STARK ENT, ALLERGY & SINUS CENTER

DEAR PATIENT: WE MUST HAVE COMPLETE INFORMATION AND ***ANY REFERRAL*** (IF REQUIRED) AT THE TIME OF YOUR VISIT. IF YOU CANNOT PROVIDE THE INFORMATION, WE WILL BE UNABLE TO FILE YOUR INSURANCE AND PAYMENT IN FULL WILL BE REQUIRED.

FIRST NAME_____***LAST NAME***_____***BIRTHDATE***____/___/_____

(SEX): MALE / FEMALE (***MARITAL STATUS)***: *NEVER MARRIED / MARRIED / DIVORCED / WIDOWED*

(RACE): *ASIAN / BLACK OR AFRICAN AMERICAN/ HISPANIC OR LATINO/ WHITE / OTHER:*_____

ADDRESS_____***CITY***_____***STATE***_____***ZIP***_____

HOME PHONE____-_____-_____ ***WORK PHONE***____-_____-_____ (EXT_____) ***CELL PHONE***____-_____-_____

**** EMAIL ADDRESS***_____

****EMERGENCY CONTACT INFORMATION***: ***RELATION TO PATIENT***_____

FIRST NAME_____***LAST NAME***_____***PHONE***_____-_____-_____

****PREFERRED PHARMACY*** *(LOCATION/PHONE#)* _____

HOW DID YOU HEAR OF US: __PHYSICIAN __FAMILY __FRIEND __PH BOOK/INTERNET __INS CO.__ OTHER_____

PRIMARY CARE PHYSICIAN: _____REFERRING PROVIDER: _____

****INSURANCE INFO***: ALL INSURANCE CO-PAYMENTS AND DEDUCTIBLES ARE DUE AT TIME OF SERVICE. WE WILL PROVIDE YOU WITH THE NECESSARY DOCUMENTATION TO FILE FOR REIMBURSEMENT UPON REQUEST. IT IS THE PARENTS/PATIENTS RESPONSIBILITY TO BE AWARE OF BENEFITS THAT THEIR INSURANCE PROVIDES FOR THESE VISITS.

PRIMARY INSURANCE CO_____***POLICY/ID #***_____

NAME OF INSURED_____***D.O.B***____/____/____***RELATIONSHIP:***SELF/SPOUSE/CHILD

SECONDARY INSURANCE CO_____***POLICY/ID #***_____

NAME OF INSURED_____***D.O.B***____/____/____***RELATIONSHIP:***SELF/SPOUSE/CHILD

YOUR INSURANCE IS FILED BY THIS OFFICE AS A COURTESY TO YOU. HOWEVER, POSITIVE VERIFICATION OF YOUR COVERAGE CANNOT ALWAYS BE MADE AT THE TIME OF SERVICE. THEREFORE, PAYMENT OF YOUR CHARGES CANNOT BE DETERMINED UNTIL THE CLAIM IS SUBMITTED TO YOUR INSURANCE COMPANY. PAYMENT WILL BE BASED ON YOUR INDIVIDUAL HELATH PLAN AND THE AMOUNT APPLIED TO YOUR PLAN DEDUCTIBLE AND/OR CO-INSURANCE WILL BE YOUR RESPONSIBILITY. YOU WILL RECEIVE SERVICES WITH THE UNDERSTANDING THAT IN THE EVENT YOUR COVERAGE IS NOT EFFECTIVE OR DR. STARK IS NOT A PARTICIPATING PROVIDER WITH YOUR INSURANCE, YOU WILL BE BILLED AND HELD FINANCIALLY RESPONSIBLE FOR THE SERVICES RENDERED.

ANY PROCEDURES PERFORMED WILL BE CONSIDERED SURGERY BY YOUR INSURANCE COMPANY AND DEDUCTIBLES AND CO-INSURANCE MAY APPLY. PROCEDURES WHICH ARE EXCLUDED FROM COVERAGE, BASED ON YOUR PLANS DETERMINATION OF MEDICAL NECESSITY WILL ALSO BE YOUR RESPONSIBILITY.

I HAVE READ THE ABOVE AND UNDERSTAND MY POSSIBLE FINANCIAL RESPONSIBILITY OF SERVICES RENDERED AND HEREBY AFFIX MY SIGNATURE AS ACKNOWLEDGMENT OF THIS UNDERSTANDING.

PATIENT'S SIGNATURE_____ ***DATE***_____/_____/_____

WITNESS SIGNATURE_____ ***DATE***_____/_____/_____