SOUND HEALTH SERVICES, P.C. | *One Group. Sound Health. Complete ENT Care.*

PATIENT INFORMATION

Last Name: _____ First:_____ MI:_____
Street Address:_____City:_____State:_____Zip:_____
Home #:_____Cell #:_____Work #:_____
Date of Birth:_____SS #:_____Marital Status: S M D W Sex:_____
Employer Name and Address:_____
Occupation:_____ Employment Status: FT PT RT Student
Primary Care Doctor:_____Referral Doctor (if different):_____
Email Address:_____
Emergency Contact Name and Number:_____
Pharmacy Name, Address, & Phone #:_____
Language: English, Bosnian, French, German, Italian, Mandarin, Spanish, Vietnamese, Other
Race: African American, American Indian or Alaska Native, Asian, Bosnian, Caucasian, Chinese, Filipino, Hispanic, Japanese, Multiracial, Native American, Native Hawaiian, Pacific Islander, Other, Undetermined
Ethnicity: Hispanic or Latino, Non-Hispanic or Latino, Other

INSURANCE INFORMATION

Primary Insurance:_____Insurance Address:_____
Insured #:_____Group#:_____Co-pay $_____
Subscriber's Name (if different than above):_____
Subscriber's Address:_____City:_____State:_____Zip:_____
Home #:_____Cell #:_____Work #:_____
Subscriber's Date of Birth:_____Subscriber's SS#_____Sex:_____
Relationship to Patient:_____
Employer Name & Address:_____
Employment Status: FT PT RT

Secondary Insurance:_____Insurance Address:_____
Insured #:_____Group#:_____Co-pay $_____
Subscriber's Name (if different than above):_____
Subscriber's Address:_____City:_____State:_____Zip:_____
Home #:_____Cell #:_____Work #:_____
Subscriber's Date of Birth:_____Subscriber's SS#_____Sex:_____
Relationship to Patient:_____
Employer Name & Address:_____
Employment Status: FT PT RT

Responsible Party Information *(Person Bringing Child In)*

Last Name:_____ First Name:_____ MI:_____
Street Address:_____ City:_____ State:_____ Zip:_____
Home #:_____ Cell#:_____ Work#:_____
Date of Birth:_____SS #:_____Relationship to Patient:_____ Sex:_____
Employer Name:_____
Employment Status: FT PT RT

Doctor patient is here to see today _____ **I will be paying by:** Cash Check Credit Card

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes to the above information. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to the physician unless my account has been paid in full. **I have received Sound Health Services, P.C. notice of privacy practice.**

Responsible Party Signature:_____ Date:_____

Revised 6/21/11

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FINANCIAL AGREEMENT

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. WE WILL REQUEST TO PHOTOCOPY YOUR INSURANCE CARD(S) AND A PHOTO I.D. FOR YOUR FILE.

- **APPOINTMENTS –** 24 hours notice must be provided in the event you cannot keep an appointment. Should you not provide this notice, a cancellation fee up to $35 may then be added to your account. Cancellations for Ancillary Services will have a higher fee.

- **REFERRALS –** If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral, YOU WILL BE REQUESTED TO SIGN A FINANCIAL WAIVER to be set up as a "Self-Pay" patient. It is then your responsibility to provide us with the referral within 48 hours or you will be personally responsible for that day's services.

- **CO-PAYMENTS –** By law we MUST collect your carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit. Should you not pay at the time of service, and we subsequently send you a statement, an administrative fee of $5 may be added to your account. Any procedure performed in this office could be deemed surgical by your insurance company and all copays and deductibles will apply.

- **FMLA AND/OR WORKMAN COMP –** There is a $25.00 charge for completion of Workman Comp or FMLA forms.

- **SURGERY DEPOSITS –** If you and your physician determine that your course of care requires surgery, a surgical deposit will be collected at time of scheduling. Our scheduling coordinators will work with you to determine estimated insurance payment and estimated patient responsibility.

- **OUT OF NETWORK PLANS –** You will be responsible for any balance your plan indicates as due on their explanation of benefits form. We will adjust the charges to coincide with your plan's UCR (Usual, Customary and Reasonable) charges. All patients will be responsible for their co-insurance and deductible. If we do not "participate" with your plan, we will send a courtesy bill to that carrier on your behalf. However, should they not pay your claim within 45 days, you will be responsible for the full amount due. Should you receive payment from your insurance carrier, please forward it to the physician's office.

  Private Insurance Authorization for Assignment of Benefits/Information Release: I, the undersigned, authorize payment of medical benefits to Sound Health Services, P.C. for any services furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize any holder of medical information about me to release to my insurance company (or the agent) information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

- **SELF-PAY PATIENTS –** Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.

- **MEDICARE –** We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one.

  Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits to be made on my behalf to Sound Health Services, P.C. for any services furnished to me. I authorize any holder of medical information about me to release to the CMS (and it agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluation and administering claims of benefits.

- **DIVORCED/SEPARATED PARENTS OF MINOR PATIENTS –** The parent who consents to the treatment of a minor child is responsible for payment of services rendered, Sound Health Services, P.C. will not be involved with separation or divorce disputes.

- **INSUFFICIENT FUND CHECKS –** A $25.00 fee will be charged to patient's account for checks returned due to non sufficient funds

- You are responsible for the timely payment of your account. Should it become necessary for us to use an outside agency to collect payment from you, you will be obligated to pay to us, to cover the costs of using a collection agency, an additional amount equal to 30% of your total unpaid balance at the time a collection agency is brought in to collect your account. WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, AMERICAN EXPRESS, DISCOVER OR CARE CREDIT. THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share with us special concerns.

Patient's Name: _____ DOB: _____

Responsible Party Signature:_____ Date:_____

Revised 03/01/2016

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AUTHORIZATION FOR RELEASE OF INFORMATION
SOUND HEALTH SERVICES, P.C.

Patient Name:_____ Date Of Birth:_____

I understand that Sound Health Services, P.C. (the "Practice") has certain rights and obligations with regard to my protected health information (information regarding my health and treatment that the Practice may have in its possession). I also understand that I have certain rights with regard to my protected health information.

I authorize the Practice to provide informational reminders regarding upcoming appointments I may have to me or anyone who may answer the telephone, or to leave such reminders on any telephone answering device or service, at the telephone number(s) I have provided the Practice as telephone numbers at which I may be contacted (other than the telephone number of my place of employment) or at the following telephone numbers _____.

I authorize the Practice to disclose my protected health information to any of the following persons (state name of person and relationship to you):

_____

_____

_____

I understand that I may revoke any authorization granted above by written notice signed by me delivered to the Practice's Privacy Official at the address stated below. My authorization remains valid until revoked by me in writing.

I acknowledge receipt of the Practice's Privacy Practices Notice effective _____, 20___ regarding the Practice's rights and obligations and my rights regarding my Protected Health Information. I acknowledge that I understand that I have the right to request and receive clarifications, explanations or further information with regard to The Practice's Privacy Practices through written request signed by me addressed to the Practice's Privacy Official.

Sound Health Services, P.C.
Attn: Privacy Official
3860 South Lindbergh
St. Louis, MO 63127

_____ _____

Patient's Signature Date: