

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

PLEASE PRINT

Date: _____

Last Name	First Name	M.I	Date of Birth
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Street Address	Apt#	City	State	Zip Code
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Mailing Address (if different than above)	City	State	Zip Code
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Home Telephone Number	Cell Phone Number	Work Telephone Number
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Social Security Number	Gender (Male/Female)	Occupation
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Responsible Party (if patient under 18)	Responsible Party SS#	Responsible Party DOB
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Responsible Party relationship to Patient	Mother's Name	Father's Name
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Referring Physician if Any	Family Physician
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Person to contact in case of emergency	Phone Number(s)	Relationship to Patient
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***** 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
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ID Number	Group Name/Number	Employer
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Insured's Name	Relationship to Patient	Insured Social Security Number	Insured DOB
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SECONDARY INSURANCE

Insurance Company Name	Insurance Company Address
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ID Number	Group Name/Number	Employer
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Insured's Name	Relationship to Patient	Insured Social Security Number	Insured DOB
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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 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.

*** Patients should note that not all medical and surgical services are covered by insurance. Patients are directly responsible for such fees. You will be informed and billed accordingly at the time of your visit.

*** 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.

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: _____