

Allergy, Ears, Nose and Throat Associates of Texas

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INSURANCE/PAYMENT INFORMATION

Primary Insurance Name _____

Policy Number _____ Group No _____

Subscriber Name _____ Subscriber Date of Birth _____

Subscriber's Employer _____ Relationship to Patient _____

Secondary Insurance Name _____

Policy Number _____ Group No _____

Subscriber Name _____ Subscriber Date of Birth _____

Subscriber's Employer _____ Relationship to Patient _____

Worker's Compensation Yes No

Claim Address

Injury No. _____ Date of Injury _____

If present condition is accident related, please provide date of injury. _____

MEDICARE PATIENTS ONLY

Medicare will only pay for services that it determines to be reasonable and necessary under 1862(a)(1) of the Medicare law. If Medicare determines that a particular service is not "reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service.

If Medicare denies payment, I personally agree to be fully responsible for payment.

Signature of Patient/Guardian

Date

PAYMENT POLICY

I irrevocably authorize my insurance benefits to be payable directly to Dr. Yunus and/or the attending physician on my behalf. I understand that I am responsible for all co-insurance and non-covered charges. I understand that payment is due in full at time of service and if not I am responsible to make the appropriate financial arrangements. I consent to the release of information from my medical record as necessary for the collection of services being rendered by this establishment. I also understand that I am responsible for the payment of reasonable attorney fees and collection expenses if required for the collection of the account.

Signature of Patient/Guardian

Date

Referring Physician's Name _____

Office Phone No _____

Primary Care Doctor's Name _____

Office Phone No _____

If other than referring physician, please tell how you learned of our office. _____

Preferred Pharmacy (include location/cross street) _____