



Patient Questionnaire

Frank Brettschneider, D.O., F.A.O.C.O.
Neal Obermyer, M.D., F.A.C.S.

Today's Date: _____

PATIENT INFO

Last Name _____ First Name _____ MI _____ Sex: M F
Age _____ Birth Date _____ Social Security _____ Driver's Lic # _____
Home Address _____
City _____ State _____ Zip _____
Home Phone _____ Cell _____ Work _____
Marital Status: Single Married Divorced Widowed
(If patient is a minor, give parent/guardian employment information):
Are you employed? Yes _____ No _____ If Yes, Name of Employer _____
Occupation/Job Description _____
Employer Address _____ Phone _____
If married, Spouse's Name _____ Spouse's Work _____
Spouse's Employer Name & Address _____
If the patient is a minor, parent(s) names(s) _____
Name of person child currently lives with _____ Relationship _____
Pharmacy you use _____ Phone _____ Prescription insurance coverage? Yes No

PRIMARY INSURANCE INFORMATION

Insurance Company Name & Address _____
Policy Holder's Name _____ Birth Date _____
Relationship to patient _____ Social Security # _____
Phone # _____ Identification # _____ Group # _____

SECONDARY INSURANCE INFORMATION

Insurance Company Name & Address _____
Policy Holder's Name _____ Birth Date _____
Relationship to patient _____ Social Security # _____
Phone # _____ Identification # _____ Group # _____

Referred by Friend Physician www.porthuronent.com Internet
 Other _____ Have you or any of your family been previous patients? Yes No
If Yes, Name Of Patient _____ When? _____
Referring Physician _____ Phone _____
Address _____
Primary Care Physician _____ Phone _____
Address _____
Dentist _____



Port Huron E.N.T.

FINANCIAL POLICY

Frank Brettschneider, D.O., F.A.O.C.O.
Neal Obermyer, M.D., F.A.C.S.

Patient Name: _____

Date: _____

Thank you for choosing Port Huron E.N.T., P.C. as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require that you read and sign prior to any treatment.

All patients must complete our Patient Information and Insurance Authorization forms prior to seeing the doctor.

For those patients not covered by medical insurance, we reserve the right to require full payment at the time of service. For those patients covered by a health plan with which we participate, payment of any applicable co-pays and/or deductibles are due at the time of service. For those patients covered by a health plan with which we do not participate, we reserve the right to require full payment at the time of service. In instances where co-pay and/or deductible amounts are not known or where no payment was made at the time of service, the patient will receive a bill for the applicable services.

Regarding Insurance

Our office will accept assignment of insurance benefits for all health care carriers with whom we have a participation agreement. It is the patient's responsibility to inform us of any changes in their health insurance coverage prior to treatment being rendered. For those plans that may require prior authorizations and/or written referrals for coverage, it is the patient's responsibility to obtain and present this information prior to treatment. Please remember that your insurance policy is a contract between the insured and the insurance company. We are not a party to that contract. A medical claim will be submitted on behalf of the patient, but follow-up for this claim and payment of all outstanding bills may be the insured's responsibility. *Please Note: After 60 days, unpaid insurance claims may be dropped to the patient's financial responsibility for payment or follow-up.*

Usual and Customary Rates/Approved Amounts

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. Our fees are based on the Centers for Medicare & Medicaid Services Relative Value Scale. For those insurance companies with which we participate, we will accept their "approved amount". This does not mean that we accept what they pay. An approved amount can be the total of what a carrier pays plus any co-insurance and/or deductible amounts. For plans that we do not participate with, the patient may be responsible for payment regardless of their insurance company's arbitrary determination of usual and customary rates.

Adult Patients

For adult patients, the ultimate financial responsibility for any service is the patient themselves, regardless of who is listed as the holder of the insurance (the insured). Billing statements will be sent to the patient at the address listed in the patient information section.

Minor Patients

In Michigan, the law describes a minor as anyone under the age of 18. We require that all minors be accompanied by a parent and/or legal guardian at every visit. In rare exceptions, a parent or legal guardian may give signed, written permission for a third party to bring the minor to the appointment. For minors, the billing statement will be mailed to the parent whose signature appears on this financial policy. The financial responsibility for the child's account will be the parent whose signature appears on this financial policy. The only exception to this would be the presentation of a Court Order indicating otherwise.

Missed Appointment

It is your responsibility to be aware of any appointment made with our office. We reserve the right to charge a fee of \$50.00 for each missed appointment or appointments cancelled without at least 24 hours prior notice. Please help us serve you better by keeping scheduled appointments.

Interest and Returned Checks

We reserve the right to charge a service fee of 35% on all unpaid balances that are submitted to an independent collection agency. Accounts that are turned over for litigation may also be assessed additional court costs. A \$35 service fee will be charged for all checks returned for insufficient funds in addition to the original balance.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy of Port Huron E.N.T., P.C. I understand and agree to this Financial Policy. My signature below affirms that I have the legal right to consent to this.

Patient or Responsible Party Signature

Date

Printed Name of Person Signing

(Revised 9/1/08)

3/3