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BOISE, ID 83704  
(208) 367-3320

Male  
 Female

Patient's Legal Name: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell / Pager \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Marital Status  
 M  S  D  W

Patient's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_

Occupation (or none, student, homemaker, retired) \_\_\_\_\_ S.S.# \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Employer \_\_\_\_\_

Spouse's S.S.# \_\_\_\_\_ Work Phone \_\_\_\_\_ Occupation \_\_\_\_\_

If Applicable:  
Patient's Legal Guardian \_\_\_\_\_

Father's Name (IF MINOR) \_\_\_\_\_ S.S.# \_\_\_\_\_ D.O.B. \_\_\_\_\_

Father's Home Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_ Phone \_\_\_\_\_

Father's Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

Mother's Name (IF MINOR) \_\_\_\_\_ S.S.# \_\_\_\_\_ D.O.B. \_\_\_\_\_

Mother's Home Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_ Phone \_\_\_\_\_

Mother's Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

Whom May We Contact in Case of Emergency? \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Referring Physician \_\_\_\_\_

Is your visit result of accident? YES  NO  Date of injury \_\_\_\_\_ Description \_\_\_\_\_

Is this a Worker's Compensation claim? YES  NO  Claim Number \_\_\_\_\_

**PRIMARY INSURANCE COMPANY NAME** \_\_\_\_\_ Phone \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Relationship to Subscriber  
Self  Spouse  Parent  Child  Step Parent  Other

Subscriber D.O.B. \_\_\_\_\_ Group No. \_\_\_\_\_ I.D. No. \_\_\_\_\_

**SECONDARY INSURANCE COMPANY NAME** \_\_\_\_\_ Phone \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Relationship to Subscriber  
Self  Spouse  Parent  Child  Step Parent  Other

Subscriber D.O.B. \_\_\_\_\_ Group No. \_\_\_\_\_ I.D. No. \_\_\_\_\_

**HIPAA Notice of Privacy Practices**  
I acknowledge the receipt of Southwest Idaho ENT, PA's notice of privacy practices.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**SOUTHWEST IDAHO EAR, NOSE AND THROAT, P.A.**  
**FINANCIAL POLICY**

Our practice is committed to providing the best treatment possible for our patients. Our charges are usual and customary for our specialty. Your insurance policy is a contract between you and your insurance company. It is the patient's responsibility to know what services are covered under their insurance policy. **Full payment is due at the time of service for all co-pays, co-insurance or any deductible amounts.** We accept cash, check, Visa, MasterCard, American Express, Discover and Care Credit.

Southwest Idaho Ear, Nose and Throat, PA uses third party agencies to collect on accounts that are past due. A twenty dollar setup fee may be charged if your account is sent to such an agency. Returned checks are subject to an additional fee and will be sent to a third party agency if not paid in full after receiving notification.

I authorize the release of any information necessary to determine liability for payment to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign benefits to which I am entitled including private insurance and other health plans to Southwest Idaho Ear, Nose and Throat, PA. This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges that are not paid by insurance.

I hereby authorize Southwest Idaho Ear, Nose and Throat, PA to appeal any incorrect insurance payment. I release Southwest Idaho Ear, Nose and Throat, PA from all legal responsibility or liability that may arise from this authorization. **I AGREE TO THE ASSIGNMENTS AND ACKNOWLEDGE MY FINANCIAL RESPONSIBILITIES DISCUSSED ABOVE.**

X \_\_\_\_\_  
Responsible Party Signature

DATE: \_\_\_\_\_

**Medicare Patients:**

Our physician's are Non-Participating providers with Medicare; therefore, we do not routinely accept assignment on Medicare claims. All physicians are required to file claims to Medicare on behalf of the patient. We will file the claims to Medicare, but on any unassigned claims, Medicare will send payment to the patient. **Payment in full is expected at the time of service for all Medicare unassigned claims.**

Medicare mandates that physicians accept Medicare assignment on certain diagnostic tests, labs, and patients with Medicaid Secondary insurance. To comply with Medicare guidelines we need all Medicare patients to sign the following statement:

*I request that payment of authorized Medicare benefits be made either to me for unassigned claims, or on my behalf to Southwest Idaho ENT, PA for assigned claims for any services furnished by that provider. I authorize any holder of medical information about me to release to the Centers of Medicare and Medicaid Services and its agents any information needed to determine these benefits payable for related services.*

X \_\_\_\_\_  
Responsible Party Signature

DATE: \_\_\_\_\_