Ear Consultants of Georgia, P.C.

Patient Information – Confidential

Thank you for choosing this office!

What is the Reason for your visit today? _____

Who may we thank for referring you? _____

Date _____ **Patient Account # _____[Office Use Only]**

Patient Name _____ Check appropriate box: ☐ Male ☐ Female

SSN _____ Birthdate _____ Age _____

Address _____ City _____ State _____ Zip _____

Home phone _____ Other phone _____ Email Address _____

Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Patient's Employer _____ Work phone _____

Address _____ City _____ State _____ Zip _____

Occupation _____ Driver's license # _____

Spouse's name _____ Employer _____ Work phone _____

Person to contact in case of emergency _____ Phone _____

Responsible Party (if patient is a minor)

Person responsible for this account _____ Relationship to patient _____

Address _____ City _____ State _____ Zip _____

Home phone _____ Driver's license # _____

Birthdate _____ Social Security # _____

Employer _____ Work phone _____

Employer address _____ City _____ State _____ Zip _____

Insured Party Information (policy holder)

Name of insured _____ Relationship to patient _____

Birthdate _____ Social Security # _____ Date employed _____

Employer _____ Work phone _____

Employer address _____ City _____ State _____ Zip _____

Insurance company _____ ID # _____ Group # _____

Insurance co. address _____ City _____ State _____ Zip _____

How much is your office visit co-pay/co-insurance? _____ Group name _____

Ear Consultants of Georgia, P.C.

Patient Name _____ **Birthdate** _____ **Patient #** _____

Do you have additional insurance? ☐ Yes ☐ No If yes, complete the following:

Name of insured _____ Relationship to patient _____

Birthdate _____ Social Security # _____ Date employed _____

Employer _____ Work phone _____

Employer address _____ City _____ State _____ Zip _____

Insurance company _____ ID # _____ Group # _____

Insurance co. address _____ City _____ State _____ Zip _____

How much is your office visit co-pay/co-insurance? _____ Group name _____

Worker's Compensation Information

Is this a worker's compensation claim? ☐ Yes ☐ No if yes, complete the following:

Employer contact _____ Employer phone # _____

Worker's Comp contact _____ Worker's Comp phone # _____

Date of Injury? _____ Description of Injury _____

_____

[Office Use Only] Claim # _____ Worker's Comp Carrier _____

Worker's Comp Carrier Address _____

_____

Procedure for Filing Claims _____

Authorization & Release With this signature, I hereby authorize Ear Consultants of Georgia, P.C. to release any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor. Furthermore, I understand that regardless of insurance, I am ultimately responsible for payment of fees for professional services rendered, including non-covered services. If my insurance company (ies) changes at any time, I am responsible to notify this office and provide a written copy or I will be ultimately responsible for payment of fees for professional services rendered at that time.

_____ _____

Signature of patient (or parent or legal guardian) Date

Late Charges and Collections Fees All payments for services provided by this practice are due and payable at the time services are rendered, or within 30 days of the patient receiving the invoice for such services. In the event payment is not received as described above, a late payment fee of 1.5% per month will be charged. In addition, in the event that any bill goes to collection, patients will be charged all costs associated with collection, including reasonable attorney fees.

_____ _____

Signature of patient (or parent or legal guardian) Date