Comprehensive
Ear, Nose and Throat, P.C.

Patient Registration Form

Patient's Name: **Birthdate:** **Sex: M F**

Street Address:

City: State: Zip code:

Home Phone: Work Phone: Cell Phone:

Patient's SSN: Circle one: Single / Married / Divorced / Widow / Widower

Patient's Spouse: Referring Doctor:

If Patient is Under 18 Years of Age:

Mother's Name: **Father's Name:**

Mother's Address: Father's Address:

Home Phone #: Home Phone #:

Work Phone #: Work Phone#:

Credit/Billing Information:

Name of person responsible for patient insurance: Relationship:

Responsible person's address:

Home phone #: Work phone #: SSN:

Responsible Person's Employer:

Employer's Address:

First Insurance Company: Policy #: Group#:

Name of Subscriber: Date of Birth:

Second Insurance Company: Policy: #: Group#:

Name of Subscriber: Date of Birth:

Name of Emergency Contact Person:
Relationship to patient: **Contact Phone #:**

Consent For Treatment by Comprehensive Ear, Nose and Throat, PC.

I, ___________________________ (patient's name) voluntarily request, consent to, and authorize Comprehensive Ear, Nose and Throat, PC., residents, assistants or other associated practitioners to provide medical and surgical treatment including, but not limited to: creation of Protected Healthcare Information, diagnostic procedures, x-rays, and administration of medications as is deemed necessary and advisable. I understand that Comprehensive Ear, Nose and Throat, PC. is a participant in the Metropolitan Hospital/ Michigan State University College of Osteopathic Medicine Statewide Campus System. Residents, Interns, and Medical Students may be participating in my care under supervision. I can at any time request that these trainees not be involved in my care by notifying my attending physician. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments and examinations provided by Comprehensive Ear, Nose and Throat, PC.

Authorization to Pay Benefits to Comprehensive ENT, PC.

I hereby authorize that payment be made directly to Comprehensive Ear, Nose and Throat, PC. for services rendered. I understand that many insurance companies pay promptly and completely for agreed upon and contracted services, however, I recognize and accept responsibility for any balance, deductible(s) or fee(s) not covered or denied by my insurance company. I agree to pay any co-pays at the time of service.

- Please provide your insurance card(s) if requested at each visit.
- A returned (bounced) check fee of **$25.00** will be added to your account for any check returned to us for insufficient funds.
- Delinquent accounts may be referred to a collection agency after every reasonable attempt has been made to contact and work with you regarding your account status.

My signature below represents that I understand and agree to the above statements of policies established by Comprehensive Ear, Nose and Throat, PC.

Signature of Patient or authorized agent for patient: ______________________________

Thank you for your understanding. Date: ______________________________

Statement of Responsibility for a Minor Child

The parent or guardian of a minor child who brings the child in for medical treatment is responsible to pay any charges incurred. If insurance is available for the child, the information must be presented at the time service is rendered. If any remaining balance is owed after payment is received from the insurance(s), that parent or guardian is responsible for payment as detailed above. I understand and agree to the above statement of responsibility established by Comprehensive Ear, Nose and Throat, PC.

Signature of Patient or authorized agent for patient: __________________________

Date: __________________________

Revised 11/11/08