NEVADA EAR + SINUS INSTITUTE

DEMOGRAPHIC INFORMATION / INFORMACION DE PACIENTE

LAST NAME/APELLIDO: _____ FIRST NAME/NOMBRE: _____ MI: ___

DATE OF BIRTH / FECHA DE NACIMIENTO:_____(MM/DD/YYYY)

SEX / SEXO: _____ RACE / RAZA: _____

SOCIAL SECURITY # / SEGURO SOCIAL:_____ ETHNICITY / ETNICO: _____

ADDRESS #1 / DIRECCION #1: _____

ADDRESS #2 / DIRECCION #2: _____CITY / CIUDAD: _____STATE / ESTADO: ___

ZIP / ZONA POSTAL: _____LANGUAGE / LENGUAJE: _____

MARITAL STATUS / ESTADO MATRIMONIAL: _____

Whom may we thank for referring you to our practice?

¿Quien podemos agradecer por referirlo a nuestra práctica?

CONTACT INFORMATION / INFORMACION DE CONTACTO

HOME PHONE / TELEFONO: _____

WORK PHONE / TELEFONO DE TRABAJO: _____

CELL PHONE / CELULAR: _____

EMAIL / CORREO ELECTRONICO: _____

EMERGENCY CONTACT INFORMATION / CONTACTO DE EMERGENCIA

CONTACT LAST NAME / APELLIDO DE CONTACTO: _____

CONTACT FIRST NAME / NOMBRE DE CONTACTO: _____

CONTACT PHONE / TELEFONO DE CONTACTO: _____

RELATIONSHIP/ RELACION: _____

ADDRESS / DIRECCION: _____

CITY / CIUDAD: _____ STATE / ESTADO: _____ ZIP / ZONA POSTAL: _____

PRIMARY CARE / ATENCION PRIMARIA

PHYSICIAN NAME / NOMBRE DEL MEDICO: _____

PRACTICE NAME / NOMBRE DE OFICINA: _____

ADDRESS / DIRECCION: _____

CITY / CIUDAD: _____STATE / ESTADO: _____ ZIP / ZONA POSTAL: _____

PHARMACY NAME / FARMACIA: _____

PHARMACY PHONE / TELEFONO DE FARMACIA: _____

PHARMACY LOCATION / UBICACION DE LA FARMACIA: _____

By signing below, I attest that the information provided above is true and accurate/

Al firmar abajo, yo doy fe de que la información proporcionada es verdadera y exacta

Signature / Firma: _____ Date / Fecha: _____

INSURANCE INFORMATION

PRIMARY INSURANCE / ASEGURANZA PRIMERIA: _____
CO-PAY / CO-PAGO: _____
GROUP # / # GRUPO: _____ POLICY # / # POLICY: _____
INSURED NAME / NOMBRE DEL ASEGURADO: _____
SSN / SEGURO SOCIAL: _____ DOB / FECHA DE NACIMIENTO: _____
RELATION TO PATIENT / RELACION: _____
ADDRESS / DIRECCION: _____ CITY / CIUDAD: _____
STATE / ESTADO: _____ ZIP / ZONA POSTAL: _____
PHONE / TELEFONO: _____
POLICY HOLDER EMPLOYER / NOMBRE DEL EMPLEADOR DEL ASEGURO:
EMPLOYER'S ADDRESS / DIRECCION DEL EMPLEADOR: _____
CITY / CIUDAD: _____ STATE / ESTADO: _____ ZIP / ZONA POSTAL: _____

