Ear, Nose, Throat and Allergy
Hearing Care and Hearing Aid Center

Price Sonkarley, MD Board Certified Otolaryngologist
Kathleen Rocuant, AuD Board Certified Audiologist
Carly Treibits, PA-C Board Certified Physician Assistant

PATIENT REGISTRATION FORM

PLEASE PRINT

Date:_____

Please provide the name of the Physician who referred you_____

How did you hear about us? _____

Patient's Last Name_____**First Name**_____**MI**_____

Date of Birth_____**M/F**_____ **Marital Status: M**_____**S**_____**D**_____**W**_____

Email Address_____

Local Address_____

City_____**State**_____**ZIP**_____

Home Ph #_____**Cell #**_____**Work#**_____

Out of state Address_____

City_____**State**_____**ZIP**_____**Ph#**_____

Emergency contact_____ **Relationship**_____**Ph #**_____

Price Sonkarley, MD

Ear, Nose, Throat, Allergy & Hearing Care

Primary Insurance Information

Insurance Company's Name_____

Policy Holders Name_____ **DOB**_____

Relationship_____

Secondary Insurance Information

Insurance Company's Name_____

Policy Holders Name_____ **DOB**_____

Relationship_____

I request that payment of authorized benefits be made on my behalf to Mark H. Montgomery, MD PA for any medical services furnished to me.

Signature_____

Your Last Name: **First Name:** **DOB:**

Reason for your visit today? **Length of time?**

Name of Physician who referred you:

YOUR PHARMACY'S NAME AND PH#

Do you have Hearing Loss? ***Do you wear Hearing Aids?***

Have you ever been diagnosed with the following? Please circle Yes or No

Skin Lesions	*YES*	*NO*	**Depression**	*YES*	*NO*
Headache/Migraine	*YES*	*NO*	**Arthritis**	*YES*	*NO*
Seasonal Allergies	*YES*	*NO*	**Thyroid Disease**	*YES*	*NO*
Asthma	*YES*	*NO*	**Diabetes**	*YES*	*NO*
COPD	*YES*	*NO*	**Cancer TYPE?**	*YES*	*NO*
Heart Attack	*YES*	*NO*	**Reflux Disease**	*YES*	*NO*
Stroke	*YES*	*NO*	**Sleep Apnea**	*YES*	*NO*
High Blood Pressure	*YES*	*NO*	**Kidney disease**	*YES*	*NO*
High Cholesterol	*YES*	*NO*	**Immunizations up to date?**	*YES*	*NO*

List type and date of all surgeries you have had:

****ARE YOU ALLERGIC TO ANY MEDICATIONS?***

Please list your current medications including over the counter remedies

Height **Weight**

Tobacco Use: Y/N **How many packs per day?** **How long?** **When did you quit?**

Do you consume Alcohol? Y/N **How many drinks per day?** **How long?**

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FINANCIAL POLICY

Medicare Part B

We accept assignment on all Medicare Part B claims. However, Medicare only pays 80% of the approved amount. We will bill your secondary insurance for the remaining 20% but if you have additional insurance besides your secondary it will be your responsibility to forward the necessary paperwork to them. Any balance remaining after claims are processed will be your responsibility.

Commercial Insurance

We are contracted with numerous insurance companies but there are literally thousands of policies, and each one is different. It is ultimately your responsibility as the subscriber to know and understand your participating provider options and medical benefits. ***All copays will be collected at the time of your visit as mandated by your insurance. Any balances due after claims are processed will be the subscriber's responsibility.***

Non-covered Services

Services not covered by your insurance will be your responsibility.

Deductibles

Every insurance policy including Medicare has an annual deductible and you the subscriber will be responsible for that amount. Please contact your insurance if you are not familiar with the guidelines and amount of your deductible.

NO SHOW FEE

FAILURE TO SHOW FOR YOUR SCHEDULED APPOINTMENT OR FAILURE TO CANCEL WITHIN 24 HOURS WILL CONSTITUTE A $150.00 "NO SHOW FEE". THIS CHARGE WILL NOT BE PAID BY YOUR INSURANCE AND WILL BE BILLED DIRECTLY TO YOU.

Outstanding Balances and Delinquent Accounts

It is the policy of our office that any account with an outstanding balance of $150.00 or more must be addressed before further appointments can be scheduled. Any account balance outstanding past 90days will be considered delinquent and ready for collection activity.

I HAVE READ THE ABOVE AND UNDERSTAND AND AGREE TO THE ARRANGEMENTS DESCRIBED. I HAVE QUESTIONED ANYTHING I DID NOT UNDERSTAND.

Signed_____

We accept Visa, MasterCard, Discover Card, American Express, cash and personal checks.

Price Sonkarley, MD

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices.

Name _____ **DOB** _____

I (patient) authorize the disclosure of my health information to my:

Family member(s) _____

Friend(s) _____

Other _____

I *do not* authorize the release of my health information to:

_____

_____

Signature _____ **Date:** _____

If patient is a minor or deemed legally incompetent:

Signature _____ **Date:** _____

Relationship _____

For office use only:

Signed and witnessed by (initials) _____

Reason for refusal to sign _____

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