TEXAS EAR AND VESTIBULAR INSTITUTE

1441 Redbud Blvd Suite 211 McKinney, TX 75069
Phone (469) 678-2211 ♦ Fax (469) 678-2253

Patient Registration Form

Please print clearly so that we can process your information quickly and efficiently. Thank you!

How did you hear about Texas Ear and Vestibular Institute?

☐ Provider Referral ☐Advertisement ☐Friend ☐Other: _____

Today's Date: ____/____/____

PATIENT INFORMATION

Name: _____
Last First MI

Date of Birth: _____ Age: _____ Sex: ___ Marital Status: ☐M ☐S ☐W ☐D

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Social Security Number: _____

Home No.: (____)_____ Business No.: (____)_____ Cell No.: (____)_____

Primary Care Physician: _____ Primary Care Physician No.: _____

Referring Physician: _____ Referring Physician No.: _____

INSURANCE INFORMATION

Primary Medical Insurance

Primary Insurance Company: _____
Policy Holder: _____
Policy Holder DOB: _____
Relationship: _____
Policy No.: _____
Group No.: _____

Secondary Medical Insurance

Secondary Insurance Company: _____
Policy Holder: _____
Policy Holder DOB: _____
Relationship: _____
Policy No.: _____
Group No.: _____

GUARANTOR OR RESPONSIBLE PARTY *(IF NOT INSURED)*

☐ **Same as Patient Information** ***(If different, please complete section below)***

Name: _____ Date of Birth: _____ Relationship:_____

Address: _____ City: _____ State: _____ Zip: _____

☐Home No.: (____)_____ ☐Business No.: (____)_____ ☐Cell No.: (____)_____

Employer: _____ Employer No.: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

EMERGENCY NOTIFICATION

Contact Person: _____ Relationship to Patient: _____

Home No.: _____ Work No.: _____

PREFERRED PHARMACY

Name of Pharmacy: _____ Phone Number: _____

Address: _____

RELEASE OF HEALTH INFORMATION

☐Texas Ear and Vestibular Institute **MAY NOT** discuss my healthcare and may not discuss and/or make financial arrangements with anyone, except as permitted by HIPAA and other applicable laws

☐Texas Ear and Vestibular Institute **MAY** discuss my healthcare and MAY discuss and/or make financial arrangements with only the following individual immediate family members listed below:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

I understand that if I would like to authorize Texas Ear and Vestibular Institute to disclose my healthcare and/or financial arrangements with anyone other than the individuals listed above, I will need to execute an authorization that meets the requirements of the HIPAA Privacy Standards

Patient Name:_____ Signature: _____ Date: ____/____/_____

Please provide a date or event, if any, upon which this Authorization will expire. Please mark only one selection.

☐No Expiration
☐Date of Expiration _____/_____/_____
☐Event: (Describe event upon which this Authorization will expire) _____

PATIENT CONTACT PREFERENCES

I prefer to be contacted in the following manner:

☐Phone #: (_____) _____ - _____
☐OK to leave message with detailed information
☐OK to leave message with contact number only
☐DO NOT LEAVE MESSAGE

Briefly describe what brings you in for an appointment: _____

_____

_____

Please mark any symptoms you are experiencing or have had in the past:

☐**Hearing Loss**	☐**Ear Pain**	☐**Ringing in your ears**	☐**Exposure to loud sounds**
☐**Ear Fullness**	☐**Ear Drainage**	☐**History of ear surgery**	☐**Family history of ear problems**
☐**Ear Infections**	☐**Dizziness**	☐**Vertigo**	☐**Balance Problems**
☐**Migraines**	☐**Other headaches**	☐**Vision Problems**	☐**Sensitivity to bright lights**

Please mark any medical conditions you have or have had in the past:

☐**Heart Disease**	☐**Diabetes**	☐**High Blood Pressure**	☐**Neurological Problems**
☐**Stroke**	☐**Kidney Disease**	☐**Bladder Disease**	☐**Chronic Use of Antibiotics**
☐**Asthma**	☐**Lung Disease**	☐**Bleeding Disorder**	☐**Immune Disorder**
☐**Use of Steroids**	☐**Use of Aspirin**	☐**Cancer, list type:**_____	

Please list any medical problems you have that are not represented above:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Please list surgeries you have had, along with year if known: _____

