MIDWESTENTCENTRE
Breathe better. Hear better. Live better.

Patient Agreement

Account #__________

KEB RRM MC BMC MPP

Date of Birth: _____/_____/_____ Name: ____ Gender: M/F

Last First M.I

SSN#: _________-_______-____________

Mobile #: [____] ___________________ May we leave a message containing health information? Yes or No

Alternate #: [____] _________________ May we leave a message containing health information? Yes or No

Street Address:___________________________________ City:____________________ State:_____ Zip:__________

Email Address:____

Primary Doctor: ____________________________ Referring Doctor: ____________________________

Emergency Contact:______________________________ Phone #:[_____]_____________ Relationship:____________

RELEASE OF PROTECTED HEALTH INFORMATION

The medical or billing staff of Midwest ENT Centre may discuss my healthcare information with the following person(s):

_______________________________________ _______________________________________

Name Relationship to patient Name Relationship to patient

MIDWEST ENT CENTRE PATIENT AGREEMENT

- I authorize Midwest ENT Centre to bill my insurance for services rendered. If uninsured, I will be responsible for all charges incurred on the date of service. I further understand that if my delinquent account is sent to collections, an additional 25% fee will be assessed to my account.
- I have had the opportunity to review and agree to abide by the Midwest ENT Centre Financial Policy (available at the front desk and on our website, www.entmidwest.com). I authorize Midwest ENT Centre to keep my payment card information securely on file, and to charge the card for amounts owed after claims are fully processed and EOB forms are finalized. Co-pays and incurred fees will be charged at the time of service. A receipt will be emailed after each transaction.
- I understand that there may be certain exams and services necessary for my diagnosis and treatment that are classified as *office-based procedures* by my insurance company. These are not included in the office visit fee and may result in additional charges as dictated by my plan. Such procedures include but are not limited to audiologic testing, imaging, endoscopic exams and treatments, and minor surgical procedures.
- I authorize Midwest ENT Centre to text me appointment reminders and send limited educational and/or marketing information. I understand such contact will be infrequent and my information will not be shared.

I have read, understand and consent to this Patient Agreement and to the Midwest ENT Centre Patient Financial Policy referenced herein. I further understand that I may revoke this authorization in writing at any time.

X ____ _______________

Patient or Guardian Signature **Date**

COPY OF NOTICE OF PRIVACY PRACTICES AVAILABLE AT FRONT DESK RECEPTION

Thank you for choosing Midwest ENT Centre for your ear, nose and throat specialty care!