

PEDIATRICS

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)

MOTHER'S NAME : _____

FATHER'S NAME : _____

SOCIAL SECURITY # : _____

SOCIAL SECURITY # : _____

BIRTHDATE: _____

BIRTHDATE: _____

EMPLOYER: _____

EMPLOYER: _____

PHONE #: _____

PHONE #: _____

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: _____

EAR, NOSE & THROAT SPECIALISTS OF TULSA, L.L.P.

6802 S. Olympia Ave. West, Suite 200 • Tulsa, Oklahoma 74132

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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