

2009  
Photo ID  
Required  
at Check In



DATE: \_\_\_\_\_

**PATIENT INFORMATION: (Please fill in all fields completely )**

How did you hear about us? \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_

Nickname \_\_\_\_\_ Date of Birth \_\_\_\_\_  Male  Female SSN \_\_\_\_\_

Address \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Home Number \_\_\_\_\_

Who Has Legal Custody of Patient?  Parent  Mother Only  Father Only  Foster Parent  Grandparent  HRS/Other

**\*IF NOT THE LEGAL GUARDIAN, COURT DOCUMENTS MUST BE PRESENT AT TIME OF VISIT**

Pediatrician \_\_\_\_\_ Referring Physician \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_ Phone Number \_\_\_\_\_

**PARENT -- LEGAL GUARDIAN INFORMATION**  
**MOTHER'S INFORMATION**

Name: \_\_\_\_\_ SSN \_\_\_\_\_ DOB \_\_\_\_\_

Address/Phone Same As Patient Home # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Cell # \_\_\_\_\_ Work # \_\_\_\_\_ Ext \_\_\_\_\_

**FATHER'S INFORMATION**

Name: \_\_\_\_\_ SSN \_\_\_\_\_ DOB \_\_\_\_\_

Address/Phone Same As Patient Home # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Cell # \_\_\_\_\_ Work # \_\_\_\_\_ Ext \_\_\_\_\_



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Patient Name: \_\_\_\_\_

Patient DOB \_\_\_\_\_

## FINANCIAL INFORMATION

PLEASE GIVE ALL INSURANCE CARDS TO THE RECEPTIONIST FOR PHOTOCOPYING.

Co-payment and annual insurance deductibles not met for the year are payable prior to services rendered. No exceptions.

Patients who carry any form of medical insurance should know that all services furnished are charged directly to the parent, foster parent, grandparent(s), legal guardian and he/she is responsible for payment. We will prepare any necessary forms to assist in making collections from your primary insurance company and will credit such collections to your account. However, we cannot render services on the assumption that your charges will be paid solely by your insurance. Most misunderstandings about insurance can be avoided if you understand what your policy provides.

Many insurance policies pay according to a schedule of benefits that is based on various criteria. This office charges fees that are reasonable in this community. Not all insurance plans will pay 100% of our charges. The parent, foster parent, grandparent(s), legal guardian is responsible to pay all sums unpaid by insurance. If it becomes necessary to collect any sum due through an attorney, then the parent, foster parent, grandparent(s), legal guardian agrees to pay all reasonable costs of collection, including attorney's fees, whether suit is filed or not.

If CORRECT insurance information or treatment authorization IS NOT present at the time of service, YOU ARE RESPONSIBLE FOR ALL OF THE CHARGES INCURRED. If you do not have medical insurance, financial arrangements must be made prior to services rendered. Otherwise, full payment must be made at the time services are rendered.

Due to the new federal government regulations (HIPAA) regarding transmission of patient information for the processing of insurance claims for medical services, we must request the completion of the following information.

### WE CANNOT PROCESS YOUR INSURANCE CLAIMS WITHOUT THE FOLLOWING INFORMATION.

Name of Primary Ins Co.	<input type="text"/>	Name of Second Ins Co	<input type="text"/>
Policy Holder Name	<input type="text"/>	Policy Holder Name	<input type="text"/>
Employer Name	<input type="text"/>	Employer Name	<input type="text"/>
Full Address of Employer	<input type="text"/>	Full Address of Employer	<input type="text"/>

If you are covered by Children's Medical Services (CMS) you must provide us the:

City:  Nurses' Name  Phone Number

Person responsible for payment  Phone #

Address  City  State  Zip Code

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### FINANCIAL POLICY

This is an agreement between the treating physician/physician extender of Pediatric Otolaryngology Head & Neck Surgery Assoc., P.A. (POHNS), as creditor, and the Patient/Debtor named on this form.

In this agreement the words "you", "your", and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us", and "our" refer to the physician/physician extender of POHNS.

By executing this agreement, you are agreeing to pay for all services that are received.

**Monthly Statement:** If you have a balance on your child's account, you will receive a monthly statement. It will show separately the previous balance, any new charges to the account, and any payment(s) or credit(s) applied to your child's account during the month.

**Payments:** Unless other arrangements are approved by us in writing, the balance on your billing statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

**Required Payments:** Any co-payments required by an insurance company must be paid at the time of service. **Because this is an insurance requirement, we cannot bill you for these.** Any outstanding deductible balance must be paid at the time of service. Because the deductible is a component of an agreement between you and your insurance carrier, we **cannot bill you for this.**

**Contracted Insurance:** If we are contracted with your insurance carrier, we are required to follow our contract and their requirements. If you have a co-pay or deductible, you must pay that at the time of service. It is the insurance carrier that makes the final determination of your eligibility. If your insurance carrier requires an office referral and/or pre-authorization, you are responsible for obtaining it. Failure to obtain the referral and/or pre-authorization may result in the cancellation of your child's appointment. Our surgery pre-certification staff will obtain the necessary authorization for the surgery procedure(s).

**Non-contracted Insurance:** Insurance is a contract between you and your insurance carrier. As a courtesy to you, we will file an insurance claim to your primary insurance carrier and your secondary carrier, if applicable. It is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by your insurance carrier. If your insurance carrier requires a referral and/or pre-authorization for the office visit **you are responsible for obtaining it.** Failure to obtain the referral and/or pre-authorization may result in the cancellation of your child's appointment. Our surgery pre-certification staff will obtain the necessary authorization for the surgery procedure(s).

**Divorce:** In the case of a divorce or separation, the party responsible for the child's account remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

(continued on reverse side)

**Past Due Accounts:** If your child's account becomes past due, we will take necessary steps to collect this debt. If we have to refer the account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer's fees which we incur, plus all court costs. In the case of suit, you agree the venue shall be in Pinellas County, Florida.

**Returned Checks:** There is a fee (currently \$35.00) for any check returned by the bank.

**Missed Appointment:** A patient with three (3) consecutive no show or missed appointments will be asked to seek care elsewhere.

**Transferring of Medical Records:** To receive a copy of your child's medical records, we must receive a signed request in writing. All copies of the medical records are subject to a fee, which is dependent upon the number of copies made for you. You authorize us to include all relevant information. If you are requesting your child's records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information.

**Waiver of Confidentiality:** You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if the past due status is reported to a credit reporting agency, the fact that your child received treatment at our office may become a matter of public record.

**Effective Date:** Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

**Payment Option if you have no insurance:**

1. You choose to pay the total cost on the day that treatment is rendered.

**Payment Options if you have insurance:**

1. You choose to pay your co-payment or your deductible of \$\_\_\_\_\_ and any out-of-pocket portions (your co-insurance requirement or any remaining unpaid balance existing on your account), at the time services are rendered.
2. You choose to pay in full for all services. We will request your insurance carrier send their payment directly to you.

**Patient's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Responsible Party:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Witness:** \_\_\_\_\_ **Date:** \_\_\_\_\_