JEFFREY ADELGLASS, M.D., F.A.C.S.
EAR, NOSE & THROAT • ALLERGY • FACIAL PLASTIC SURGERY

Welcome to our practice!
We strive to make each of your visits pleasant and comfortable. Due to the increased requirements of insurance companies, and to help us better serve your needs; please take a few minutes to answer the following questions.

PATIENT INFORMATION

Who may we thank for referring you? _____

Patients Name _____ _____ _____
First **Middle Initial** **Last**

Sex: M F Birthdate _____ **Age** _____ **S.S.N.** _____

Mailing Address: _____

_____ _____ _____
City **State** **Zip Code**

_____ _____ _____
Home Phone **Work Phone** **Cell Phone**

_____
E-mail address

_____
PCP (Primary Care Physician) **Address** **Phone**

Will we be filing any insurance on your behalf? _____

Please provide us with a copy of your insurance card.

*** If it is an HMO, provide the receptionist a copy of your referral from your PCP upon completion of the form.**

INSURED PARTY INFORMATION

Parent/Guardian/
Insured's Name: _____ _____ _____
First **Middle Initial** **Last**

Sex: M F Birthdate _____ **Age** _____ **S.S.N.** _____

Mailing Address: _____

_____ _____ _____
City **State** **Zip Code**

_____ _____ _____
Home Phone **Work Phone** **Cell Phone**

Emergency Contact: _____ **Relationship:** _____

Phone Number: _____

- ARE YOU INTERESTED IN LEARNING MORE ABOUT THE COSMETIC **PROCEDURES** WE PROVIDE? YES NO
- ARE YOU INTERESTED IN OUR SKIN CARE OR NUTRITIONAL PROGRAMS? YES NO
- WOULD YOU LIKE TO MEET WITH A PATIENT CARE COORDINATOR WHILE YOU ARE HERE TODAY AT NO CHARGE? YES NO

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EXPLANATION OF PAYMENT AND INSURANCE FILING PROCEDURES

Our office is pleased to assist you in filing claims with your insurance company for reimbursement of your expenses. We will wait ninety (90) days for your insurance company to pay your claim. If they deny your claim and/or do not pay your claim for any reason, any remaining balance must be paid by you within thirty (30) days. We will not fight your insurance company for payment. We file insurance for you as a courtesy.

- It is the patient's responsibility to pay any deductible, co-insurance, and/or co-payments at the time services are rendered.
- Our office NEVER guarantees that your insurance will pay. We will make every attempt at the beginning of your health care to receive verification of your policy benefits. However, if for some reason your insurance claim is denied, you are responsible for the amount due on your account immediately.
- We recommend that you also contact your insurance company to verify the ENT and Allergy coverage on your policy.
- We will not file insurance for patients that do not live in Texas. We will provide you with a receipt of all services rendered.
- If injections, allergy testing, ear cleaning, or other in-office procedures are recommended for your treatment; please be aware that they may be considered surgical procedures and will be applied to your deductible.
- Our office will not file with a secondary insurance policy unless Medicare is your primary.
- There will be a $25 fee on all returned checks. Checks will not be presented to the bank twice.
- You may receive a copy of your records at any time with a written request. There is a $25 fee for all records received by our office. A 72 hour notice is required to get copies completed.

I fully understand the above policies and agree to them. I understand that I am responsible for payment to Dr. Jeffrey Adelglass and/or Associates for all charges incurred by myself, regardless of my insurance coverage. For your convenience, we accept Cash, Visa, Master Card, American Express, Discover, and personal checks (with proper identification) as methods of payment.

CONSENT FOR TREATMENT
I give permission to the physician and whomever he may designate as his assistant(s)/associate(s) to administer such treatment as is necessary, and to perform any medical care or procedures as are considered therapeutically necessary based on findings during examination or treatment.

NOTICE TO PATIENTS OF FINANCIAL INTEREST
I understand that should Dr. Adelglass feel radiology services are necessary for diagnosing or treating my health, I may be referred to Presbyterian Plano Center for Diagnostics and Surgery. I am informed by this notice that Dr. Adelglass holds a financial interest in the Hospital and Radiology Services. I also understand that I have the option, at my discretion, to use an alternate health care facility.

AUTHORIZION TO RELEASE INFORMATION
I hereby authorize Dr. Jeffrey Adelglass, and/or Associates to release any medical information pertaining to the examination, treatment, history, prescription of medications, and medical expenses of myself to any physician, hospital, clinic, insurance company, and all other agencies deemed necessary in order to process insurance claims. This authorization also includes the release of any pertinent medical information to any specialist or other medical facility the physician may refer the patient to for medical treatment or evaluation.

ASSIGNMENT OF BENEFITS
I authorize payment of medical benefits to Dr. Jeffrey M. Adelglass, and/or Associates, for services rendered. I understand that I am financially responsible for any co pays, co-insurance, or deductibles required by my insurance company. I also understand that I am responsible for charges that are not covered by my insurance company.

By my signature I agree to comply with the Financial Policy, Consent for Treatment Policy, Notice of Financial Interest, Authorization to Release Information Policy, and Assignment of Benefits.

_____ _____
Insured's or Authorized Person's Signature Date