# Ear, Nose, Throat & Allergy Center of Austin

Karen L. Stierman, M.D. Russell D. Briggs, M.D., F.A.C.S.

*2765 Bee Caves Road, Suite 205 • Austin, TX 78746*
*1730 E. Whitestone Blvd., Suite 100 • Cedar Park, TX 78613*
*4112 Links Lane, Suite 204 • Round Rock, TX 78664*
*512-328-7722 • Fax: 512-328-7724*


**Patient Information** (Please Print) Today's Date____/____/____

Name_____
*Last First M.I.*

Address_____
*Street Apt # City State Zip*

Home Phone (_____) _____ Cell Phone (_____) _____ Email _____

SS#_____ Date of Birth _____/_____/_____ Age _____ Sex _____

In case of an Emergency, who should be notified? _____ Phone (_____)_____

**Do we have permission to**:

Y / N Leave a message on your HOME answering machine?

Y / N Leave a message at work?

Y / N Leave a message on cell phone or text?

Y / N Send email regarding your medical care?

Race: African American, Caucasian, Hispanic, Asian, Other

Ethnicity: Hispanic or Latino, Not Hispanic or Latino

Preferred Language: English, Spanish, Other _____

Y / N Discuss your medical condition with any member of your household?

If so, with whom _____Relationship_____

**Referring Physician**_____ **PCP**_____

**Guarantor (Responsible party---if different from patient)**

Name_____
*Last First M.I.*

Address_____
*Street Apt # City State Zip*

Home Phone (_____) _____ Cell Phone (_____) _____ Ext. _____

SS#_____ Date of Birth _____/_____/_____ Age _____ Relationship to Patient: _____

**Primary Insurance Information**

Primary Insurance Name _____ Employer (Group) _____

Policy Holder _____DOB____/____/____SS#_____
Last First M.I.

Effective Date _____/_____/_____

**Secondary Insurance Information**

Secondary Insurance Name_____ Employer (Group) _____

Policy Holder _____DOB____/____/____SS#_____
Last First M.I.

Effective Date _____/_____/_____

**PLEASE CONTINUE...**

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**RELEASE OF INFORMATION**

I authorize Ear, Nose & Throat Center of Austin to release any information to any physician involved in my care, hospital, and/or my insurance company including the diagnosis and the records of any treatment or examination rendered to me during the period of such Medical and Surgical care.

**ASSIGNMENT OF BENEFITS**

I authorize and request payments of insurance benefits directly to Ear, Nose & Throat Center of Austin otherwise payable to Me. I further certify I have provided Ear, Nose & Throat Center of Austin a complete list of the insurance companies with which I have Medical and/or Surgical coverage.

**CONSENT TO TREATMENT**

I authorize Ear, Nose & Throat Center of Austin and/or authorized persons employed by them to perform and/or initiate medical evaluation and treatment and authorize or order related services on my behalf.

**FINANCIAL AGREEMENT**

Unless other arrangements have been made in advance by either you or your health coverage carrier, payment in full is due at the time of service. Acceptable methods of payment are cash, personal check, Visa, MasterCard, Discover, and American Express. There will be a $25 fee on any returned checks.

We have made prior arrangements with many health plans to accept an assignment of benefits. We will submit a claim to those plans for which we have an agreement and will only require you to pay the authorized deductible and co-payment at the time of service. After the claim has been considered, we will bill you for any balance not previously paid. If you have insurance coverage with a plan that we do not have a prior agreement, we will prepare and send a claim for you on an unassigned basis. This means our charges for your care and treatment are due at the time of service and your insurer will send their reimbursement directly to you.

Your insurance policy is a contract between you and your insurance company; the doctor is not involved. If you have questions or concerns regarding your plans coverage on procedures, services considered screenings, medications or particular conditions, you are responsible for obtaining this information prior to your appointment. You agree to pay in full for all services considered “non-covered” services per your insurance policy if you choose to have the service provided.

If your insurance company does not pay in consideration of the services provided, or you do not have insurance, you agree to pay all charges of Ear, Nose & Throat Center of Austin. Each bill is due and payable upon presentation or mailing of a statement to you. Should the account become delinquent, you agree to pay all costs of collection, including interest applied by a collection agency and attorney fees. Any suit filed may be brought in the county where the services are rendered.

**Please Initial Below**

_____**Specific to the field of Otolaryngology, your physician may need to perform certain procedures for proper diagnoses of your condition. This may include, but is not limited to, fiberoptic examination of the voicebox, throat or sinuses. Most insurance carriers consider these exams to be surgical procedures and therefore are subject to surgical deductibles and copay as they apply. Payment for these procedures are due at the time of service.**

I agree that all of the information provided is current and correct to the best of my knowledge. I agree to notify Ear, Nose, & Throat Center of Austin of any changes to the information provided in this form as soon as possible.

**Patient Name (please print)** _____

**Signature of Guarantor**_____**Date**_____