Midwest
EAR, NOSE & THROAT
SURGERY, PSC

PATIENT REGISTRATION FORM

NAME _____ DOB _____ AGE _____ SSN _____

PHONE _____ (home) _____ (work) _____ (cell) _____

ADDRESS _____ EMAIL _____

CITY _____ STATE _____ ZIP _____

PLACE OF EMPLOYMENT _____

REFERRING or PRIMARY PHYSICIAN _____ PHONE _____

PRIMARY INSURANCE _____

ID# _____ GROUP # _____ PRIMARY INSURED PH _____

PRIMARY INSURED NAME IF DIFFERENT _____ DOB _____

SSN _____ EMPLOYER _____ PHONE _____

SECONDARY INSURANCE _____

ID# _____ GROUP # _____

PRIMARY INSURED NAME IF DIFFERENT _____ PHONE _____

I hereby consent to MIDWEST ENT using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for healthcare services rendered to me or to carry out the practice's health care operations. I understand that I have the right to request restrictions on how MIDWEST ENT uses and discloses my protected health information for treatment, payment or health care operations. MIDWEST ENT is not required to agree to any restriction, but should we; the restriction is binding to the practice. I have the right to revoke this consent in writing, except to the extent that MIDWEST ENT has taken action in reliance on this consent.

All co-payments are due at time of CHECK-IN. We will be happy to assist you with filing your insurance claims. However, you remain ultimately responsible for payment. Please check with your insurance to see if they require a second opinion or pre-certification if you should be scheduled for special tests or surgery. If a pre-cert is required and not obtained, you could be denied coverage and therefore responsible for your bill. A claim will be filed with yor health benefits carrier and you will be notified when payment has been received. Payment in full of any deductible or co-insurance will be expected within ten (10) days of that notice. If no payment is received from your insurance carrier within forthy-five (45) days, then the balance is due and payable by you. **There will be a $10 late fee added per month on all balances over 30 days unless payment arrangements have been approved**.

_____ _____

Patient or Guardian Signature Date