_____

_____

Please list all medications that you take, along with dose (you may provide a separate list if you have one):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Are you allergic to any medications? ☐**Yes** ☐**No**
If allergic to medications, list them here:_____

Do you smoke or use nicotine products? ☐**Yes** ☐**No**
If yes, please list type and how often: _____

Do you drink alcohol? ☐**Yes** ☐**No**
If yes, please list how often: _____

Do you drink caffeine? ☐**Yes** ☐**No**
If yes, please list how much: _____

What is your occupation? _____

☐**Full-Time** ☐**Part-Time** ☐**Self-Employed** ☐**Student** ☐**Retired**

ASSIGNMENT OF BENEFITS

I hereby assign, transfer, and set over to Texas Ear and Vestibular Institute all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. All deductibles and co-pays are due at the time services are rendered and will be collected based on the information provided by your insurance company. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. This authorization will remain valid until I revoke it by written notice.

Print Name of Patient/Guarantor/Legal Guardian: _____ Date: _____
Signature of Patient/Guarantor/Legal Guardian: _____ Date: _____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Texas Ear and Vestibular Institute to (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used in processing insurance claims for the period of a lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Texas Ear and Vestibular Institute. On behalf of myself and/or my dependents, and understand that my making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

Print Name of Patient/Guarantor/Legal Guardian: _____ Date: _____
Signature of Patient/Guarantor/Legal Guardian: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below, I acknowledge that I have received a copy of the Notice of Privacy Practices and understand my rights as a patient of Texas Ear and Vestibular Institute.

With my consent, Texas Ear and Vestibular Institute may use and disclose of my protected health information protected under Health Insurance Portability and Accountability Act of 1996 for treatment, billing/payment, and health care operations.

I understand that I have the right to request, now and in the future, how protected health information is used or disclosed to carry out treatment, payment, and health care operations. I understand that while Texas Ear and Vestibular Institute is not required to agree to my requested restrictions, if does agree, it is bound by that agreement.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Practice's Privacy Officer. I understand Texas Ear and Vestibular Institute may refuse me further service if I revoke the consent.

Print Name of Patient/Guarantor/Legal Guardian: _____ Date of Birth:___/___/___
Signature of Patient/Guarantor/Legal Guardian: _____ Date: _____

(_____)
Initial

Financial Responsibility Agreement: I understand that charges not covered by my insurance company or my secondary insurance if applicable, as well as any applicable co-payments, co-insurance, and deductibles are my responsibility. All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance by either the patient or his/her health insurance carrier. If your insurance company has not paid your account in 90 days, the balance may be transferred to you for payment.

If your insurance is with an HMO or other managed care program, Texas Ear and Vestibular Institute will bill them only if you present an appropriate authorization form from them. You may still be responsible for any deductibles, co-payments, or non-covered services. If you do not have an appropriate authorization each visit and/or treatment, the responsibility for the payment will be yours.

For companies with whom our physicians do not participate, payment for the first visit for the services is your responsibility. Texas Ear and Vestibular Institute will bill to your insurance carrier after second visit.

I understand that if I default on payment for services, that my account my be transferred to an independent collection agency, designated as credit risk and payment for services will be required at the time of registration for all future visits. I have read the financial policy as above. I understand and agree to above financial policy.

We currently accept cash, Visa, Mastercard, and American Express. Unfortunately, we are not accepting checks at this time. If you have any questions regarding your bill, please contact our billing office, CureMD, at 347-732-1357.

(_____)
Initial

Missed Appointments: Your appointment time is set aside especially for you. Resources are assigned for each individual patient. We ask that for the courtesy to the Doctor and to other patients that you keep your scheduled appointments.

If you must change or miss an appointment, we require a 24-hour notice. Failure to provide a 24-hour notice to cancel your scheduled appointment will result in a "no show" fee of $50.00. A no-show fee must be paid prior to being seen at your next visit. Please note that insurance companies do not pay for no-show fees and therefore will not be billed for that charge.

(_____)
Initial

Consent of Treatment: I authorize the staff at Texas Ear and Vestibular Institute to provide any diagnostic tests and examination indicated for treatment.

(_____)
Initial

Medication Policy Consent: I authorize Texas Ear and Vestibular Institute to obtain a medication history and/or list of current medications via my pharmacy for medical records.

(_____)
Initial

Disability or Insurance Forms: There will be a charge of $25 for the completion of medical forms. Payment is due at the time that you pick up the forms. Please allow 7-10 days for the completion of these forms.