GATEWAY ENT
ear, nose and throat specialists

MRN#: _____ (For Office Use) **DATE:** _____

PATIENT REGISTRATION FORM

Please complete the following as accurately as possible. Present all Insurance Cards with your Driver's License at check-in.

PATIENT INFORMATION

Patient Name: (Last) _____ (First) _____ (MI) _____ **Sex:** _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor **Date of Birth:** _____

Language: ☐ English ☐ Bosnian ☐ French ☐ German ☐ Mandarin ☐ Spanish ☐ Vietnamese ☐ Italian ☐ Other: _____ ☐ Declined

Race: ☐ African American ☐ American Indian ☐ Caucasian ☐ Chinese ☐ Filipino ☐ Hispanic ☐ Japanese ☐ Multiracial ☐ Native Amerian ☐ Declined

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Declined

Home Address: _____ _____ _____ _____
Street Number *(include Apt/Condo #, if applicable)* City State Zip

Phone Numbers: (Home) _____ (Mobile) _____ (Work) _____ Ext. _____

Preferred Phone Contact: ☐ Home ☐ Work ☐ Mobile..... OK to receive Text messages? ☐ Yes ☐ No

Email Address: _____ ☐ I would like to receive correspondence via email

Preferred Local Pharmacy: _____ **Phone Number:** _____

Referring Physician: _____ **Primary Care Physician:** _____

How did you hear about us: ☐ Flyer ☐ Insurance ☐ Radio ☐ Facebook ☐ Patient ☐ Other: _____

GUARANTOR INFORMATION (Person bringing in Minor)

Guarantor's Name: (Last) _____ (First) _____ (MI) _____

Date of Birth: _____ **Sex:** _____ **Relationship to Patient:** _____

Billing Address: _____ _____ _____ _____
(If different from above) Street Number or P.O. Box *(include Apt/Condo #, if applicable)* City State Zip

Home Phone Number: _____ **Mobile Number:** _____

INSURANCE INFORMATION

PRIMARY Insurance: _____ **Subscriber/Policy Number:** _____

Policy's Holder Name: (Last) _____ (First) _____ (MI) _____

Date of Birth: _____ **Sex:** _____ **Relationship to Patient:** _____

Billing Address: _____ _____ _____ _____
(If different from above) Street Number or P.O. Box *(include Apt/Condo #, if applicable)* City State Zip

Home Phone Number: _____ **Mobile Number:** _____

SECONDARY Insurance: _____ **Subscriber/Policy Number:** _____

Policy's Holder Name: (Last) _____ (First) _____ (MI) _____

Date of Birth: _____ **Sex:** _____ **Relationship to Patient:** _____

Billing Address: _____ _____ _____ _____
(If different from above) Street Number or P.O. Box *(include Apt/Condo #, if applicable)* City State Zip

Home Phone Number: _____ **Mobile Number:** _____

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 payment of benefits be made to the physician unless my account has been paid in full. **I have received Gateway ENT notice of privacy practice.**

Responsible Party Signature: _____ **Initials:** _____ **Date:** _____

In Lieu of Signature Option, if not available, please type name and initial.

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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 A COPY OF YOUR INSURANCE CARD 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 of $35 may then be added to your account. Cancellations on Ancillary Service 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 REQUIRED 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 personally be responsible for that day's services.
- **CO-PAYMENTS:** By law we MUST collect your carrier designated copay. This payment is expected at the time of service. Please be prepared to pay the copay 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 FMLA or Workman Comp forms.
- **SURGERY DEPOSITS:** If you and your physician determine that your course of care requires surgery, a surgical deposit will be collected at the time of scheduling. Our scheduling coordinators will work with you to determine the estimated insurance payment and estimated patient responsibility.
- **OUT of NETWORK PLANS:** You will be responsible for any balance your plan indicates as due to their explanation of benefit 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. Should you receive payment from your insurance carrier, please forward it to the physician's office.

  Private Insurance Authorization of Benefits/Information Release: I, the undersigned, authorize payment of medical benefits to Gateway ENT for any service furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize any holder of 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 Gateway ENT for any services furnished to me. I authorize any holder of medical information about me to release to the CMS (and its 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 PARENT of MINOR PATIENTS:** The parent who consents to the treatment of a minor child is responsible for payment of services rendered. Gateway ENT will not be involved with separation or divorce disputes.
- **INSUFFICIENT FUND CHECKS:** A $25.00 fee will be charged to a patient's account for checks returned due to on sufficient funds.
- **You are responsible for the timely payment on your account. Should it become necessary for us to use an outside agency to collect payment from you, you will be obligated to pay us, to cover the costs of using a collection agency and an additional 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 Full Name: _____ Date of Birth: _____

Responsible Party Signature: _____ **Initials:** _____ **Date:** _____

In Lieu of Signature Option, if not available, please type name and initial.

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AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's Full Name: _____ Date of Birth: _____

I understand that Gateway ENT (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 Gateway ENT to report any test result to be left on any telephone answering device or service.

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

Name of Person(s):	**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 September 23, 2013 regarding the Practice's rights and obligations and my rights regarding Protected Health Information. I acknowledge that I understand that I have the right to request and receive clarifications, explanations or further information with regards to the Practice's Privacy Practices through written request signed by me addressed to the Practice's Privacy Official.

Gateway ENT
Attn: Privacy Official
9701 Landmark Parkway
St. Louis, MO 63127

Signature of Patient/Patient's Representative: _____ **Initials:** _____ **Date:** _____
In Lieu of Signature Option, if not available, please type name and initial.

Basis of Representative's authority to act for Patient: _____