Zaher Srour, M.D.

Advanced Otolaryngology & Allergy, LLC

Ear, Nose, Throat - Facial Plastic & Reconstructive Surgery

864 Broadway, Hanover, PA, 17331 www.HanoverENT.com **Tel:717-632-2221**

Patient Registration Form

Patient's Last Name, First Name, MI:_____

Sex: F M T Birth date:___/___/___ **Social Security**:___/___/___

Marital Status: S M W D EMAIL ADDRESS:_____

Race: _____ Language: _____

Patient Address:_____

Pt Home Tel #:_____ Pt Cell #:_____

Pt Employer:_____ Pt Work Tel #:_____

Name of Insurance Policy Holder: _____

Relationship to patient:_____ Social Security: ___/___/___

Date of Birth:_____ **Pharmacy Used**:_____

Emergency Contact Information

Contact Name:_____ Home Tel #:_____

Relationship:_____ Work/Other Tel #:_____

Primary Care Provider (Family Doctor)

Name:_____

Office Tel #:_____

Referring Provider

Name:_____

Office Tel #:_____

Whom May we thank for this referral (if not a provider)? _____

Insurance billing authorization & assignment of benefits

I have completed this form full and completely and certify that I am the patient or duly authorized general agent/guarantor to furnish the information requested. I authorize the physician, designate, or practice to release pertinent insurance information regarding my medical care, services, and treatment to the Centers for Medicare & Medicaid Services and/or my current insurance carrier and their agents for the purpose of determining the benefits payable for the services rendered. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf to the aforementioned provider/practice. I understand that I am responsible for all dues regardless of insurance coverage.

CONSENT TO TREAT

I request and give consent to Advanced Otolaryngology & Allergy, LLC , its providers and staff to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as are considered necessary or beneficial for my health and well being. This includes, but limited to, injections, testing (e.g. Allergy, vertigo & hearing testing), endoscopies, biopsies and surgical procedures. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

Patient or Guarantor Signature:_____ **Date:** ___/___/___

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Advanced Otolaryngology & Allergy, LLC - FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to the success of your treatment. Please understand that payment of your bill is considered a part of the treatment process.

EXPECTED AMOUNT DUE: By law we MUST collect your carriers designated co-pay/co-insurance and/or deductible. PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE. WE ACCEPT PAYMENT BY CASH, CHECK, OR CREDIT/DEBIT CARD.

INSURANCE PARTICIPATION: We may accept assignment of benefits from designated insurance carriers. However, we do require that the estimated co-payments and deductibles be paid at the time of service. The balance is your responsibility whether your insurance company pays or not. We bill primary and secondary insurances only, as a courtesy. If your insurance company has not paid your account in full within 45 days, the balance due will be automatically transferred to your account. Please be aware that some, and perhaps all of the services provided to you may be considered non-covered or your insurance coverage changes to a plan with which we do not participate, you will be responsible for payment for the services that has been rendered.

OUT OF NETWORK PLANS: You will be responsible for any balance your plan indicates as due on their explanation of benefits form. We will adjust the charges to coincide with your plan's UCR (Usual, Customary and Reasonable) charges. All patients will be responsible for their co-pay, co-insurance and deductible. If we do not participate with your plan, we will send a courtesy claim to that carrier on your behalf. Should you receive payment from your insurance carrier, it is your responsibility to forward it to our office.

SELF-PAY PATIENTS & COSMETIC CASES: **FULL** payment is expected at the time of service.

AUTO INSURANCE: Payment in full is requested at the time of the visit. We will provide you a receipt so you can file the claim with your carrier.

WORK RELATED INJURY: We **must** receive your claim information as well as your health insurance information, before you can be seen.

ENT PROCEDURE: Your insurance company requires that we bill our services to you using a coding system known as CPT (Current Procedural Terminology). Many codes that we use to describe the service performed are found in the **"surgery" section** of the CPT code book. This does not mean that you had an operation. This is merely the way the CPT book is organized for ease of use by both the insurance companies and physicians. Your Insurance Company may cover the care rendered for "surgical" codes differently than for office visits. Therefore, your insurance explanation of benefits may reflect that the service was paid as a surgical procedure, with deductible and co-insurance guidelines applied.

Minor Patients: The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved payment at time of service.

Late, Missed Appointments, NO SHOW POLICY: Please help us serve you better by keeping scheduled appointments. If you are going to be more that 15 minutes late, please be courteous and call us. There are times where we will need to re-schedule the appointment, because we may not always be able to fit you in. If you are unable to keep your appointment, we do require the courtesy of a phone call to cancel that appointment 1 Business day (24 hours) in advance. A "No Show Fee" of $50 will be charged to the account if no call received of cancellation for any type of appointment. This $50 will not be billable to insurance and will be out of pocket for the patient. Repeated incidents of not showing for an appointment may lead to release from our office and termination of Patient- Doctor Relationship. A no show for Allergy testing of $100 and for surgery 500$ will be charged a if no cancellation documented before 7 working days.

REFERRALS: If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral, we will reschedule your appointment.

PAST DUE ACCOUNTS: Open accounts with no acceptable* payment activity for 60 days will be considered past due. A billing charge will be assessed to the account balance along with a finance charge of 1.5% per month, with a minimum of $10.00. You will be responsible for the original past due balance along with these additional charges.
PLEASE INITIAL THAT YOU UNDERSTAND._____.
COLLECTIONS: Open accounts with no acceptable* payment activity for 90 days will be automatically placed with our collection agency. If this action becomes necessary, you will be responsible for all costs of collection on unpaid balances including, but not limited to, 1 ½ % interest monthly (18% annually), collection fees (up to 50%), court costs and reasonable attorney fees.
PLEASE INITIAL THAT YOU UNDERSTAND_____.
***Acceptable payment on an account will be determined on an individual basis.**

Thank you in advance for your understand of our Financial Policy. Please let us know if you have any questions or concerns.

Patient Authorization: I certify that the above information is correct to the best of my knowledge. I also understand that I am financially responsible for all charges whether or not covered by my insurance. I agree to pay IN FULL within 30 days of receipt of notice all balances due such as non-covered services, coinsurances, deductibles and co payments not paid by my insurance company in addition to any fees charged against my account. I have also read and understand the Financial Policy as presented to me. Upon request I may have a copy of these agreements.

Print Patient Name: _____

Signature of Patient or Responsible Party: _____ **Date:**____/____/**2017**

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