SOUTHWEST IDAHO ENT
Ear Nose and Throat, P.A.

PATIENT INFO:

Patient's Legal Name: First _____ Middle _____ Last _____ ☐ Male ☐ Female

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Cellphone _____ Work Phone _____ Ext. _____

Email Address _____

D.O.B. _____ Marital Status ☐ M ☐ S ☐ D ☐ W ☐ Other _____

Spouse's Name _____ D.O.B. _____

Primary Care Physician _____ Referring Physician _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander
☐ Caucasian ☐ Hispanic or Latino

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other _____ Preferred Language _____

Patient's Employer _____ Work Phone _____

Patient's Legal Guardian (If Applicable) _____

Father's Name (IF MINOR) _____ D.O.B. _____

Father's Home Address _____ City _____ State _____ Zip _____ Phone _____

Father's Employer _____ Occupation _____ Work Phone _____

Mother's Name (IF MINOR) _____ D.O.B. _____

Mother's Home Address _____ City _____ State _____ Zip _____ Phone _____

Mother's Employer _____ Occupation _____ Work Phone _____

PRIMARY INSURANCE COMPANY NAME _____ Phone _____

Subscriber Name _____ Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Step Parent ☐ Other

Subscriber D.O.B. _____ Subscriber # _____ Group # _____

SECONDARY INSURANCE COMPANY NAME _____ Phone _____

Subscriber Name _____ Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Step Parent ☐ Other

Subscriber D.O.B. _____ Subscriber # _____ Group # _____

To whom may we disclose your health information if you are not available? (e.g. Appointment Times, Test Results, Financial)

_____

Whom may we contact in case of emergency? _____

Relationship _____ Phone _____

SOUTHWEST IDAHO EAR NOSE AND THROAT, P.A.
FINANCIAL POLICY

Our practice is committed to providing the best treatment possible for our patients. Our charges are usual and customary for our specialty. Your insurance policy is a contract between you and your insurance company. It is the patient's responsibility to know what services are covered under their insurance policy. Full payment is due at the time of service for all co-pays, co-insurance or any deductible amounts.

We are not affiliated with any hospital and we are unable to accept their approval for financial assistance. We do not offer a sliding fee scale for our charges. If you require financial assistance from our office or want to arrange a payment plan, please contact our billing office at 208-367-6950. We accept cash, check, Visa, Mastercard, American Express, Discover and CareCredit.

If you do not cancel 24 hours prior to your appointment time, or arrive to your appointment more than 15 minutes late, you will be charged a no-show fee of $50.

Southwest Idaho Ear Nose and Throat, PA uses third party agencies to collect on accounts that are past due. Returned checks are subject to an additional fee and will be sent to a third party agency if not paid in full after receiving notification.

The physicians at Southwest Idaho Ear Nose and Throat may need to perform additional testing during your visit. In order to accurately diagnose and treat your medical condition, your physician may prescribe diagnostic tests such as Hearing and Balance Tests, Nasal Endoscopy, Laryngoscopy, CT Scans, Biopsies and/or other diagnostic testing including cerumen removal (ear cleaning). Each insurance policy processes these tests differently and charges may be applied to your deductible and/or co-insurance or co-pay. Every effort will be made to obtain any required authorization prior to your testing. If you wish to discuss charges prior to testing please ask to speak with the billing staff.

I authorize the release of any information necessary to determine liability for payment to obtain reimbursement on any insurance claim. I request that payment of authorized benefits be made on my behalf. I assign benefits to which I am entitled including private insurance and other health plans to Southwest Idaho Ear Nose and Throat, PA. This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges that are not paid by insurance including all diagnostic testing.

I hereby authorize Southwest Idaho Ear Nose and Throat, PA to appeal any incorrect insurance payment. I release Southwest Idaho Ear Nose and Throat, PA from all legal responsibility or liability that may arise from this authorization.

I AGREE TO THE ASSIGNMENTS AND ACKNOWLEDGE MY FINANCIAL RESPONSIBILITIES DISCUSSED ABOVE.

Signature: _____ Date: _____

Responsible Party Signature

HIPAA Notice of Privacy Practices: I acknowledge the receipt of Southwest Idaho ENT, P.A.'s notice of privacy practices.

Signature: _____ Date: _____

Is your visit the result of accident? ☐ YES ☐ NO

Date of Injury: _____ Description: _____

Is this a Worker's Compensation claim? ☐ YES ☐ NO

Claim Number: _____