S. C. E. N. T. A
Space Coast Ear Nose & Throat, Associates

SPACE COAST
HEARING & BALANCE

PATIENT REGISTRATION

Last Name:________________________________ First Name:______________________________

Address:____

City:_____________________________________ State:________ Zip Code:________________

Home Phone:______________________________ Cell Phone:______________________________

Social Security:___________________________ DOB:____________________ Sex: M / F

Email Address: ____

Emergency Contact:____

Relation:__________________________________ Phone #:________________________________

Primary Physician:________________________ Pharmacy Name:_________________________

INSURANCE INFORMATION

Primary:___________________________________ Secondary:______________________________

Ins #:_____________________________________ Ins #:__________________________________

Group #:___________________________________ Group #:________________________________

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RESPONSIBLE PARTY INFORMATION – PERSON INSURANCE IS UNDER
(Patients that are minors please fill out parent information)

Last Name:________________________________ First Name:______________________________

Social Security:___________________________ DOB:______________________ Sex: M /F

Address:____

City:_____________________________________ State:__________ Zip Code:_______________

Home Phone:______________________________ Cell Phone:______________________________

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the physician of the surgical and/or medical benefits. If any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

Signature:________________________________ Date:____________________________________

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

Signature:________________________________ Date:____________________________________

CONSENT FOR COMMUNICATION AND/OR DISCLOSURE

I request that the following alternatives or limitations relating to communication directed to me by my healthcare provider or employee of Space Coast Ear Nose & Throat, Associates.

Do we have permission to call you at home or cell and leave a message regarding?

Appointment Information	YES	NO
Billing Information	YES	NO
Medical Information	YES	NO

I give my permission to share the following information with the person(s) names below:
Do not list Doctor's names. For minor's please list parent names.

Name:______________________________ Relationship:_____________________

Appointment Information	YES	NO
Billing Information	YES	NO
Medical Information	YES	NO

Name:______________________________ Relationship:_____________________

Appointment Information	YES	NO
Billing Information	YES	NO
Medical Information	YES	NO

Name:______________________________ Relationship:_____________________

Appointment Information	YES	NO
Billing Information	YES	NO
Medical Information	YES	NO

X____________________________________ ______________________________

Patient or Guardian Signature **Date**

PARENT/GUARDIAN ONLY

I give the following people permission to bring my child to appointments and make medical decisions: ID will be required at check in and needs to be at least 18 yrs old.

Name:____________________________________ Relationship:_____________________

Name:____________________________________ Relationship:_____________________

Name:____________________________________ Relationship:_____________________

Name:____________________________________ Relationship:_____________________

X____________________________________ ______________________________

Patient or Guardian Signature **Date**

FINANCIAL POLICY

We have established the following policies to improve communication regarding appointments, medical records and your financial responsibility at the time of service or prior to any scheduled surgery. If you have any questions, please feel free to ask a staff member.

YOUR INSURANCE POLICY: It is the policy of Space Coast Ear Nose & Throat, Associates and Complete Hearing & Balance Solutions to collect any applicable co-payment and/or deductible at the time of service or prior to surgery. Please be aware that your insurance may require a higher copayment for a specialist office visit.

At this time, our office is a participating provider for most insurance plans and most of the major insurance networks. If we are not a participating provider for your insurance plan, we will still file an insurance claim as a courtesy. However, you will ultimately be responsible for any fees.

If you are enrolled in a (HMO) insurance plan, you must obtain a referral from your primary-care physician (PCP) before your office visit. We will assist you in this process if applicable. Please be aware that without a referral from your PCP, your office visit may have to be rescheduled.

Any fees we charge are for our services only. Any services provided outside of our office will be billed separately by that provider. This would include laboratory, CT scans, MRI scans and surgery performed at the hospital or another facility. Please speak directly with those providers regarding their fees.

Federal law prohibits our office from writing off any balances due after insurance. Patients who are experiencing financial difficulties should speak to the office manager prior to their office visit.

MISSED APPOINTMENTS/LATE CANCELLATIONS: Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to your appointment for an office visit. We reserve the right to charge $25 for missed or late cancelled appointments and $50 for a missed or late cancelled office procedure and/or surgery. This fee is not covered by your insurance company. Excessive abuse of scheduled appointments may result in discharge from the practice. Our office understands that emergencies do arise, but please call our office to discuss this with a staff member.

COPAY/COINSURANCE/DEDUCTIBLES: It is our policy to collect your copay, coinsurance and/or deductible prior to services rendered. If you are unable to pay at the time of service, we will need to reschedule your appointment.

AUDIO & FOLLOW UP APPTS: If you are having a hearing test and following up with a doctor on the same day or different day, your insurance company may charge you two copays because those appointments are separate.

NO INSURANCE/SELF PAY: If you do not have health insurance, we do offer medicare rates. You will need to pay the full amount at the time services are rendered

PAST DUE ACCOUNTS: Those older than 60 days or those failing to honor agreed-upon payment terms will be sent to a collection agency. Our office will forward your account balance plus any fees charged by the collection agency. Once the collection agency receives your information, your past due debt will be reported on your credit history. Additionally, you will be dismissed from our practice for financial matters and will have to seek healthcare elsewhere.

REFUNDS: Overpayments will be refunded upon request to the responsible party within 30 days. Please keep in mind that an overpayment from your insurance company is not a credit to you and cannot be refunded to you.

MEDICAL RECORDS: Upon request, we will provide you with copies of your medical records. Please allow 3 business days for these requests.

PATIENT CALLS/MESSAGES: The practice maintains an automated attendant with voicemail. We make every effort to answer patient calls as they come in; however, if the staff member you are trying to reach is not available, please leave a message. It is not necessary to leave several messages. Patient calls are handled in order of priority within 48 hours. If you are experiencing an emergency and unable to reach a staff member, please go to the nearest emergency room.

YOUR ACCOUNT: You will be mailed a statement on a monthly basis for any balance due. We request that you pay upon receipt of the statement. Should you have any questions concerning your statement, please do not hesitate to call our office and speak to someone in billing. If your balance is not paid we will need to collect the full amount at your next office visit. Your account must be current prior to any scheduled services. For your convenience, our office accepts cash, checks, VISA, MasterCard and American Express. There will be a $25 charge for returned checks.

PATIENT DISMISSAL: Failure to observe these policies, demonstration of unacceptable behavior or medical noncompliance can result in dismissal from the practice.

I hereby understand and agree to the financial policies of Space Coast Ear Nose & Throat, Associates.

X_______________________________________ _______________________

Patient or Guardian Signature Date