Nevada ENT & Hearing Associates
9770 S. McCarran Blvd.
Reno, NV 89523

PLEASE PRINT
Date:______________________

____
Last Name First Name M.I Date of Birth

____
Street Address Apt# City State Zip Code

____
Mailing Address (if different than above) City State Zip Code

____
Home Telephone Number Cell Phone Number Work Telephone Number

____
Social Security Number Gender (Male/Female) Occupation

____
Responsible Party (if patient under 18) Responsible Party SS# Responsible Party DOB

____
Responsible Party relationship to Patient Mother's Name Father's Name

____
Referring Physician if Any Family Physician

____
Person to contact in case of emergency Phone Number(s) Relationship to Patient

***** IN ORDER FOR US TO FILE A CLAIM WITH YOUR INSURANCE COMPANY, YOU MUST COMPLETELY FILL OUT ALL INSURANCE INFORMATION. YOUR INSURANCE COMPANY REQUIRES THAT WE HAVE THIS INFORMATION *****

PRIMARY INSURANCE

____
Insurance Company Name Insurance Company Address

____
ID Number Group Name/Number Employer

____
Insured's Name Relationship to Patient Insured Social Security Number Insured DOB

SECONDARY INSURANCE

____
Insurance Company Name Insurance Company Address

____
ID Number Group Name/Number Employer

____
Insured's Name Relationship to Patient Insured Social Security Number Insured DOB

AUTHORIZATION TO USE & DISCLOSE HEALTH INFORMATION

I authorize Nevada ENT & Hearing Associates, LLC, to request/disclose a copy of the specific health and medical information described below regarding:

Name of Patient: ______________________________________date of birth:__________________

consisting of items such as; clinical notes, prescriptions, lab results, xray results,
(please note if the family or friends listed below are able to bring in the patient w/o your presence)

etc:____

____

Names of family or friends who can call and check on your well being and/or who can pick-up prescriptions, records, etc. when you are unable to:

Name: __________________________ Phone: ________________ Relationship to patient__________

Name:___________________________ Phone: ________________ Relationship to patient__________

For the purpose of Medical Care:

We are requesting this Authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us:

- We cannot condition our provision of services or treatment to you on the receipt of this signed authorization
- You may inspect a copy of the protected health information to be used or disclosed
- You may refuse to sign this Authorization
- We will provide you with a copy of the signed authorization, if requested.

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization.

Unless revoked earlier or otherwise indicated, this Authorization will expire in 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

Signature of Patient: _____________________________________ Date:_____________________

Signature of Guardian:____________________________________ Date:_____________________

NEVADA ENT & HEARING ASSOCIATES

Financial Office Agreement

Patients Name:___________________________________ **Date of birth:**________________

The doctors of Nevada ENT & Hearing Associates participate in many insurance plans, but not all of them. It is your responsibility to know whether the doctor you are seeing is a participant on your plan. Charges for services rendered by Nevada ENT will be will be submitted directly to your insurance company for payment, as a courtesy to you. You will be responsible for any amount not paid by your insurance. Should you not have insurance coverage, you will be responsible for payment at the time of your visit.

All copays are due at the time of service. If your insurance is subject to co-insurance or deductible, our office will collect a minimum of $20.00 at the time of service.

*** Patients should note that not all medical and surgical services are covered by insurance. Patients are directly responsible for such fees. Including services billable in a post-op period.

*** Please be aware that you may be subject to an additional **co pay** by your **Insurance Company** if you are seen by the **Doctor and the Audiologist** on the same day. you are responsible for any balance due after your insurance has processed and paid your claim

*** It is your responsibility to notify this office of you preferred hospital, lab and radiological facilities, and if prior authorization is required.

*** it is your responsibility to make sure your insurance processes and pays your claims in a timely manner.

*** **No Show and 24 Hour Cancellation** policy effective September 1st, 2017. A fee of $25.00 will be applied if you no show to your scheduled appointment or do not provide 24 hour notice for a cancellation. This fee must be paid before we will schedule another appointment. New patients will not be scheduled after 2 consecutive no shows.

Authorization

I authorize Dr Joshua Meier, Dr David Mathis, Dr Anthony Zamboni, Dr Jenny Van Duyne, Dr Thomas Killeen, Dr Richard Johnson, and/or Dr Richard Panelli to release any information acquired during my examination and treatment for the purpose of claim payment. I further authorize payment directly to the physicians for benefits due me for this service. I recognize and accept personal responsibility for any balance remaining after payment of such benefits.

Signature: ____ Date: _______________________

Signature of Guardian:_____________________________________ Date:_______________________

Patients Name:_______________________________________ DOB___________________

REASON FOR TODAY'S VISIT

____

____

Height Weight Pharmacy and Location

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

Name of Medications	**Dosage**	**How Often Taken**

ARE YOU ALLERGIC TO ANY MEDICATION? ____ Yes ____ No

If Yes, please list below

Name of Medication	Type of Reaction

List any surgeries you have had (including dates):

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