PATIENT REGISTRATION

Date:______________ Reviewing Staff Name:_________

Last Name First MI Birth date Soc Sec# Gender Marital Status-Spouse Name

Local Address City State Zip Local Phone #(____)_______________

Cell Phone #(____)_______________

Work Phone #(____)_______________

If seasonal resident, please list permanent address here:
Address City State Zip Phone #(____)___________________

Employer or Former occupation if retired Address City,State,Zip Work #

Spouse's Employer Address City,State,Zip Work #

Emergency Contact's Name Relationship Phone Number

If patient is a minor, please list RESPONSIBLE PARTY'S name:_______________________________
Home Phone Number #________________________________Work Phone #_____________________________

This information required under Federal Electronic Record Requirements:

Ethnicity: Hispanic or Non-Hispanic (circle) Preferred Language: _______________

HEALTH INSURANCE: PLEASE PRESENT YOUR INSURANCE CARDS FOR COPYING (staff initials____)

PLEASE PRESENT YOUR PHOTO IDENTIFICATION FOR COPYING (staff: expiration_____________)

ALL PATIENTS MUST SIGN: AUTHORIZATION FOR TREATMENT & FINANCIAL RESPONSIBILITY AGREEMENT

I hereby consent to necessary medical diagnosis and treatment for myself, my child or the above named minor, for whom I am legally responsible. I also am hereby advised services may include diagnostic services that include, but are not limited to biopsies, office microscopic and/or endoscopic procedures that Medicare and/or insurance companies may classify as "surgical" procedures on their statements (or "explanation of benefits") that are used to evaluate the sinuses, ears, nose, throat and tubes that connect the back of the nasal cavity to the ears (Eustachian tubes). To ensure confidentiality and privacy, I agree that any type of electronic recording is strictly prohibited.

I further authorize the release of medical information to any insurance carrier, and direct payment to Dr. Klausner for any treatment or examination rendered. I hereby acknowledge and accept all financial responsibility for medical services rendered. I agree to pay any copay, coinsurance and deductibles due at the time of service. As a courtesy, this office will file in and out-of-network insurance claims for patients. As an additional courtesy, this office will attempt to call my carrier to verify benefits. This verification of benefits is not a guarantee that my insurer will cover the visit, as unfortunately many times erroneous information is given regarding benefits, deductible, network participation and coverage by insurance carriers. For these reasons I acknowledge that it is ultimately my responsibility to contact my carrier to verify my financial responsibility. I also understand that all past due balances will be charged an additional 1.5% interest per month until the account is settled. I agree to pay all costs of collection including reasonable attorney's fees. I further acknowledge that there is a minimum **$25.00** fee for returned checks and that a **$50.00** fee will be charged to my account if an appointment is not cancelled at least 24 hours prior to that scheduled time. If you are being seen OUT OF NETWORK, we require that you sign the agreement below AND pay your bill in full at the time of service unless other arrangements have been made. I also understand and acknowledge that I am personally responsible to pay Dr. Klausner in full at the time of service for services that my health insurer will not cover due to non-payment of my health insurance premiums, including but not limited to insurance obtained through the Affordable Care Act "Marketplace".

This agreement will remain in effect until notification of change is received.

SIGNATURE _______________________ DATE _______________________

MEDICARE AGREEMENT

I authorize Dr. Klausner to release any information needed for Medicare claims to the Social Security Administration and Health care Administrators or its intermediaries or carriers. I also authorize Dr. Klausner to release information needed to determine benefits to my supplemental insurance company and assignment of the benefits directly to Dr. Klausner. I understand that as a courtesy to me, Dr. Klausner will file my secondary insurance. If my secondary insurer has not paid within 60 days, I agree to be responsible for that amount in full.

SIGNATURE _______________________ DATE _______________________

5/18/18