Authorized person(S) or Personal Representative(S)

Persons authorized to bring patient, consent to medical treatment and access medical information. Please list below.

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

Acknowledgement of Receipt of Notice of Privacy Practices

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding, my health information.

_____ _____

Signature of Patient, Guardian or Personal Representative Date

_____ _____

Print Name of Patient, Guardian or Personal Representative Relationship to Patient

Insurance Assignment and Release

I certify that I, and/or my dependant(s), have insurance coverage with _____And assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible to all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The Above named doctor may use any health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from date signed below.

_____ _____

Signature of Patient, Guardian or Personal Representative Date

_____ _____

Print Name of Patient, Guardian or Personal Representative Relationship to Patient

Agreement to Pay

I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court costs, if such be necessary. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other State

You agree, in order for us to service your account or to collect monies you may owe, Montgomery Otolaryngology and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

I/We have read this disclosure and agree that Montgomery Otolaryngology, its employees and/or agents may contact me/us as described above.

_____ _____

Signature of Patient, Guardian or Personal Representative Date

_____ _____

Print Name of Patient, Guardian or Personal Representative Relationship to Patient

HEAD AND NECK SURGERY
Montgomery Otolaryngology

1111 Olive Street
Montgomery, AL 36106-1129

(PLEASE PRINT)

Patient Information

Name: _____
(LAST) (FIRST) (MI)

Street Address/City/State/Zip: _____

SSN: _____ (Insurance Companies require SSN for claim submission)

Sex: M / F Birth Date: _____ Race: _____ Ethnicity: _____ Marital Status: M / W / S / D

Please Circle Preferred Contact Method: Mail Phone Patient Portal

Home Phone: ( )_____ Cell: ( )_____ Email: _____

Patient Employer/School: _____

Occupation: _____ Employer/School Phone: ( )_____

Spouse's Name: _____ Employed By: _____ Work Phone: ( )_____

Incase of an emergency who should be notified: _____ Phone: ( )_____

Nearest Friend or Relative: _____ Relationship To Patient: _____

Phone: ( )_____

Responsible Party

Person Responsible for Account:

_____
(LAST) (FIRST) (MI)

Relationship to Patient: _____ Birth Date: _____

SSN: _____ Phone: ( ) _____

Street Address/City/State/Zip (if different from patients):

_____

Insurance Information

(Is Patient Covered By Additional Insurance? __Yes __ No)

PRIMARY INSURANCE (Please Provide a copy of your insurance card)

Primary Insurance Company: _____

Primary Insurance Holder: _____ Contract ID #: _____
(Name as Appears on Card)

Primary Insurance Holder Birth Date: _____ Group #: _____

SECONDARY INSURANCE (If applicable)

Secondary Insurance Company: _____

Secondary Insurance Holder: _____ Contract ID #: _____
(Name as Appears on Card)

Primary Insurance Holder Birth Date: _____ Group #: _____