Southeast Texas Ear, Nose & Throat, LLP

740 Hospital Drive, Suite 300, Beaumont, TX 77701 409-212-8111/409-981-1787 Fax

GENERAL INFORMATION FOR THE PATIENT

Patient _____ DOB _____

Please read the information below concerning copay and pre-existing clauses that your insurance policy might include that could cause you additional fees. Complete the next section letting us know if there is anyone you would authorize us to speak to about your care or financial concerns. The last section is to provide the name of the pharmacy you would prefer we use and give authorization to get history, if needed.

COPAY MAY NOT COVER ALL SERVICES PROVIDED DURING YOUR VISIT:

Insurance companies often will consider the doctor's visit with the patient as the only portion covered under the copay. All other procedures performed in the office including hearing tests, allergy testing and injections, laryngoscopy, ear cerumen removal or other office surgeries or procedures, x-rays, etc. can be excluded and charged to your deductible for the year or not covered at all. Because this may be the case with your insurance, by your signature below you agree to be responsible for any charges not covered under the scope of the office visit for procedures being rendered today should the insurance not pay.

PRE-EXISTING/WAITING PERIOD CLAUSES MAY CAUSE DENIAL:

More insurance plans are now adding "Pre-existing" or "Waiting Period" clauses to your insurance policy. *Pre-existing* means that if you have been treated for this or a similar diagnosis during the pre-existing period, they will not pay anything toward the claim. Sometimes this clause will be waived by an insurance company if you can submit a Prior Coverage letter from your previous insurance company showing coverage within their accepted lag time. *Waiting period* means that you have agreed when you signed up for your policy to not have coverage for a specific type of service for a specific length of time. In both of these cases, the insurance company will not tell us the details about whether they will pay for services in our office.

I have been instructed that Southeast Texas Ear, Nose & Throat, LLP does not know for certain whether any payment will be received from the insurance company for the services I am receiving today. By my signature below, I understand that I will be financially responsible today as well as any future services provided that the insurance deems as not covered or my financial responsibility based upon my policy specifics. I know that I can contact my insurance company to get further clarification on my plan details if I wish prior to accepting care through this office.

PEOPLE AUTHORIZED TO DISCUSS MEDICAL/FINANCIAL INFORMATION ABOUT PATIENT

_____	_____	_____
Name	Relationship	Phone Number
_____	_____	_____
Name	Relationship	Phone Number

PHARMACY YOU WOULD LIKE TO USE FOR PRESCRIPTION NEEDS-IF KNOWN – By completing this section you are giving us authorization to obtain past prescription history if available

_____	_____
Name and Location	Phone Number (If known)

Please sign below that you have read and understand the information provided and completed the form to the best of your knowledge.

X_____ _____

Signature Date

(ONLY PATIENT AGE 18+, PARENT OR LEGAL GUARDIAN MAY SIGN)