Prof., LLC

PATIENT REGISTRATION FORM

Patient Information

Last Name:	First Name:	M.I.:	Preferred name/nickname:
Address:		City/State/Zip:	
Mailing address (if different):			
Home Phone:	Cell Phone:	Work Phone w/ext.	
Preferred method of communication: ☐Voice ☐ Text ☐ Email ☐Other:		Preferred Phone: ☐ Cell ☐ Home ☐ Work ☐ Other:	
Marital Status: ☐Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner		Employer:	
Date of Birth:	Soc. Sec. #:	Email address:	
Emergency Contact:	Phone:	Relationship to Patient:	

Responsible Party

Person responsible for the bill (Only if patient is a minor child): Last Name: First Name: M.I.:		Relationship to Patient:
Date of Birth:	Soc. Sec. #:	Phone:
Address:	City/State/Zip:	
Employer:		

You may attach a copy of your insurance card instead of completing the below information

Insurance & Payment Info

Primary Medical Insurance	Secondary Medical Insurance
Ins. Co. Name:	Ins. Co. Name:
Insurance ID #:	Insurance ID #:
Policy Holders Name:	Policy Holders Name:
Effective Date:	Effective Date:
Policy Holders SSN:	Policy Holders SSN:
Relationship to Patient:	Relationship to Patient:
Employer Name	Employer Name

Other Information

Can we leave messages regarding your medical care, test results and financial obligations or business office needs?: ☐ No ☐ Yes. If yes, what is your preferred contact method: ☐ Cell ☐ Home ☐ Work
Race (please select one): ☐ Caucasian or White ☐ Native American or Alaska Native ☐ Asian ☐ Black of African-American ☐ Hawaiian or Other Pacific Islander ☐ Hispanic ☐ Other Race ☐ Decline
Ethnicity (please select one): ☐ Hispanic ☐ Not Hispanic or Latino ☐ Decline
Preferred Language (please select one): ☐ English ☐ Spanish ☐ Other:
Preferred Pharmacy Name & Location:
Family or Primary Care Provider(s):

I certify that the information I have furnished is complete and accurate. I hereby authorized payment of benefits payable under my insurance plan and/or of any government payment plan be paid directly to West River Ear Nose and Throat, Prof., LLC (WRENT), which I agree will be credited to my account. I authorize assignee to obtain my plan provisions under ERISA and to act as authorized representative on my behalf on insurance claims. A photocopy of this assignment is to be considered as valid as the original. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I understand that I will be responsible to WRENT for all amounts including those not paid by my insurance payer due to their payment rules or guidelines. A finance charge of 18% will be charged on all guarantor owed balances after 60 days. I hereby give my consent for WRENT to use and disclose my protected health information for the purposes of treatment, payment and health-care operations.

Signed: ____________________________________ **Date:** ________________________

NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices outlines our obligations to you under federal privacy law. We are obligated to provide you with a copy of our Notice at the time of your appointment. **In addition, we ask you to let us know to whom you will allow access to your medical records, account and/or billing information.** The phone number(s) and address you provide us will be used to contact you for appointment reminders, medical follow-up, questions regarding account information, billing and insurance claims questions, mailing account statements and other contacts unless you tell us otherwise. We may ask you to complete an authorization for release of medical information if there are any questions or concerns.

I acknowledge that I have received a copy of West River Ear Nose and Throat, Prof., LLC's Notice of Privacy Practices.

Patient/Responsible Party Signature____ **Date** ______________________

❑ Attempt made to obtain acknowledgement of receipt of Notice of Privacy Practices however the patient either refused to sign or other: _____
____

Please list the name(s) of family, friends or others we may communicate with regarding your treatment, appointments, prescriptions, test results, billing and insurance questions, etc.:

Name	Relationship	E-mail address	Phone #

CONSENT FOR CARE OF MINOR

Children under the age of 14 must be accompanied by an adult for any appointment.

As the Parent or guardian to ________________________________, Age _________, a minor, I authorize the following:

____ I authorize ________________________, to be seen at West River Ear, Nose, and Throat with a parent or guardian present.
Initials

____ I authorize ________________________, to be seen and treated at West River Ear, Nose, and Throat when accompanied only by the
initials following adult, friend, child care provider or other:

Name	Relationship

This consent shall remain in full force and effect until revoked by me or the minor attains eighteen (18) years of age.

____ ____________________________
Parent or Guardian Date