an office policy that will not allow any patient to add additional charges to their account if their balance is over \$200.00 and/or 90 days past due.**

I have read the above statement, understand and will comply with this policy.

**Patient or Responsible Party**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_