

Patient Name: \_\_\_\_\_ Chart Number: \_\_\_\_\_

**SUBSCRIBER INFORMATION**

**PRIMARY INSURANCE:** \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Relation to patient: \_\_\_\_\_

Subscriber's Address: \_\_\_\_\_ Phone#: \_\_\_\_\_

Date of birth insured: \_\_\_\_\_ Grp#: \_\_\_\_\_ ID#: \_\_\_\_\_

**SECONDARY INSURANCE:** \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Relation to patient: \_\_\_\_\_

Subscriber's Address: \_\_\_\_\_ Phone#: \_\_\_\_\_

Date of birth insured: \_\_\_\_\_ Grp#: \_\_\_\_\_ ID#: \_\_\_\_\_

**RESPONSIBLE PARTY:** \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

SS#: \_\_\_\_\_ DOB: \_\_\_\_\_

**PLEASE NOTE**

**PAYMENT IS REQUIRED AT TIME OF SERVICE  
THERE WILL BE A \$25.00 FEE FOR RETURNED CHECKS  
FOR YOUR CONVENIENCE, WE ACCEPT ALL MAJOR CREDIT CARDS**

I understand that I am financially responsible for all charges and guarantee payment of this account.

I hereby authorize EAR MEDICAL GROUP to release any information required in the course of my examination or treatment for insurance claims. Furthermore, I authorize payment directly to EAR MEDICAL GROUP for medical and/or surgical benefits, which may otherwise be payable to me for their services.

I authorize any physician, hospital, laboratory, or x-ray facility to release to any physician of EAR MEDICAL GROUP any and all medical information hospital record, laboratory studies or x-rays that may be requested. A copy of this authorization is as binding as the original.

Patient / Parent / Guardian name (please print): \_\_\_\_\_

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

## Ear Medical Group Financial Policy

It is our office policy to inform you of our patient payment procedure. Please review the section below that is applicable to you, as checked, and initial it.

1 \_\_\_\_\_ **Patient with Insurance**. You are responsible for deductibles, copays, noncovered services, coinsurance, and items considered “not medically necessary” by your insurance company. Please pay co-payment and coinsurance amounts as services are rendered. The remaining balance should be taken care of 30 days after receipt of payment from the insurance company. If you or your insurance carrier makes payment exceeding your balance, reimbursement will be remitted. If payment cannot be made at each visit, notify the front desk staff to visit with our insurance department.

2 \_\_\_\_\_ **Patient without Insurance (private pay)**. Please make payment for your care at each patient visit. If payment cannot be made at each visit, notify the front desk to make other arrangements.

3 \_\_\_\_\_ **Worker’s Compensation Patient**. As a Worker’s Compensation patient, you may be covered by insurance if your injury is reported at work and verified with your employer. Please be sure to inform the office personnel that injury resulted during employment. The patient is ultimately responsible for the balance due.

4 \_\_\_\_\_ **Personal Injury (accident)**. If you are a personal injury patient, our office will bill the appropriate insurance companies. If we are unable to obtain payment, the charges for the services rendered will be your responsibility. Please give all information needed for billing. If an attorney is involved and asks you not to submit insurance claims, a doctor’s lean must be signed by you are your attorney.

5 \_\_\_\_\_ **Medicare**. Our office will submit your Medicare charges to Medicare and your secondary insurance, if applicable. You are responsible for deductibles, copays, and any noncovered services.

6. We do not participate with \_\_\_\_\_. If we do not participate with your individual insurance, please make payment for your care at each patient visit. If payment cannot be made at each visit, notify the front desk staff and make arrangements with the insurance department.

# Guarantee of Payment

\_\_\_\_\_ I understand that I am totally responsible for payment of all fees and services rendered, irrespective of insurance coverage or other responsibilities.

**NOTE: The guarantor of each account is ultimately responsible for payment in full of the account. Current, accurate information regarding guarantor and insurance coverage must be provided.**

\_\_\_\_\_ I have been advised that if my health insurance carrier / HMO / Medicaid / Medicare plan claims that the services I received today are not considered reasonable and medically necessary for my care, I will be responsible for payment of these services.

\_\_\_\_\_ I understand that if I am participating in an HMO plan, my primary care physician (PCP) must authorize the services that I requested and received today. I have been advised that if I did not notify my PCP in advance for a referral authorization, my HMO plan may deny payment for services and thus, I will become responsible for payment of all services.

\_\_\_\_\_ I have been provided with an overview of the billing process and have read the copy of the "Understanding Your Financial Responsibilities" handout.

## ASSIGNMENT

\_\_\_\_\_ I request that payment of authorized Medicare benefits be made on my behalf to Ear Medical Group for any service furnished to me by these providers.

\_\_\_\_\_ The signature below authorizes payment of mandated medigap benefits to Ear Medical Group. Medigap - \_\_\_\_\_ Policy Number - \_\_\_\_\_ Group Number - \_\_\_\_\_

\_\_\_\_\_ I assign the benefits from my insurance carriers to this clinic for the medical/surgical benefits I am entitled.

## RELEASE OF INFORMATION

\_\_\_\_\_ I authorize the Ear Medical Group to release to my insurance carrier(s) any information needed to determine benefits or benefits payable for related services.

\_\_\_\_\_ I have read and agree with understanding my financial responsibilities and the payment, policy, assignment, and release of information paragraph stated which apply to me.

**X** \_\_\_\_\_  
Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Person signing on behalf of patient

\_\_\_\_\_  
Relationship to patient