



ear • nose • throat

PATIENT INFORMATION FORM
Please Accurately Complete the Entire Form

Appointment Date _____

Time _____

340 N. Belair Road
 Evans, GA 30809

1303 D'Antignac Street
 PO Bldg 4, Suite 1000
 Augusta, GA 30901

Phone: (706) 868-5676 ♦ Toll Free: (800) 801-9125

J. Douglas Harmon, M.D.
 Alan B. Whitehouse, M.D.
 W. Andrew Wells, M.D.
 William E. Barfield, M.D.

R. Glen Owen, Jr., M.D.
 Christopher L. Vickery, M.D.
 Edward A. Porubsky, M.D.
 R. Tyson Deal, M.D.

James F. Kimbrough, M.D.
 Robinson W. Schilling, Jr., M.D., FACS

*** Must present patient's Insurance Cards and a Picture ID of the patient or the guarantor at time of visit ***

Patient Information

Please print clearly. ALL information must be filled out before services can be rendered.

Patient Name (as printed on insurance card) _____ SSN _____

Mailing Address _____ City _____ State _____ Zip _____

Physical Address (if different than above) _____ City _____ State _____ Zip _____

Home Phone _____ Cell/Other Phone _____ Email _____

Date of Birth _____ Age _____ Single Married Widowed Divorced Male Female

Primary Care Physician _____ Phone Number _____

Employer Name _____ Phone Number _____

Responsible Party Information

For patients that are under the age of 18, a parent or guardian must be listed.

Parent / Guardian Name _____ Relationship to patient _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell/Other Phone _____ SSN _____ Date of Birth _____

Email _____ Employer _____ Phone _____

Primary Insurance Information

Please enter the Primary Insurance Policy Holder's information

Primary Insurance Company _____ Member ID # _____

Group Number _____ Group Name _____

Member (Policy Holder) Name _____ Relationship to patient _____

Member SSN _____ Member Date of Birth _____ Male Female

Employer Name _____ Phone Number _____

Address _____ City _____ State _____ Zip _____

Secondary Insurance Information

Please enter the Secondary Insurance Policy Holder's information

Secondary Insurance Company _____ Member ID # _____

Group Number _____ Group Name _____

Member (Policy Holder) Name _____ Relationship to patient _____

Member SSN _____ Member Date of Birth _____ Male Female

Employer Name _____ Phone Number _____

Address _____ City _____ State _____ Zip _____

Self-Pay Information (No Insurance)

Self Pay _____ Driver License Number _____ State _____



Release of Information / Insurance Assignment

Insurance Authorization & Assignment:

I hereby authorize examination and treatment by Augusta ENT, P.C. I authorize release of medical information to insurance carriers necessary to process claims and assign to the physician payments for medical services. I understand that it is my responsibility to remit payments for charges not covered by my insurance company. I understand that it is my responsibility to see that all claims, pre-certification, and authorizations are completed by my insurance company, since I am responsible for all professional services rendered to myself and/or dependent.

Signature: _____ **Date:** _____

Medicare Patients Only:

I authorize any holder of medical or other information about me to be released to the Social Security Administration and Health Care Financing Administration, its intermediaries, or carrier information needed for this or any related Medicare claim. I permit a copy of this authorization to be used in place of the original and also request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature: _____ **Date:** _____



Payment Policy

ALL PATIENTS:

All co-pays are due *before* services are rendered. You must pay any coinsurance or deductible balances immediately after receiving your first statement. If you cannot pay the entire balance at that time, you must call the billing department to make payment arrangements.

Services that your insurance company **does not cover** must be paid prior to the service being rendered.

Private Pay patients must pay the entire amount of the office visit due at the time of service. Payments may be arranged for any testing or procedures performed in addition to the office visit cost.

If you do not make payment arrangements on past due balances or default on the payment arrangements you will be notified by our collection department of possible termination of doctor-patient relationship and your account will be turned over to an outside collection agency. Should your account be placed with a collection agency, the collection agency fee that is charged to our office will be transferred to your account, which is your responsibility to pay.

Our office offers a number of payment options, including, Cash, Check, Money Order, Discover, Visa, American Express, and Master Card. We also offer a payment assistance program, Care-Credit, for which you can apply. Our staff can explain this program to you.

Signature: _____ **Date:** _____