VIRGINIA ENT – PATIENT FORM

Patient#: _____

Name (First, MI, Last):	**Date of Birth:**	**Sex:**	**Social Security #:**
Street Address:	**City:**	**State:**	**Zip Code:**
Primary Care Physician:	**Referring Physician:**		
Virginia ENT staff has my permission to leave messages which may contain medical information on my preferred phone below; please place a check mark in the box next to your preferred phone: ***(Initial)***_____			
Home Phone # : ☐	**Work Phone # :** ☐	**Cell Phone #:** ☐	
Email Address:	**May we contact you by phone?** **Y** **N** **May we contact you by email?** **Y** **N**		
Primary Insurance:	**Policy ID:**	**Policyholder:**	**Policyholder DOB:**
Name of Emergency Contact:	**Relationship to Patient:**	**Emergency Contact # :**	
Guarantor (Person responsible for payment):	**Guarantor Date of Birth:**	**Guarantor Phone #:**	
Guarantor Street Address:	**City:**	**State:**	**Zip Code:**
Guarantor Employer Name:	**Address :**	**Phone #:**	

I have received a copy of the "**Notice of Privacy Practices**" for Virginia Ear, Nose & Throat Associates, P.C. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy. This notice is posted in our offices, on our website and copies are available at any time. I understand that I may ask questions of Virginia ENT if I do not understand any information in the Notice of Privacy Practices.

_____
(Initial)

Authorization Form for Use & Disclosure of Protected Health Information

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. We have explained that disclosures may be made to family and friends related to patient's health. It has also been explained that we will only disclose information relevant to current treatment. By signing below, I authorize Virginia ENT to disclose health care information to the following individuals (list those that apply):

Name	Phone Number	Relationship to Patient
Name	Phone Number	Relationship to Patient
Name	Phone Number	Relationship to Patient

_____ _____
(Signature of Patient) *(Date)*

_____ _____
(Signature of Patient's Representative/Parent) *(Date)*

_____ _____
(Printed Name of Patient's Representative/Parent) *(Date)*

PLEASE COMPLETE BOTH SIDES

(Revised 05/19)

Virginia Ear, Nose & Throat Associates, P.C.

Consent for Treatment, Assignment of Benefits & Financial Policies

Patient Name: _____ Patient #:_____

- **Consent For Treatment**
  I authorize Virginia Ear, Nose & Throat Associates to provide medical treatment to myself or my dependent.

- **Assignment of Benefits**
  I request that payment of authorized Medicare, Medicaid or applicable private insurance benefits be paid directly to Virginia Ear, Nose & Throat Associates for services provided under their care.

- **Release of Medical Information**
  I authorize Virginia Ear, Nose & Throat Associates to release necessary medical information to my insurance company, its agents, or any third party payer in order for payable benefits for these services to be determined.

- **Collection of Co-Pays and Deductibles**
  Per our agreement with your insurance carries, you are required to pay any applicable copayments at the time of service. In addition, if you are insured with a high deductible insurance plan and have not met your deductible, we will collect **$100** for new patients and **$60** for established patients at time of service.

- **Financial Responsibility**
  I understand that Virginia Ear, Nose and Throat Associates will file my insurance claims as a courtesy; however, I am ultimately responsible for full payment of all charges. Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the patient's responsible party, understands that Virginia ear, Nose & throat Associates has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient, or the patient's responsible party, understands and agrees to pay all attorney fees in the amount of thirty-three and one-third percent (33 1/3 %) of the total unpaid balance due, plus court costs and filing fees incurred by Virginia ear, Nose & Throat Associates. I understand and agree that should Virginia ear, Nose & throat Associates be awarded judgment relating to this agreement or any debt incurred thereof, I will pay a service charge of one and one-half percent (1 ½ %) per month , eighteen percent (18%) per annum, beginning on the date of judgement.

- **Referrals/ Authorizations**
  I understand if my insurance company requires a referral, I am responsible for obtaining a referral prior to my visit. If I do not have a referral I will be required to sign a waiver before being seen by the physician and payment in full for services rendered will be collected at the check-out desk.

- **Missed Appointments**
  We require at least 24 hours' notice if you must cancel an appointment, failure to do so may result in a $25 "no show" fee.

- **Returned Checks**
  Our office will charge $25 for any check that is returned for insufficient funds.

I have read the above statements and I understand my responsibilities. I acknowledge that Virginia Ear, Nose & Throat Associates, PC, will scan this document and destroy the original, and agree the scanned document is the same as the original.

_____ _____
Signature of Patient or Responsible Party (Date)

_____ _____
Printed Name of Patient or Responsible Party (Relationship to Patient)

(Revised 5/19)