THE ENT& ALLERGY CENTERS OF TEXAS

PATIENT REGISTRATION

Patient Information

Last Name _____ First Name _____ Middle _____

Date of Birth _____ /_____/_____ Age_____ Marital Status ☐Single ☐Married ☐Divorced ☐Widowed

Social Security Number: _____ - _____ - _____ Email _____ Sex ☐Male ☐ Female

Address _____ APT #_____ City _____ State _____ Zip _____

Primary Phone _____ - _____ - _____ Alternate Phone _____ - _____ - _____

Employer _____ Work Phone _____ - _____ - _____

Emergency Contact _____ Relationship _____ Phone _____ - _____ - _____

Preferred Language: ☐ English ☐ Spanish ☐ Decline to Answer ☐ Other _____
Race: ☐ Asian/Pacific Islander ☐ Black/African American ☐ American Indian/Eskimo ☐ White/Caucasian ☐ Other
Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

****Complete This Section ONLY if Patient is under 18 Years Old****

Parent/Guarantor Information (Complete if Patient is under 18 Years)

The parent/guardian accompanying the child to the visit is responsible for payment due at the time of service. Our office staff will not get involved in matters involving third party personal billing as the result of custody, court order, or personal circumstances.

Last Name _____ First Name _____ Date of Birth ____ /____ /_____

Address _____ APT #_____ City _____ State _____ Zip _____

Employer _____ Work Phone _____ - _____ - _____

Cell Phone _____ - _____ - _____ Home Phone _____ - _____ - _____

Relationship to Patient: ☐ Parent ☐ Guardian ☐ Spouse Email_____

****Complete This Section if You Have Medical Insurance****

Primary Medical Insurance

Policy Holder Name_____ Group #_____

Carrier_____ Policy Holder Date of Birth _____/ _____/ _____

Member ID #_____ Relationship to Patient: ☐ Self ☐ Parent ☐ Guardian ☐ Spouse

Policy Holder Address (if different from patient's address) _____

Policy Holder Phone _____- _____ - _____

Secondary Medical Insurance

☐Not Applicable

Policy Holder Name_____ Group #_____

Carrier_____ Policy Holder Date of Birth _____/ _____/ _____

Member ID #_____ Relationship to Patient: ☐ Self ☐ Parent ☐ Guardian ☐ Spouse

Policy Holder Address (if different from patient's address) _____

Policy Holder Phone _____- _____ - _____

THE ENT& ALLERGY CENTERS OF TEXAS

GUARANTEE OF PAYMENT: If insurance is filed on my behalf for charges associated with care provided by The ENT & Allergy Centers of Texas (ENTTX), I assign to the provider all payments from 1st party, 3rd party, medical, accident or any other insurance coverage responsible for payment. ENTTX may use and disclose my healthcare information to an insurance company, 1st party, 3rd party or accident insurance payor for the purposes of payment if a claim is filed on my behalf. I acknowledge that if ENTTX submits a claim to my insurance carrier, it is done so as a courtesy and that I am ultimately responsible for all charges incurred, unless both parties mutually agree otherwise. I agree that I will pay my estimated out of pocket based on the best available information of my current policy and understand this is only an estimate. While ENTTX makes every effort to verify my correct insurance information, I understand ENTTX cannot guarantee the accuracy of my bill until it has been fully processed by my insurance carrier. If insurance is filed on my behalf to a plan that is later discovered to be a limited benefit plan or one that restricts the provider's ability to collect from other sources, I understand and agree that the acceptance of that coverage will be rescinded, and the balance will be pursued from the other source. I understand that if paying by check and it is returned or if a credit card dispute is initiated by me or on my behalf, a processing fee of $30 will be assessed. I attest that the information provided to ENTTX and written herein is true and accurate.

Disclosures

PRIVACY PRACTICES & PATIENT RIGHTS: By signing this form, I acknowledge that a copy of the company's Notice of Privacy Practices and Patient Bill of Rights has been provided to me for review and is available for take home at my request. I am aware the documents may be downloaded anytime on the company website.

ANCILLARY SERVICES: Your provider may recommend diagnostic laboratory tests and/or radiology exams to help aid in the treatment and diagnosis of your condition. Some of these services are not performed in our facility. Laboratory tests may be sent to an outside third-party lab for processing. Radiology exams may be read and interpreted by a third-party. These third-party services may be billed to you by the third-party company. ENTTX is not responsible for these ancillary charges if determined to be your responsibility.

CONSENT TO TREATMENT: By signing this consent form, I voluntarily consent to the administration, treatment and cost of medical services, surgical procedures, radiology procedures, medication, equipment/supplies, and other ancillary medical services for myself or my dependent. I understand that a copy of this consent form may be used with the same effectiveness as the original.

Patient or Guarantor Signature: _____ Date _____

If Guarantor, Relationship to Patient: _____ Date _____

PCP Name _____PCP Phone #_____

PHARMACY NAME: _____

PHONE #_____ CROSS STREETS: _____

Please note that prescriptions will be sent electronically to the pharmacy you provide.
If you require a prescription to be sent to a different pharmacy, please let us know.

