THE HEAD & NECK CENTER, P.C.

PATIENT INFORMATION

PATIENT NAME:_____ DATE OF BIRTH: _____

IF MINOR – RESPONSIBLE PARTY:_____EMAIL ADDRESS:_____

ADDRESS:_____CITY_____STATE_____ZIP_____

PRIMARY PHONE #_____ SECONDARY PHONE #_____

SINGLE___ MARRIED___ DIVORCED___ WIDOWED___ GENDER _____

NOTIFY IN CASE OF EMERGENCY: _____ PHONE_____

REFERRED BY_____ ***FAMILY DOCTOR***_____

PRIMARY INSURANCE CO. NAME: _____

NAME OF SUBSCRIBER:_____ DATE OF BIRTH:_____

SUBSCRIBER'S EMPLOYER:_____

SECONDARY INSURANCE CO. NAME: _____

NAME OF SUBSCRIBER:_____ DATE OF BIRTH:_____

SUBSCRIBER'S EMPLOYER:_____

OTHER COVERAGE:_____

ADDRESS: _____PHONE:_____

INSURANCE IS CONSIDERED A METHOD OF REIMBURSING THE PATIENT FOR FEES PAID TO THE DOCTOR AND IS NOT A SUBSTITUTE FOR PAYMENT. IT IS MY RESPONSIBILITY TO PAY ANY DEDUCTIBLE AMOUNT, CO-INSURANCE, OR ANY OTHER BALANCE NOT PAID FOR BY INSURANCE. ANY PERSONAL OPEN BALANCE REMAINING AFTER 90 DAYS IS SUBJECT TO A $75.00 DELINQUENT ACCOUNT FEE.

I HEREBY ASSIGN ALL MEDICAL BENEFITS INCLUDING APPLICABLE MEDICARE BENEFITS TO BE PAID DIRECTLY TO THE HEAD & NECK CENTER, P.C. I HEREBY AUTHORIZE MY ATTORNEY TO PAY DIRECTLY AND/OR RESERVE FROM ANY SETTLEMENT, CLAIM, OR AWARD RECEIVED ON MY BEHALF MONIES SUFFICIENT TO PAY THE HEAD & NECK CENTER, P.C. FOR SERVICES RENDERED. IN THE EVENT THAT ANY SETTLEMENT OR AWARD IS INSUFFICIENT TO COVER THE FEES INCURRED IT IS MY RESPONSIBILITY TO PAY THE BALANCE DUE.

I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO CENTER FOR MEDICARE AND MEDICAID SERVICES AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS PAYABLE FOR RELATED SERVICES.

I AUTHORIZE THE HEAD & NECK CENTER, P.C. TO RELEASE ANY INFORMATION CONCERNING MY MEDICAL CARE TO MY INSURANCE COMPANY, INCLUDING WORKMEN'S COMPENSATION CARRIERS AND AUTO INSURANCE COMPANIES IF APPLICABLE, AND TO MY PHYSICIAN AND HEALTH CARE PROVIDERS.

I EXPRESSLY AGREE AND ACKNOWLEDGE THAT MY SIGNATURE ON THIS DOCUMENT AUTHORIZES THE HEAD & NECK CENTER, P.C. TO SUBMIT CLAIMS FOR BENEFITS, FOR SERVICES RENDERED, OR FOR SERVICES TO BE RENDERED, WITHOUT OBTAINING MY SIGNATURE ON EACH AND EVERY CLAIM TO BE SUBMITTED AND THAT I WILL BE BOUND BY THIS SIGNATURE AS THOUGH THE UNDERSIGNED HAS PERSONALLY SIGNED THAT PARTICULAR CLAIM. I AUTHORIZE THAT A PHOTOCOPY OF THIS SIGNATURE WILL BE AS VALID AS THE ORIGINAL.

SIGNATURE_____**DATE**_____