

PATIENT INFORMATION
GREENLEY OAKS EAR, NOSE & THROAT

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PATIENT INFORMATION: PLEASE PRINT CLEARLY **TODAY'S DATE:** _____

PATIENT NAME: _____ **Referring Physician:** _____

Sex: M F **Primary Physician:** _____

Mailing Address: _____ **City:** _____ **Zip:** _____

Telephone: () _____ **Cell Phone:** _____ (optional)

Birthdate: _____ **age:** _____ **SS#** _____

Employed Retired Other Student

EMPLOYER: _____ **Work Telephone ()** _____

Employer

address: _____ **City:** _____ **zip:** _____

_____ complete this section only if someone else other than the patient is financially responsible

Responsible Party: _____ **Birthdate:** _____

Relationship to patient: _____ **SS#:** _____

Employer: _____ **Address:** _____

Mailing address(if different than patient) _____

Telephone () _____ **work#** _____

Name of spouse: _____ **Birthdate:** _____

Emergency contact: _____ **Telephone:** _____

HOW DID YOU LEARN ABOUT OUR PRACTICE: _____

MAY WE CONTACT YOU AT WORK? YES NO

MAY WE LEAVE A MESSAGE ON YOUR MACHINE? YES NO

MAY WE DISCUSS YOUR MEDICAL CARE OR FINANCIAL OBLIGATION

WITH ANY ONE ELSE other than YOU? YES NO

IF YES:

NAME: _____ **RELATIONSHIP:** _____

GREENLEY OAKS EAR, NOSE & THROAT

PATIENTS NAME: _____ TODAY'S DATE: _____

INSURANCE INFORMATION

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY: _____

SUBSCRIBER'S NAME: _____ BIRTHDATE: _____

POLICY ID NUMBER: _____ GROUP NUMBER: _____

SECONDARY INSURANCE

NAME OF INSURANCE COMPANY: _____

SUBSCRIBER'S NAME: _____ BIRTHDATE: _____

POLICY ID NUMBER: _____ GROUP NUMBER: _____

**MEDICAL HISTORY: IF YOU HAVE A LIST OF MEDICATIONS PLEASE GIVE IT TO THE
RECEPTIONIST TO COPY**

MEDICATIONS: SEE LIST or

DRUG ALLERGIES: _____

PRIOR SURGERIES: _____

**OTHER CONDITIONS WE SHOULD KNOW
ABOUT:**

PATIENT NAME: _____

DATE: _____

PLEASE READ THOROUGHLY

Assignment of Benefits:

I assign all medical/surgical payments, to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to: Greenley Oaks Ear, Nose & Throat. This assignment will remain in effect and valid until revoked by me in writing. A photocopy of this agreement is to be considered as valid as an original. I understand that regardless of insurance, I am financially responsible for all charges. I hereby authorize Greenley Oaks to release all information necessary to secure payment from any carrier that they bill for my services.

***CLAIM SUBMISSION**

We will submit your claims for processing only for insurance companies that we are contracted providers with. We will assist you with filing your claim with your insurance company if you happen to have an insurance that we are not contracted with. What this means is you will need to pay for services rendered at the time of the service. We will give you a receipt that you then can file with your insurance company for reimbursement. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not a party of that contract. We will only bill secondary/supplemental insurances that we are contracted with. We will only bill them once. If the secondary/supplemental insurance hasn't paid within 45 days the balance becomes patient responsibility.

***PATIENT PAYMENT RESPONSIBILITY**

Patients are responsible for any co pay due at the time of service. Patient is responsible for payment of services at the time of service unless we are contracted providers of your insurance and we are billing the service for you. Balances over 90 days past due will be referred to an outside collection agency unless the office is contacted and other arrangements are made. There will be a \$25.00 no show charge for missed appts. not canceled 24 hours before appt. There will be a \$20.00 NSF charge on all returned checks.

I have completed this form fully and completely and certify that I am the patient or duly authorized general agent authorized to furnish the information requested. I understand that even though I may have some type of insurance coverage, I am fully responsible for payment of services rendered by Greenley Oaks ENT physicians & staff through physician direction.

I UNDERSTAND THAT PAYMENT IS DUE AT THE TIME OF SERVICE. I understand that necessary billing papers will be furnished to me by this office to bill my insurance for my reimbursement of medical services if not being billed by Greenley Oaks ENT.

ANY BALANCE LEFT ON ACCOUNT AFTER 90 DAYS WILL BE TURNED OVER TO COLLECTION, unless payment arrangements are made with the office manager in advance. If my account is referred for collection, I understand that it will result in IMMEDIATE DISMISSAL from the practice for ALL MEMBERS OF MY FAMILY and MYSELF.

I have read and understand the above assignment, patient responsibility and office policies. I agree to all of the above.

Signature of patient/legal guardian: _____

Date: _____