SHENANDOAH HEAD & NECK SPECIALISTS PATIENT INFORMATION SHEET

Chart #: _____ **Date**: _____ **Patient's Name**: _____

Date of Birth: _____ **Sex**: _____ **Social Security #**: _____

Mailing Address: _____ City/State/Zip: _____

Physical Address: _____ City/State/Zip: _____

Home Phone: _____**Cell Phone:** _____**Email**: _____

Parents Names if Minor: Father: _____ SSN: _____

Mother: _____ SSN: _____

In Case of Emergency Please Contact: _____**Relationship:** _____ **Phone #**: _____

INSURANCE INFORMATION

PLEASE PRESENT INSURANCE CARD(S) TO THE FRONT DESK WHEN ARRIVING FOR YOUR APPOINTMENT. CO-PAY IS DUE AT TIME OF SERVICE.

PATIENT AND RESPONSIBLE PARTY AUTHORIZATION/ AUTHORIZATION TO TREAT

1. I authorize Shenandoah Head & Neck Specialists, LLC and SHNS Hearing Services, LLC to apply for benefits on my behalf for the covered services rendered and request that payments for the above insurance company be made directly to the provider for the treated person named. I certify that the information reported about my insurance coverage is current and accurate. I further authorize the release of any necessary information, including medical information for this or any related claim to the above agent. I understand I am responsible for any balance not covered by my insurance.
2. I understand that if I see a provider and have an Audio Test on the same day my insurance company may charge a co-pay for each department.
3. After payment is received from your insurance company, any outstanding balance will be transferred to your personal responsibility. At that time, you will be asked to settle your account within 90 days. Any unpaid balance will incur a $25.00 late fee. Failure to pay your bill in a timely manner may result in us forwarding your account to a collection agency.
4. Should we proceed with collections, you will be responsible for any costs charged to us by our collection agent. In addition, we will schedule no future appointments until you have settled this outstanding balance. IN ALL CASES, PROCESSIONAL FEES ARE THE PATIENT, SPOUSE, GUARDIAN AND/OR PARENT'S RESPONSIBILITY. Finance charge (NO CHARGE IF PAID WITHIN 30 DAYS OF BILLING DATE) is computed by a "periodic rate" of 1 ½% per month, which is an ANNUAL PERCENTAGE RATE OF 18% applied to the previous balance without deducting current payments and/or credits appearing on any given bill. Patient or responsible party agree to pay all collection fees at 40% of principal balance and any legal expenses, including but not limited to Collection Agency and attorney fees, all court related costs, service and filing fees, interrogatory and garnishment fees as well as any interest that may be adjudicated for the collection of past due debts. In order for us to service your account or to collect any amounts you may owe us, you authorize us and our affiliated physicians, as well as their affiliates which include debt collectors, to contact you at any telephone number associated with your account, including wireless telephone number, which could result in charges to you. Methods of contact include but are not limited to the use of prerecorded voicemail messages, artificial voicemail messages, automatic telephone dialing systems, predictive telephone dialing systems, automated SMS text message reminders and facsimile as applicable.
5. Our return check policy is a $25.00 fee. If unpaid within 30 business days, your account may be forwarded to a collection agency.

_____ _____ _____

Responsible Party (Print) Responsible Party Signature Date