SHENANDOAH HEAD & NECK SPECIALISTS PATIENT INFORMATION SHEET

Chart #: _____ Staff Verification: _____ Date: _____

Patient's Name: _____ **Date of Birth**: _____

Age: _____ Sex: _____ Marital Status: _____ **Social Security** #: _____
Mailing Address:
_____ City/State/Zip: _____
Physical Address if PO Box:
_____ City/State/Zip: _____
Home Phone: _____ **Cell Phone:** _____
Email: _____
Parents Names if Minor: Father: _____ **SSN**: _____
Mother: _____ **SSN**: _____
In Case of Emergency Please Notify: _____
Relationship: _____ Phone #: _____

INSURANCE INFORMATION

Primary Insurance Carrier: _____
Policy ID#: _____ **Group #:** _____
Name of Policy Holder: _____ **Date of Birth**: _____
Name of Employer: _____
Employer Address: _____
Relationship to Patient: Circle one: Self Spouse Mother Father Other _____

Secondary Insurance Carrier: _____
Policy ID#: _____ **Group #:** _____
Name of Policy Holder: _____ **Date of Birth**: _____
Name of Employer: _____
Employer Address: _____
Relationship to Patient: Circle one: Self Spouse Mother Father Other _____

PATIENT AND RESPONSIBLE PARTY AUTHORIZATION/ AUTHORIZATION TO TREAT

1. I authorize Shenandoah Head & Neck Specialists, 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 correct and further authorize the release of any necessary information, including medical information for this or any related claim to the above agent.
2. 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.
3. 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 any and 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 pre recorded voicemail messages, artificial voicemail messages, automatic telephone dialing systems, predictive telephone dialing systems, automated SMS text message reminders and facsimile as applicable.
4. 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 **Signature** **Date**