New Patient Information

Account #	Patient SSN#				
Patient Last Name	First Name		Middle Initial		
Mailing Address:	Apt/Suite#	City	State	Zip Code	
Home Phone ( )	Birth Date MM/DD/YY / /	Age	Sex M F	Race W B H A I	
Primary Care Physician			Marital Status M S D W		
Patient's Occupation	Patient's Employer		Employer's Phone ( )		
Employer's Address	Suite#	City	State	Zip Code	
Relative Not Living With You	Relationship		Phone ( )		
Emergency Contact			Phone ( )		

PLEASE COMPLETE THIS SECTION COMPLETELY IF PATIENT IS A MINOR

	Parent/Guardian SSN#				
Parent/Guardian Last Name	First Name		Middle Initial		
Mailing Address:	Apt/Suite#	City	State	Zip Code	
Home Phone ( )	Birth Date MM/DD/YY / /	Age	Sex M F	Race W B H A I	
Parent/Guardian Occupation	Parent/Guardian Employer		Employer's Phone ( )		
Employer's Address	Suite#	City	State	Zip Code	

Health Insurance Information

	Insured SSN#				
Insured Last Name	First Name		Middle Initial		
Mailing Address:	Apt/Suite#	City	State	Zip Code	
Home Phone ( )	Birth Date MM/DD/YY / /	Age	Sex M F	Race W B H A I	
Insured Occupation	Insured Employer		Employer's Phone ( )		
Employer's Address	Suite#	City	State	Zip Code	
Insurance Carrier (Primary)	**Insured ID#**		**Insured Group#**		

Address Correspondence to:
Office Manager
Ear Nose and Audiology Associates of the Carolinas, P.A., 7006 Shannon Willow Road, Charlotte NC 28226
Phone (704) 544-6533 Fax (704) 544-6583

New Patient Information

Insurance Carrier (*Secondary)	Insured ID#	Insured Group#

***Please Note Our Office only <u>accepts Secondary insurance</u> Plans if <u>Medicare is the Primary Insurance.</u>**

How Did you Hear About Us?	Referring Physician ☐ Newspaper ☐ Phone Book ☐ Web search ☐ Friend ☐ TV Commercial ☐ Insurance Directory ☐

Referring Physician Last Name	First Name	Middle Initial

Mailing Address:	Apt/Suite#	City	State	Zip Code

Phone # ( )

IMPORTANT INFORMATION
PLEASE READ <u>ALL</u> OF THE FOLLOWING AND ACKNOWLEDGE BY SIGNING

ACCEPTANCE OF FINANCIAL RESPONSIBILITY: I understand that I am responsible for all medical expenses regardless of insurance coverage and whether or not there is an accident with another person at fault.

COLLECTION COST: I hereby agree that should my account become delinquent more than 30 days that I will pay all cost incurred by Ear Nose Throat and Audiology Associates of the Carolinas, P.A. for the collection of my delinquent account including but not limited to legal fees, court cost and collection agency cost.

AUTHORIZATION FOR USE/DISCLOSURE OF INFORMATION: I have read and fully understand by Ear Nose Throat and Audiology Associates of the Carolinas, P.A. Notice of Patient Information Practices. I acknowledge receipt of a copy of the policy. I understand that by Ear Nose Throat and Audiology Associates of the Carolinas, P.A. may use or disclose my personal health information for purposes of carrying out treatment, obtaining payment and evaluating the quality of services provided. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice in writing. I also understand that the practice will consider the request for restriction on a case-by-case basis, but does not have to agree to request for restriction. I understand that other physicians involved in my care, including my referring and/or primary care physician will be kept informed of my treatment. I also understand that any agencies involved in my care including Vocational Rehabilitation Services, Children Rehabilitation Services and Baby Net will also be kept informed of my treatment.
I hereby consent to the use and disclosure of my personal health information for the purpose as noted in the Ear Nose Throat and Audiology Associates of the Carolinas, P.A. Notice of Patient Information Practices. I understand that I have the right to revoke this authorization in writing, at any time by sending a written notification to the Office Manager at the address noted below.

ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to by Ear Nose Throat and Audiology Associates of the Carolinas, P.A. of the medical and/or surgical benefits of my insurance plan(s)

CONSENT FOR RX HISTORY, EVALUATION AND TREATMENT: I hereby authorize Ear Nose Throat and Audiology Associates of the Carolinas, P.A., their physicians, employees or agents to perform a physical examination and/or any medical treatment deemed necessary by the treating physician. This includes, but not limited to any medical examination, procedure or test ordered, and RX history performed or obtained by the Physician to be carried out by the designated staff.

_____ _____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN **RELATIONSHIP TO PATIENT**

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