northwest ENT associates

PATIENT INFORMATION SHEET

NOTE: YOU WILL BE REQUIRED TO FILL OUT THIS FORM EVERY 6 MONTHS

Please Complete All Information on This Form

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.	**Patient Name** (Please Print): _____		
Address: _____			
E-mail: _____ ☐ pls send appt. confirmation via email			
☐ Single ☐ Married ☐ Widowed ☐ Partnered ☐ Student		☐ Male ☐ Female	
SSN:	_____	Home Phone	_____
Birth Date:	_____/_____/_____	Cell Phone:	_____
Employer:	_____	Work Phone:	_____
Spouse/Parent:	_____	Work Phone:	_____
Employer:	_____	Occupation:	_____
PERSON RESPONSIBLE FOR BILL (if other than patient, i.e. parent/spouse/guardian):			
Name:	_____	Phone:	_____
Birth Date:	_____	Employer Occupation:	_____ _____
EMERGENCY CONTACT OUTSIDE OF HOME:	Relationship: _____		
Name:	_____	Phone:	_____
Referred by (How did you hear about us?): _____			
Primary Physician: _____			
Clinic Address: _____			
City: _____ Zip: _____		Phone: _____	Fax: _____
Are you being seen as the result of an auto accident? ☐No ☐ Yes – please provide the following information:			
Date of Accident: __/__/____ Time: _____ State in Which Accident Occurred: _____			

INSURANCE INFORMATION: Please fill in completely using your insurance card

PRIMARY:	_____		Group#:	_____
ID #:	_____		Phone#:	_____
Subscriber:	_____		Claims Address:	_____
Relationship:	_____	**DOB:**__/__/__		_____
SECONDARY:	_____		Group#:	_____
ID #:	_____		Phone#:	_____
Subscriber:	_____		Claims Address:	_____
Relationship:	_____	**DOB:**__/__/__		_____

PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING

Assignment, Release and Financial Agreement: I authorize treatment of the person named above and agree to pay all fees for such treatment. I hereby authorize my insurance benefits to be paid directly to the provider of service and I understand that I am financially responsible for non-covered services. I also authorize the physician to release any information required. I agree that I will not withhold or delay payment if my insurance company denies payment of any of my charges. I am financially responsible for a billing fee and understand that balances over 60 days may incur a billing fee of 1% per month (12% APR), (RCW19.52), with a minimum charge of $1.00 monthly. I have also been informed of the $25.00 fee (per RCW 62A.2-515&520) on checks returned for NSF. In the event it should become necessary to place any unpaid balance due for services rendered to me or my family for collection, I/we agree to pay interest, collection fees, and should legal action be filed, reasonable attorney fees, filing fees and other costs the court determines proper.

Medicare Authorization: I authorize the doctor to release to the Federal Government or its designated agent information on this or related medical claims. I permit a copy of this authorization to be used in place of the original and request payment of my insurance benefits be made to myself or to the doctor if assignment is accepted. ☐ Lifetime ☐ Ending ____/____/____

Phone Messages/e-mail/Mail: I authorize **NW ENT ASSOCIATES** to leave messages at my home or alternate number or be contacted via the e-mail address I have provided for all administrative issues ☐ Y ☐ N. I also authorize **NW ENT ASSOCIATES** to send me information regarding special offers, promotions, new products or services, and reminders to the address that I have provided – I can opt out of those at any time.

Privacy: We are required by law to maintain the privacy of, and provide individuals with, a notice of our legal duties and privacy practices with respect to protected health information. A signature below only acknowledges that you have received the **NOTICE OF HEALTH INFORMATION PRACTICES OF NORTHWEST FACE** handout.

Patient or Guardian Signature: _____ **Today's Date**: _____

INTERNET REGISTRATION USERS PLEASE SIGN AT THE OFFICE IN FRONT OF A WITNESS