Reminder Messages: We have an electronic system that can text, email or call you to remind you of your scheduled appointments. Messaging may include billing reminders. Please select below how you would like to receive this contact:

☐ Text to mobile #_____
☐ Email to:_____
☐ Leave a message at #_____

THE ENT& ALLERGY CENTERS OF TEXAS

******Complete This Section to Authorize Release of your Records to Another Individual******

Release of Information

By signing this form, I authorize ENTTX to release verbally, electronically, and/or in writing my confidential medical information for purposes of treatment, payment of charges, quality assurance and utilization review, transfer and follow-up procedures to my insurance carrier, employer (if treatment is related to employment), any other healthcare providers. I also approve the release of my medical records to the following person(s):

Name_____ Relation _____ Phone _____

Name_____ Relation _____ Phone _____

☐ I hereby authorize the release of my COMPLETE health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse.

OR

☐ I hereby authorize the release of my COMPLETE health record WITH EXCEPTION of the following information:

- ☐ Mental health records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Financial account information
- ☐ Other (please specify): _____

OR

☐ I hereby authorize the release of the following information:

- ☐ Records for dates of service from _____ to _____
- ☐ Narrative reports ☐ Lab results ☐ Hospital records ☐ Pathology results ☐ Radiology results

I understand that a photocopy or facsimile of this authorization is valid as the original.

Patient or Guarantor Signature: _____ Date _____

If Guarantor, Relationship to Patient: _____ Date _____

****Complete This Section ONLY if Your Visit is Related to a Work Injury****

Injury Information

Date of injury _____ /_____ /_____ Time of Accident _____:_____ ☐ AM or ☐ PM Was Employer Notified: ☐Yes ☐No
If yes, when? _____ /_____ /_____ Claim Number _____ Describe how injury happened _____

Employer Information

Company Name _____ Phone Number _____
Address _____ APT #_____ City _____ State _____ Zip _____
Supervisor _____ Phone Number _____
HR Contact _____ Phone Number _____
Employer's Insurance Carrier: _____ Carrier's Phone _____
Contact Notes _____

****Complete This Section ONLY if Your Visit Involves a Motor Vehicle Accident****

Accident Details

Date of Accident _____ /_____ /_____ Time of Accident _____: _____ ☐ AM or ☐ PM
Have you reported the accident and injury to **your** auto insurance company? ☐ Yes ☐ No If yes, when? _____ /_____ /_____
Have you reported accident and injury to the **other driver's** insurance carrier? ☐ Yes ☐ No
Have you filed a PIP or NO-FAULT application with **your** auto insurance carrier? ☐ Yes ☐ No
Were you the driver of the vehicle? ☐ Yes ☐ No If you were a passenger, please identify the driver _____
If you were a passenger, was the driver a member of your household? ☐ Yes ☐ No
Who was at fault in the accident? ☐ other vehicle ☐ your vehicle
If you have a copy of the Police Report or Other Driver Exchange of Information form, please provide a copy to registration.
Your Auto Insurance Carrier's Name _____
If your auto insurance is under someone else's name, please provide this information _____
Address for Claims_____
Effective Date of Policy _____ / _____ / _____ Policy Number # _____ Claim Number # _____
Other Driver's Auto Insurance Carrier's Name_____ Other Driver's Name _____
Address for Claims _____
Effective Date of Policy _____/_____/_____ Policy Number # _____ Claim Number # _____

****Complete This Section ONLY if Your Visit is Related to an Accidental Injury NOT Work Related or Involving a Motor Vehicle****

Accident Details

Date of Accident _____ /_____ /_____ Time of Accident _____: _____ ☐AM or ☐ PM
Claims will be paid by _____
Responsible Party _____ Insurance Carrier _____
Insurance Carrier Address & Phone _____
Claim Adjuster Name _____
Describe how your injury occurred _____
Where were you when the injury occurred? _____
If your injury occurred at a commercial establishment or school campus, please provide the name and location: _____
_____

LIABILITY COVERAGE - ASSIGNMENT OF BENEFITS LANGUAGE: In consideration services rendered, I hereby assign and transfer to ENTTX all money due or to become due or payable to me under any insurance policy and/or first party or third-party payment agreement, up to the total amount of my account with ENTTX. In the event the patient is entitled to benefits arising out of any policy of insurance insuring patient or any other first or third party liable to patient, whether in contract or tort, said benefits are hereby assigned to ENTTX for application to the patient's bill. Said benefits include but are not limited to: any health insurance plan; any first party liability policy, such as personal injury protection benefits, medical payments benefits, uninsured and/or underinsured motorists benefits; any third party liability policy, such as commercial liability benefits, homeowners liability benefits, automobile liability benefits, medical malpractice liability benefits; the proceeds from any first or third party settlements and/or judgments relating to injuries or conditions associated with my treatment. I hereby appoint, ENTTX and any agent acting on its behalf, as my authorized representative to pursue any claims, penalties and administrative and/or legal remedies on my behalf for collection against any responsible payer of any and all benefits due me for the payment of charges associated with my treatment. I will be responsible for and will pay any amount due to ENTTX not paid by my insurance company, first or third-party payer, and if the insurance company refuses to pay any amount of my claim, I agree to pay my entire bill to ENTTX. I understand that first and third-party liability coverage is primary to health insurance coverage and, if known, will be filed as primary to health insurance. I also agree to review all charges when I receive the initial invoice and immediately assert any disputes to the services provided and/or charges before submitting them to any liability carriers for compensation.

Patient or Guarantor Signature: _____ Date _____

If Guarantor, Relationship to Patient: _____ Date _____