

Clear Lake Medical Center ENT

DEPENDENT PATIENT INFORMATION

If your dependent is still on your insurance (regardless of age), please fill out this form.

Patient's Name _____ Age _____ Sex _____

Date of Birth _____ Email _____

Home Address _____ Apt# _____

City _____ State _____ Zip Code _____ SS# _____

Home Phone# _____ Cell# _____

Patient Status Employed Full Time Student Part Time Student Under age 6

Race (check one) Native American Asian Pacific Islander African American White Hispanic Other _____

Ethnicity (Please circle) Hispanic Non-Hispanic Other _____ Preferred Language _____

Preferred method of contact Email Text Voice at _____

Patient's complaint or illness for today's appointment _____

Did your doctor ask you to see an ENT doctor? Yes No Referring Physician _____

Primary Care Physician (PCP) _____

Have any of your family members been seen in this practice? Yes No If so, who? _____

How did you hear about us? Friend Relative Publication Insurance Internet Physician Other _____

Mother's Name _____ **DOB** _____

Address (If different from patient) _____ Apt# _____

City _____ State _____ Zip Code _____ SS# _____

Home Phone# _____ Cell# _____ Occupation _____

Employer's Name _____

Business Phone# _____ Ext. _____

Father's Name _____ **DOB** _____

Address (If different from patient) _____ Apt# _____

City _____ State _____ Zip Code _____ SS# _____

Home Phone# _____ Cell# _____ Occupation _____

Employer's Name _____

Business Phone# _____ Ext. _____

Clear Lake Medical Center ENT

The physicians and staff at Clear Lake Medical Center E.N.T. and Bay Area Audiology 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. By executing this agreement, you are agreeing to pay for all services that are received. **Please feel free to ask any questions about our fees and/or our financial policy.**

Cancellations/Missed Appointments: Clear Lake Medical Center E.N.T. and Bay Area Audiology is committed to providing exceptional care. Unfortunately, when one patient cancels without giving enough notice, they prevent another patient from being seen. Please call us at **281-332-4575 within 24 hours** to make any changes or cancellations. If prior notification is not given, you will be **charged \$25.00** for the missed appointments.

NSF Checks: A returned check **fee of \$35** will be charged to your account when a payment made by check to our office, is not honored by the bank. The payment will be reversed from your account which may result in additional fees added to your account.

Monthly Statements and Payments: If you have a balance on your account, you will be sent a monthly statement. Unless we approve other arrangements, your balance is due and payable upon receipt.

Required Payments: Any co-payments, deductibles, coinsurance must be paid at the time of service. This is required by your insurance.

Payment if you have no insurance: You may choose to pay with cash, check, or credit card on the day that treatment is rendered.

Insurance: Insurance is a contract between you and your insurance company. An insurance card must be made available to us before you are seen as a patient. **Although we may estimate what your insurance will pay, it is the insurance company that makes the final determination of your eligibility and allowed amounts.** You are responsible for any portion of our charges not paid by insurance less the amount written off due to a contract we may have with your insurance company. Should there be a *pre-existing* clause in your coverage, which results in our claim not being paid, you will be responsible for payment of all amounts denied by insurance. If your insurance requires a referral or authorization, you are responsible for obtaining it. Failure to obtain the referral or authorization prior to your visit may result in denial of payment or reduced payment from your insurance company.

Medicare Recipients If you are enrolled in a *Medicare Advantage* plan, which replaces your traditional Medicare coverage, **it is your responsibility to notify our office** and provide the correct information prior to your treatment.

I have been given an opportunity to read and understand your notice of privacy practices. I authorize the release of any medical or other information to my insurance carrier, referring physician or to the following individuals:

I authorize payment of medical benefits for myself or my dependents to Clear Lake Medical Center E.N.T. or Bay Area Audiology. I understand that I am responsible for any amount not covered insurance.

Signature

Relationship to Patient

Today's Date