
North Dallas Ear, Nose and Throat

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NEW PATIENT INFORMATION SHEET

Please print clearly. Please complete all information so that your claim can be processed quickly and efficiently. Thank you!

PATIENT INFORMATION

Name (First, M.I. Last): _____ Nickname: _____

Address (No PO Boxes): _____

City, State, Zip _____

Date of Birth: ____/____/____ Social Security #: ____/____/____ Sex: Male/ Female

Home #: (____)____-____ Work #: (____)____-____ Cell #: (____)____-____

Marital Status: Single Married Divorced Widowed

Are you employed? Yes No Full Time Part Time Self Retired

Primary Email Address: _____ Can NDENT email confidential information/ reminders to this address? Y / N

Employer Name & Employer Address: _____

Referring Physician: _____ PCP: _____

If you were not referred by a physician how did you hear about our office? _____

PRIMARY INSURANCE COMPANY & SUBSCRIBER INFORMATION (This Section Only Needs to Be Completed If The Insurance Is In Another Name)

Name: _____ Relationship to patient: _____ Employer Name: _____

Address: (if different from above) _____

City, State, Zip _____

Date of Birth: ____/____/____ Social Security #: ____/____/____ Sex: Male/ Female

Home #: (____)____-____ Work #: (____)____-____ Cell #: (____)____-____

Primary Insurance Company: _____ ID#: _____ Group#: _____

SECONDARY INSURANCE COMPANY & SUBSCRIBER INFORMATION (This Section Only Needs to Be Completed If The Insurance Is In Another Name)

Name: _____ Relationship to patient: _____ Employer Name: _____

Address: (if different from above) _____

City, State, Zip _____

Date of Birth: ____/____/____ Social Security #: ____/____/____ Sex: Male/ Female

Home #: (____)____-____ Work #: (____)____-____ Cell #: (____)____-____

Secondary Insurance Company: _____ ID#: _____ Group#: _____

ACCIDENT INFORMATION

Is this illness/injury the result of an accident? Y / N Where did it occur? Work Auto Other Date of accident _____

Have you reported this illness/injury to your employer? Yes No

Notice: This office does not treat worker's compensation illness/injury or file worker's compensation claims.

Patient Initials: _____

Assignment of Benefits/Release of Information/Notice of Privacy Practices/Appointment of Authorized Representative

~Please read and initial each paragraph~

_____ North Dallas Ear, Nose & Throat, P.A. entity, and associated physicians are committed to securing the privacy of your health information. We are supplying you with a copy of our notice of privacy practices. You are not required to read this notice. By initialing, you are acknowledging receipt of this notice.

_____ I have requested that payment of authorized Medicare and other insurance benefits be made on my behalf to North Dallas Ear, Nose & Throat, P.A. for any services furnished to me by any health care providers associated with that group. I authorize any holder of medical information about me to release to the healthcare financing administration and its agents or insurance company any information needed to determine these benefits or the benefits payable for the related services.

_____ I appoint North Dallas Ear, Nose & Throat, P.A. to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

_____ Unless I request to the contrary, in writing, I will receive appointment reminders on my home/cell/work telephone and or to the email address provided, which ever is the policy of this practice.

Patient Financial Responsibility Statement

In order to maintain our fees at the lowest possible level, it is important that we have a good understanding with our patients regarding financial responsibility. We hope that this summary will be helpful toward that end. We encourage you to discuss it with us and to ask questions.

We understand that our health coverage is provided through _____ (insurance company)

- ~ If you have out-of-network benefits, we will happily file claims on your behalf.
- ~ You must pay any co-payment and any applicable deductible amounts at the time of service unless other arrangements have been made.
- ~ The remainder of your bill will be sent to your health plan for direct payment to our office.
- ~ If your insurance carrier has not paid our claim within 45 days, we will expect payment to our office
- ~ If, by mistake, your plan remits payment to you, please send it to us along with all paperwork sent to you at the time.
- ~ You will remain responsible for amounts and any services that are not covered by your insurance plan.
- ~ Your health plan may refuse payment of a claim for some of the following reasons:
 - * This is a pre-existing illness that is not covered by your plan
 - * You have not met your full calendar year deductible
 - * The type of medical service provided is not covered by our plan
 - * The health plan was not in effect at the time of service
 - * You have other insurance which must be filed first

Please understand that financial responsibility for medical services rests between you and your health plan. While we are pleased to be of service by filing your medical insurance for you, we are not responsible for any limitations in coverage that may be included in your plan. If your health plan denies this claim for any of these reasons, our office cannot be responsible for this bill. It is your responsibility as the patient to pay the denied amounts in full.

Our primary mission is to provide you with quality, cost effective, medical care. Together we are trying to adapt to the changing way that health care is financed and delivered. Again, we value you as a patient and our first priority is to provide you with the best possible care. With this housekeeping chore complete, we are pleased to serve you.

Sincerely,

North Dallas Ear, Nose & Throat, P.A.

I have completed this for in its entirety with accurate information. I have read and understand my obligations and responsibilities. I acknowledge that I am fully responsible for supplying correct insurance/billing information and payment of any services not covered or approved by my insurance carrier.

_____ (Signature of patient or authorized representative) Date _____

We are now requiring 24 hours notice for the cancellation/rescheduling of your appointment. This policy does not apply to patients who call to cancel/reschedule their appointment 24 or more hours in advance of the scheduled visit, or to patients who have sudden emergencies less than 24 hours before the appointment, which can be discussed with the office manager.

- ~ After the first "No Show/failure to cancel" the patient will be given a phone call and a friendly reminder that the office visit was missed.
- ~ After the second and subsequent missed appointments a "no show" charge of \$25.00 will be sent to the patient. This charge is not billable to the insurance company.
- ~ Please note that it has been, and will continue to be, our policy as a courtesy to our patients to call and attempt to confirm your appointment the day before. It is very important that you verify every contact number on file to ensure that your appointment will not be cancelled or rescheduled.

_____ (Signature of patient or authorized representative) Date _____