

MECKLENBURG EAR, NOSE AND THROAT

PATIENT INFORMATION

Last Name _____ First Name, MI _____

Street Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

DOB _____ SSN# _____ Marital Status _____ M/F _____

Emergency Contact _____ Relationship _____ Phone _____

Primary Physician _____ Employer _____

Primary Insurance _____ ID # _____ GRP# _____

Policy Holder _____ DOB _____ SSN _____

Copay _____

Secondary Insurance _____ ID # _____ GRP# _____

Policy Holder _____ DOB _____ SSN _____

Copay _____

Assignment of Insurance Benefits

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or my dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or services to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I assign all benefits for said services to Mecklenburg ENT. I further understand I am financially responsible for charges not covered by my insurance plan.

“No Show” Policy

Mecklenburg Ear Nose & Throat reserves the right to charge a \$35.00 “no show” fee to any patient who does not cancel an appointment at least 24 hours in advance.

Privacy Practices

I have received a copy of the Mecklenburg Ear Nose and Throat privacy practices which summarizes the ways my identifiable health information may be used and disclosed by the provider. I understand the provider has the right to revise these privacy practices.

Signature of Subscriber/Guardian

Date