Ears to You

Patient Registration

Today's date _____ How did you hear about us? _____

Patient Information

Patient's name (as it appears on insurance card) _____
(First) (Middle initial) (Last)

Address _____

City _____ State _____ Zip Code _____

Home phone _____ Work phone _____ Cell phone _____

Email address _____

Birthdate _____ Employment status (circle): Full time Part time Not employed

Primary insurance information: **If same as above, enter "same" as appropriate.**

Insured's name (as it appears on insurance card) _____
(First) (Middle initial) (Last)

Address _____

City _____ State _____ Zip Code _____

Home phone _____ Work phone _____ Cell phone _____

Patient relation to insured (circle): Self Spouse Child Other: _____ Insured date of birth _____ Insured sex (circle) **M F**

Insurance co. _____ Insurance ID # _____ Insurance group # _____

Other insurance information: **If same as above, enter "same" as appropriate.**

Insured's name (as it appears on insurance card) _____
(First) (Middle initial) (Last)

Address _____

City _____ State _____ Zip Code _____

Home phone _____ Work phone _____ Cell phone _____

Patient relation to insured (circle): Self Spouse Child Other: _____ Insured date of birth _____ Insured sex (circle) **M F**

Insurance co. name _____ Insurance ID # _____ Insurance group # _____

Primary care physician

Referring physician _____ Address _____

Physician telephone _____ Fax _____

- **Please provide a copy of all insurance cards.**
- **All Medicare patients will need a referral or prescription from their physician in order for us to bill insurance.**

Please read and sign the back.

Notice to our patients

- **All co-pays and deductibles are due at the time of service.**
- **We will gladly file insurance for covered services if we receive proper information. After a 60-day wait, the bill becomes your responsibility.**
- **We do not arbitrate any denials; that is expressly between you and your insurance company.**

Authorization to release information

I authorize the release of information necessary to process claims and to request that payment be made directly to Ears to You. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Ears to You will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Ears to You will be credited to my account upon receipt.

Authorization to release information to the following:

Name _____

Address _____

Name _____

Address _____

Name _____

Address _____

Payment for services

I understand that charges for services rendered and products delivered are due on the date of service, unless other arrangements are made or services and/or products are a benefit covered by my insurance.

I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I further agree in the event of nonpayment to bear the cost of collection and/or court costs and reasonable legal fees, should this be required.

My signature below acknowledges that I have read and agree to abide with the above information.

Signature _____ **Date** _____

For office use only:

_____ Notice of privacy policy	_____ Data entry of patient information
_____ Copy of all insurance cards	_____ Data entry of insurance information
_____ Confirmation of eligibility	_____ Data entry of appointment
_____ Referral (make copy for billing; original in chart)	_____ Organize and file chart