# River Cities ENT Specialists

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J. Brett Chafin, M.D.
B. Joseph Touma, M.D.

Date: _____ Scheduled with: _____

Referred by: _____ City: _____ Family Physician: _____

How did you hear of our office? Doctor _____ Friend _____ Relative _____ Yellow pages _____

**PATIENT**

| PATIENT'S FIRST NAME | MIDDLE NAME | LAST NAME | SEX ☐ M ☐ F | DRIVER'S LICENSE NO. | AGE | DATE OF BIRTH MO. DAY YR. |
|---|---|---|---|---|---|---|
| | | | | | | |

| PATIENT'S STREET ADDRESS | APT. NO. | CITY | STATE | ZIP |
|---|---|---|---|---|
| | | | | |

| PATIENT'S SOCIAL SECURITY NO. | RESIDENCE PHONE NUMBER ( ) | RELATIONSHIP TO RESPONSIBLE PARTY ☐ SELF ☐ SPOUSE ☐ OTHER ☐ STEPCHILD ☐ CHILD | MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED |
|---|---|---|---|
| | | | |

| PATIENT'S EMPLOYER & EMPLOYER'S ADDRESS | POSITION | HOW LONG | BUSINESS PHONE ( ) |
|---|---|---|---|
| | | | |

**SPOUSE OR PARENT**

| FULL NAME OF SPOUSE OR PARENT | SOCIAL SECURITY NUMBER | DATE OF BIRTH MO. DAY YR. |
|---|---|---|
| | | |

| RESPONSIBLE PARTY'S STREET ADDRESS | APT. NO. | CITY | STATE | ZIP |
|---|---|---|---|---|
| | | | | |

| EMPLOYER OF RESPONSIBLE PARTY & EMPLOYERS ADDRESS | POSITION | HOW LONG | BUSINESS PHONE ( ) |
|---|---|---|---|
| | | | |

**IMPORTANT PLEASE COMPLETE**

| NEAREST RELATIVE NOT LIVING AT SAME ADDRESS | RELATIONSHIP TO PATIENT | PHONE NUMBER ( ) |
|---|---|---|
| | | |

| STREET ADDRESS | APT. NO. | CITY | STATE | ZIP |
|---|---|---|---|---|
| | | | | |

| ACCIDENT INJURY ☐ YES ☐ NO DATE _____ TIME _____ WHERE HAPPENED? ☐ WORK ☐ HOME ☐ SCHOOL ☐ AUTO | COMPLAINT/INJURY |
|---|---|
| | |
| IF WORKMEN'S COMPENSATION FILL IN CLAIM NO. _____ | |
| DRUG ALLERGIES: PLEASE LIST | |

**INSURANCE**

| PATIENT'S PRIMARY INSURANCE COMPANY | PATIENT'S SECONDARY INSURANCE COMPANY |
|---|---|
| | |

| CITY | STATE | ZIP | CITY | STATE | ZIP |
|---|---|---|---|---|---|
| | | | | | |

| POLICY NO. (GROUP, CERT., SOC. SEC. NO.) | POLICY NO. (GROUP, CERT., SOC. SEC. NO.) |
|---|---|
| | |

| NAME OF POLICY HOLDER | DATE OF BIRTH | NAME OF POLICY HOLDER | DATE OF BIRTH |
|---|---|---|---|
| | | | |

| RELATIONSHIP TO PATIENT | EMPLOYER | RELATIONSHIP TO PATIENT | EMPLOYER |
|---|---|---|---|
| | | | |

**All charges incurred will be the responsibility of the patient, or that of his parents, guardian, or agent.**

**AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:**

I hereby authorize payment directly to River Cities ENT Specialists, PLLC

**Signed:** _____

(Patient or Parent if Minor)

**AUTHORIZATION TO RELEASE INFORMATION:**

I hereby authorize River Cities ENT Specialists, PLLC to release any information acquired in the course of my examination or treatment.

**Signed:** _____

(Patient or Parent if Minor)

**(Continued on Back)**

# FINANCIAL POLICY

**It is our hope that you will understand that our financial and billing policies are necessary to maintain vital health care services to our patients and the community. The following are our office's current financial policies..**

**INSURANCE:**

**We will bill all PRIMARY insurance companies and any secondary insurances for our patients. Please provide us with complete and accurate insurance information, as well as any change of address, telephone number or employer.**

**PRECERT:**

**It is the patient's responsibility to notify the insurance company or to make office personnel aware of any requirements for precertification of testing.**

**PPO/HMO:**

**All require a referral/confirmation form prior to the office visit or the PPO/HMO will not pay for the services provided.**

**CO-PAYMENTS & DEDUCTIBLES:**

**Co-payments and deductibles will be collected after seeing the physician on the day of your appointment. All insurance companies require that the physician collect all co-pays and deductibles from the patient.**

**Your insurance coverage is a contract between you and your insurance company. You are still responsible for payment of your account.**

**MEDICARE:**

**We are a participating office. We will file your Medicare claims. We will also file your Medicare secondary insurance claims if you will provide us with the necessary information. (See authorization below).**

**MEDICAID:**

**We are participating with West Virginia, Ohio and Kentucky Medicaid on referral from the family physician. Please bring a copy of your current card. If you are under the PAAS program or KENPAC, we must have a written referral from your physician on the Medicaid card. If you do not have the referral or your current card, we will ask you to reschedule your appointment**

**NON-INSURED:**

**Payment is due at the time of service. If it is necessary to establish payment arrangements please contact our billing department.**

**AUTO ACCIDENTS AND PERSONAL INJURY:**

**All auto accident and personal injury patients are required to pay at the time of service. An itemized statement will be given to the patient upon request at time of payment.**

**STATEMENTS:**

**Statements are issued monthly. Messages on the statement will indicate the status of your account**

**I have read and understand this financial policy.**

**I understand my insurance coverage is a contract between myself and my insurance company and I agree to accept financial responsibility for payment of charges incurred.**

**Signature**_____ **Date**_____

**(parent or guardian if patient is a minor)**

## MEDICARE PATIENTS ONLY

**I request that payment of authorized Medicare benefits be made either to me on my behalf to River Cities Ear, Nose & Throat Specialists, PLLC (J. B. Touma, M.D., J. Brett Chafin, M.D., Scott R. Gibbs, M.D., B. Joseph Touma, M.D.) for any service furnished to me by that physician. I authorize release to the Health Care Financing Administration and its agents any medical information about me to determine the payments for related services.**

**Signature**_____ **Date**_____