

PATIENT INFORMATION - PLEASE PRINT

Patient Name:		Phone#:	Work Phone#:
Address:		City, State, Zip:	
Employer:	Occupation:	Student: Full-Time or Part-time (Circle one, if applicable)	
Date of Birth: ____/____/____	Sex: M or F	SS#: ____/____/____	Marital Status (Circle one) S M D W
Emergency Phone#:		Emergency Contact Name:	
Primary Care Physician (This is the physician you see for routine medical care)		Referring Physician (This is the physician that recommended that you contact us)	

IMPORTANT:
Who else would you like to advise regarding your visit here (your allergist? Cardiologist? Rheumatologist?)

BILLING INFORMATION - PLEASE PRINT

Name of Responsible Party (if different from patient)			
Address:		City, State, Zip:	
Home Phone#:		Work Phone #:	
Employer:		SS#: ____/____/____	
Primary Insurance Carrier & Address:		Insured's Name:	
Policy#:	Group#:	Insured's Date of Birth: ____/____/____	
Patient's Relationship to Insured:			
Secondary Insurance Carrier & Address:		Insured's Name AND Employer:	
Policy#:	Group#:	Insured's Date of Birth: ____/____/____	
Patient's Relationship to Insured:			

***** IMPORTANT *****

If your health insurance requires a referral, you must have your valid referral available at the time of your visit. Payment for your copay is required at the time of the visit. For your convenience, we accept Mastercard and VISA. A service charge may be added to your account when the copayment is not made on the day of your visit.

Please see back side of this form.

Buffalo Otolaryngology Group, P.C. Agreement and Acknowledgement

- Buffalo Otolaryngology Group, **DOES NOT** participate with my health insurance company. I understand that I am personally responsible for payment of all fees*. Payment is due at time of visit. The Buffalo Otolaryngology Group will file insurance claims on my behalf.
- Buffalo Otolaryngology Group **DOES** participate with my insurance. I understand that all copays and services not covered by my insurance are my responsibility. If I fail to obtain a valid and current referral, I am responsible for payment of any charges. The Buffalo Otolaryngology Group will file insurance claims on my behalf.
- If you fail to meet your financial obligation to the group, any additional fees required to collect this amount will be added to your outstanding balance and you may be terminated from the practice.
- If you fail to pay your copayment at the time of service, we reserve the right to reschedule your appointment.

*The schedule of fees is available for my review at the reception desk.

By signing this form, you acknowledge that Buffalo Otolaryngology Group has provided you with its Privacy Notice, which explains how your health information will be handled in various situations. We must try to have you sign this form on your first date of service with us after April 14, 2003. This includes the situation where your first date of service occurred electronically. If your first date of service with us was due to an emergency, we must try to give you our Privacy Notice and get your signature acknowledging receipt of the notice as soon as we can after the emergency.

I also understand that as part of my treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity and I consent to such disclosure for these permitted uses, including via fax.

PATIENT NAME (Please print):

Signature

Date

Relationship to Patient

OFFICE USE ONLY: Buffalo Otolaryngology Group staff should complete if Acknowledgement is not signed:

Please explain why the patient was unable to sign the acknowledgement and Buffalo Otolaryngology's efforts in trying to obtain the patient's signature.

[] Patient refused to sign/read.

_____/_____/_____
Initials / Date