NORTH COUNTY EAR, NOSE, & THROAT
HEAD AND NECK SURGERY, INC.
Pediatric and Adult
3909 Waring Road, Suite A
Oceanside, California 92056
(760) 726-2440 Fax (760)726-0644

**PEDIATRIC/TEEN PATIENT REGISTRATION** Today's Date _____

Patient Name _____ Date of Birth ___/____/____ Age ___(yrs) ___ (mos)

Parent/Guardian Phone Numbers: H _____ W _____ Cell _____

Street Address _____ City_____ Zip_____

Email Address _____ Patient Social Security # _____

Emergency contact name and phone number: _____

Preferred Language _____ Interpreter name and phone number_____

Can we leave voice mail messages with health information at the above number(s) and relay health information

(such as test results) to whomever answers at the above number(s)? Yes____ No____

**Referring Provider** _____ **Primary Care Provider** _____

**Insurance information**

Primary insurance _____ Policy # _____

Member's Name _____ Social Security #: _____ Date of Birth: _____ Employer _____

Secondary insurance _____ Policy # _____

Member's Name _____ Social Security #: _____ Date of Birth:_____ Employer _____

Insurance preferred lab _____ Insurance preferred radiology facility_____

**Release/Assignment/Acknowledgement**

I hereby authorize North County Ear, Nose and Throat, Head and Neck Surgery, Inc. to release pertinent information to other health care providers involved in my dependent's care and/or insurance companies holding policies on my dependent.

I authorize my insurance company to directly remit payment to North County Ear, Nose and Throat, Head and Neck Surgery, Inc. for medical and surgical services provided.

I understand that I am ultimately responsible for all charges incurred. It is my responsibility to know my insurance and make sure that if I am using an HMO my dependent has an authorization from my primary care doctor and/or insurance company to see this doctor.

I understand that by not providing the office with all information requested and/or copies of my insurance card(s) at the time of service, this could delay the processing of my claim and I could be personally responsible for payment of these services.

*Notice to consumers:* I understand that medical doctors are licensed and regulated by the Medical Board of California, (800) 633-2322, www.mbca.gov *Privacy Notice and Patient Rights* -I acknowledge that I have reviewed these documents on www.northcountyenthns.com and that I may receive paper copies of these documents from the office staff.

*My signature below indicates my acceptance/understanding of the above statements*

Signature of parent or legal guardian_____ Date _____

NORTH COUNTY EAR, NOSE, & THROAT
HEAD AND NECK SURGERY, INC.
Pediatric and Adult
3909 Waring Road, Suite A
Oceanside, California 92056
(760) 726-2440  Fax (760)726-0644

PATIENT NAME _____ DATE OF BIRTH _____

**Financial Policy**

Your insurance policy is a contract between you and your insurance company. Therefore, you are responsible for the cost for services you receive from North County Ear, Nose & Throat, Head and Neck Surgery, Inc. If our office has a contract with your insurance company, we will bill your insurance for you. It is your responsibility to know whether prior authorization or a second opinion is required by your insurance company prior to any office visit, surgery, or hospitalization. This requirement may affect your benefits and amounts by your insurance. Please inform this office if such authorization is required before services are rendered.

It is also your responsibility to notify us of any change in your insurance type, primary physician, primary medical group, or if other changes have occurred that could affect your insurance coverage for services about to be provided. If we are not informed prior to rendering services, you may be responsible for the cost of the services.

We accept assignment for all Medicare patients. Co-payments and deductibles are due and payable at each visit. We regret that a charge of $4 must be added when a bill is mailed for any co-pays due and a $10 charge added to each overdue bill.

**Disability Forms**

Because disability and other related forms have become more prevalent, extensive and therefore more time-consuming to fill out, there is now a minimum $20 charge for completing them. This is not covered by insurance and is therefore the patient's responsibility.

**Returned Checks**

There is a $20 charge for returned checks.

**Missed Appointments and Canceled Surgery**

Your appointment time is reserved for you. If you are unable to keep the office appointment, we request that you notify us at least 6 working hours beforehand. For surgeries, a 72 hour notification is needed. This allows us to schedule another patient in your timeslot. If we are notified later than that, there is a $50 charge for missed physician appointments and surgery, and a $40 charge for missed audiology appointments.

Signature of parent or legal guardian_____ Date _____

FOR PHYSICIAN USE ONLY:

The physician has reviewed the above information.

Physician stamp or signature:_____Date_____