SECONDARY INSURANCE / ASEGURANZA SEGUNDARIA: _____
CO-PAY / CO-PAGO: _____
GROUP # / # GRUPO: _____ POLICY # / # POLIZA: _____
INSURED NAME / NOMBRE DEL ASEGURADO: _____
SSN / SEGURO SOCIAL: _____ DOB / FECHA DE NACIMIENTO: _____
RELATION TO PATIENT / RELACION: _____
ADDRESS / DIRECCION: _____ CITY / CIUDAD: _____
STATE / ESTADO: _____ ZIP / ZONA POSTAL: _____
PHONE / TELEFONO: _____
POLICY HOLDER EMPLOYER / NOMBRE DEL EMPLEADOR DEL ASEGURO: _____
EMPLOYER'S ADDRESS / DIRECCION DEL EMPLEADOR: _____
CITY / CIUDAD: _____ STATE / ESTADO: _____ ZIP / ZONA POSTAL: _____

EMPLOYMENT STATUS / ESTADO DE EMPLEO
Employed/Empleo ☐ Unemployed/Desempleado ☐
Student/Estudiante ☐ Retired/Jubilado ☐
OCCUPATION / OCUPACION: _____
BUSINESS NAME / NOMBRE DEL NEGOCIO: _____
BUSINESS PHONE / TELEFONO DEL NEGOCIO: _____

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Signature / Firma: _____ Date / Fecha: _____

YOUR INSURANCE CARD AND PICTURE ID ARE REQUIRED AT THE TIME OF YOUR VISIT /
SU TARJETA DE SEGUROS Y DE IMAGEN ID SE REQUIEREN EN EL MOMENTO DE SU VISITA

FINANCIAL POLICY

We are committed to providing you with the best possible care. **We must emphasize that as medical care providers, our relationship is with you, not your insurance company. Your insurance is a contract between you, your employer and the insurance company, we are not party to that contract.** All charges are your responsibility from the date of service rendered. We realize that insurance companies need processing time; however, all charges will become due and payable if the insurance company does not reimburse **Nevada Ear + Sinus Institute** within 90 days or within the guidelines mandated by the NV state Board Bill #SB145.

Please familiarize yourself with your insurance policy and its requirements. Many companies require a referral from the primary care physician. **We will attempt to obtain these as a courtesy; however, the policyholder must be pro-active in assuring the requirements are met prior to the visit.**

If you have medical insurance, with which we are contracted, we will bill your insurance company. All deductibles, co-payments and non-covered items are due at the time of check-in.

Collection Fees Policy:

I, _____(parent /guardian name), hereby agree to be financially responsible for all charges incurred regardless of insurance coverage. In the event my account is referred to a collection service due to lack of payment on my part, I agree to pay all collection / legal fees that may be added to my account.

_____ _____

Signature of patient, parent / guardian Date

Returned Checks: A $25 non-sufficient funds fee will be charges for checks initially returned unpaid by your bank. We repost and forward all returned checks to Clark County District Attorney's office.

INITALS: _____

No Show Fees: There is a $25 no-show/late-cancellation fee. All appointments must be cancelled by 3 p.m. of the previous day. Insurance will not cover charges for no-show/late-cancellation.

INITALS: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

AUTHORIZATION TO RELEASE OR USE INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

I hereby authorize the release or use of my individually identifiable health information (protected health information or PHI) and medical information by _____ in order to carry out treatment, payment, or health care operations. You should review the Practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form. We reserve the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised notice by writing our practice or requesting a copy from our front desk staff. You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or heath care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice.

IF YOU WOULD LIKE TO REVIEW A COPY OF OUR PRACTICE'S NOTICE OF PRIVACY PRACTICES, PLEASE REQUEST FROM RECEPTIONIST

SI DESEA REVISAR UNA COPIA DEL AVISO DE NUESTRA PRÁCTICA DE PRÁCTICAS DE PRIVACIDAD , POR FAVOR PEDIR DE RECEPCIONISTA

I AGREE AND CONSENT TO _____ RELEASING INFORMATION TO ME IN THE FOLLOWING MANNERS:

VIA MAIL
ADDRESS / DIRRECION: _____

_____

_____

VIA TELEPHONE
PHONE / TELEFONO: _____

VIA FAX
FAX : _____

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Al firmar abajo, yo doy fe de que la información proporcionada es verdadera y exacta

Signature / Firma:_____ Date / Fecha:_____