PATIENT INFORMATION FORM

Account _____ Date _____

Patient

Last name_____ First name_____ Middle_____

Street address _____ Apt. # _____

City _____ State_____ Zip_____

Home phone (_____) _____ Work phone (_____) _____ Cell phone (_____) _____

Date of birth _____ Last 4 digits SS#_____ Age_____ Sex M F

Driver's license # _____ Marital status _____

Email_____

Employer _____ Employer phone #_____

Employer address _____ City _____ State_____

Spouse's name_____ Spouse's employer_____

Employer address _____ Employer phone # _____

Friend or relative (not living with you _____ Phone # (_____)_____

Referred by _____ Referring physician_____

Personal physician _____ Phone # (_____)_____

Pharmacy Phone # (_____) _____

Insurance Information

Primary Insurance Co. _____ Policyholder Name _____

Policyholder Birthdate _____

Second Insurance Co. _____ Policyholder Name _____

Policyholder Birthdate _____

Guarantor Information (for minor children only)

Name _____ Street address_____

City _____ State_____ Zip_____

Home phone (_____) Relationship to patient_____ Occupation_____

Have you had any recent testing (MRI, CT scan, etc.) for head or neck. If possible, please bring copy of report.

Yes_____ No_____ If yes, where and when_____

I understand, acknowledge, and agree that I am responsible for payment of any health care services provided to the extent not covered by my health insurance, for the reason I did not have a referral (authorization) from my primary care physician.

I understand that I am responsible for all charges regardless of insurance status as well as any associated cost for collection should such action become necessary. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

I hereby authorize the release of any information acquired in the course of my examination or treatment to my insurance company.

Your signature below indicates your consent for treatment of/as patient and responsibility for paying the bill.

I hereby authorize the payment of medical benefits directly to the physician.

SIGNATURE_____ DATE_____

Dr. Michael A. Freedman Patient Financial Policy

The physician and staff are here to serve your needs as our patient. It is our goal to create an experience for our patients that hopefully will limit the amount of stress patient may encounter. Our PATIENT FINANCIAL POLICY is intended to describe our expectations regarding payment for services we provide.

This FINANCIAL POLICY details the expectations of practice as they relate to patients making payment of provided services. Patients should acknowledge the following policy requirements:

1. The patient, or his/her designated guarantor, is responsible for payment of services.
2. All office charges, co-payments, and applicable deductible amounts are due at the time of service unless otherwise specified. There is a service charge of $35.00 for a returned check.
3. The provision of the insurance card for payment of services will be accepted and filed on the behalf of the patient; however, the patient is still responsible for payment if his/her insurance fails to adequately provide payment in a timely or appropriate manner.
4. It is the obligation of the patient to obtain and provide any referral notification required by the patient's insurance carrier. Without the appropriate referral the patient's appointment will have to be rescheduled.
5. Patient account balances are due within 30 days of the receipt of the billing statement unless otherwise specified.
6. There is a minimum $15.00 charge to copy medical records.
7. Patient may contact our office to make payment arrangements:
    - Balances less than $150.00 must be paid within 90 days.
    - Balances of $151.00 to $500.00 must be paid within 6 months.
    - Balances greater than $500.00 must be paid within 12 months or less
8. After 90 days, if no arrangements have been made for payment or if no payment has been received, collection proceedings will begin. A **$35.00 collection fee** will be added to your account and sent to our collection service **American Profit Recovery Services.**
9. We will be billing your insurance for all services done in our office. In addition to the office visit there are several services that additional charges:
    - Flexible Endoscopy, Nasal Endoscopy (surgical procedure), etc.
    - Kenalog and Celestone Steroid Injections
    - Allergy Testing and Injections
    - Audio Testing
10. For all services rendered to minor patients (under the age of 18), we will look to the adult accompanying the patient.
11. **UNLESS CANCELED AT LEAST 24 HOURS IN ADVANCE OUR POLICY IS TO CHARGE $50.00 FOR A MISSED APPOINTMENT. REMINDERS REGARDING THE APPOINTMENTS ARE SENT OUT VIA TEXT MESSAGE/VOICEMAIL THROUGH OUR SERVICES SOLUTION REACH.**

"I, _____ (print name) (Patient/Guarantor), acknowledge that I have received and read this Financial Policy Statement."

Signature of Insured or Authorized Representative _____ Date_____