ADULT

Ear, Nose & Throat Specialist of Tulsa, L. L. P.

6802 South Olympia Ave. West, Suite 200
Tulsa, Oklahoma 74132
(918) 388-9740 • Fax (918) 388-9741

Tom A. Hamilton, D.O.

TODAYS DATE: ____________________ **REASON FOR VISIT:** ____________________

DEMOGRAPHICS

LAST NAME : ____________________ **ADDRESS:** ____________________
FIRST NAME: ____________________ ____________________
MIDDLE NAME: ____________________ ____________________
SOCIAL SECURITY # ____________________ **PREFER TO BE CALLED:** ____________________
DATE OF BIRTH: __________ **AGE:** __________ **HOME PHONE:** __________ **CELL PHONE:** __________
MARITAL STATUS: __________ **SEX:** __________ **E-MAIL:** __________ **FAX:** __________
EMPLOYER: ____________________ **WORK #:** __________ **JOB TITLE:** __________
REFERRING PHYSICIAN: ____________________ **PRIMARY CARE PHYSICIAN:** ____________________

RESPONSIBLE PARTY (If other than patient)

LAST NAME : ____________________ **ADDRESS:** ____________________
FIRST NAME: ____________________ **RELATIONSHIP TO PATIENT:** ____________________
MIDDLE NAME: ____________________ **HOME PHONE:** __________ **WORK #:** __________
EMPLOYER: ____________________ **CELL PHONE:** __________ **PAGER #:** __________

PRIMARY HEALTH INSURANCE (Insured's Information)

INSURED'S NAME: ____________________ **INSURED'S RELATIONSHIP TO PATIENT:** ____________________
INSURANCE CO: ____________________ **POLICY OR ID NO:** ____________________
INSURED'S DATE OF BIRTH: ____________________ **INSURED'S SOCIAL SECURITY NO:** ____________________
GROUP NO: ____________________ **PLAN TYPE:** __________ **AUTHORIZATION REQUIRED?** ______
POLICY EFFECTIVE DATE: ____________________ **EMPLOYER:** ____________________

SECONDARY HEALTH INSURANCE (Insured's Information)

INSURED'S NAME: ____________________ **INSURED'S RELATIONSHIP TO PATIENT:** ____________________
INSURANCE CO: ____________________ **POLICY OR ID NO:** ____________________
INSURED'S DATE OF BIRTH: ____________________ **INSURED'S SOCIAL SECURITY NO:** ____________________
GROUP NO: ____________________ **PLAN TYPE:** __________ **AUTHORIZATION REQUIRED?** ______
POLICY EFFECTIVE DATE: ____________________ **EMPLOYER:** ____________________

SIGNATURE: ____________________ **DATE:** ____________________

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Financial Policy

We are committed to providing you with the best possible care. If you have medical insurance, we are here to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our financial policy.
You must realize, however that:

Payment is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, MasterCard, Visa, American Express or Discover. For patients with no insurance, we do allow a discount on self-pay patients if paid at the time of the service.

A $35 fee will be charged for all returned checks plus if any bank fee and your account will be placed on a "cash only" basis.

Your insurance is a contract between you, your employer and the insurance company. If you have any questions regarding network providers, referrals, covered services, benefits and/or financial obligation please contact member services through your insurance company in a timely manner. All charges not covered by your insurance company will be your responsibility.

While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. If we do not have your correct information, insurance cards or referral, then we will be unable to properly file a claim to your insurance company in a timely manner. All charges not covered by your insurance company will be your responsibility.

Should your account balance become uncollectable due to bankruptcy, we will allow 30 days of medical care after which you will be dismissed from our practice.

The accompanying parent or adult is responsible for full payment at the time of service. In case of divorce, we are not responsible for billing multiple parties. It is the responsibility of the parent/guardian whom brings the child in to work out the payment arrangements between custodial and non-custodial parents.

I AGREE THAT IF IT BECOMES NECESSARY TO FORWARD MY ACCOUNT TO A COLLECTION AGENCY, I WILL ALSO BE RESPONSIBLE FOR THE FEE CHARGED BY THE AGENCY FOR THE COSTS OF COLLECTION IN ADDITION TO THE ORIGINAL AMOUNT DUE.

We realize that financial problems may affect timely payment on your account. If such problems do arise, we encourage you to contact our Billing Office promptly to resolve any issues on your account (918) 388-9090.

If you have any questions about the above information or any uncertainty regarding your insurance coverage, PLEASE do not hesitate to ask us. We are here to help you. We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH BY ENT SPECIALISTS OF TULSA.

Please Sign and Date to show that you understand and have received a copy

____
Patient Name and Date of Birth

____
Print Name of Responsible Party/Patient

____
Signature of Responsible Party/Patient Date

If, at any time, the responsible party provides a wireless telephone number where he/she may be contacted, he/she consents to receive calls (including auto-dialed calls and pre-recorded messages) at that wireless number from {hospital, doctors office, collection agency}, its successors and assignees, and the affiliates, agents, and independent contractors, including servicers and collection agents, of each of them regarding the services rendered, or your related financial obligations.

____
Patient or Responsible Party Signature Date