CANYON VIEW
EAR, NOSE & THROAT

Patient Registration Form

Date: _____

Patient's Legal Name: _____
First Middle Last

Date of Birth**:** _____ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

Social Security Number: _____ Male ☐ Female ☐

Mailing Address: _____ City: _____Zip Code: _____

Home or Cell Phones: ( ) _____ Cell Phone: ( ) _____

Email Address**:** _____ Work Phone: ( ) _____

Primary Care Physician: _____City: _____

Referring Physician: _____City: _____

Pharmacy: _____ Preferred Language: _____

Race: American Indian or Alaska Native ☐ Asian ☐ Black or African American Native ☐

Hawaiian or Other Pacific Islander ☐ White ☐ Other/Prefer Not to Respond ☐

Ethnicity: Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Prefer Not to Respond ☐

HOW DID YOU HEAR ABOUT US? _____

Responsible Party Information

Responsible Party**:** _____ Relationship to Patient: _____

Date of Birth: _____ Social Security Number: _____

Home or Cell Phone: ( ) _____ Email Address: _____

Mailing Address**:** _____ City: _____ Zip Code: _____

Employer: _____ Work Phone: ( ) _____

Insurance Information

PRIMARY Insurance Company: _____

Policy or Member Number: _____ Group Number: _____

Policyholder's Name: _____ **Date of Birth**: _____ SSN: _____

SECONDARY Insurance Company: _____

Policy or Member Number: _____ Group Number: _____

Policyholder's Name: _____ **Date of Birth:** _____ SSN: _____

*Is today's visiting the result of a work injury or a car accident?*_____

Date accident or injury occurred: _____*Claim Number:* _____

Emergency Contact Information

Emergency Contact: _____Relationship: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____ Work Phone: ( ) _____

Name of Nearest Relative: _____Relationship: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____ Work Phone: ( ) _____

Patient Financial Policy

Your clear understanding of our Patient Financial Policy is important to us. Please ask if you have any questions about our fees, our policies, or your responsibilities.

If you have insurance, we will try to help you receive maximum benefits. Our office will file claims for all reimbursable services, to both your primary and secondary insurance carriers, as a courtesy to you.

You are expected to present a current insurance card at each office visit, otherwise you may be asked to reschedule your appointment. Additionally, failure to provide complete and accurate insurance information at the time of your office visit may result in you being responsible for the entire bill.

You are responsible for all co-payment, co-insurance, deductible, estimated portion and/or any non-covered service amounts at the time of your office visit. Failure to pay your co-payment at the time of your office visit may result in a $10 billing charge. We may elect to send you a bill for any amount you owe, at our own discretion.

Insurance is a contract between you and your insurance company. We are NOT a party to this contract. We will not become involved in disputes between you and your insurance company, other than to supply factual information as necessary. Your insurance company makes the final determination of your eligibility and benefits.

You are responsible for the timely payment of your account. If your insurance company does not make payment on your behalf within 45 days from the date of service, you may be responsible for any outstanding balance.

If you do not have insurance, payment for all services rendered is due at the time of the office visit. Please see our Self-Pay Policy for additional details. Our Self-Pay Policy applies to patients without insurance coverage, patients covered by insurance plans in which our office does not participate, or patients who have not provided our office with current insurance information by the time of their office visit.

In the case of workers' compensation injury or automobile accident, you must obtain the claim number, phone number, contact person, and name and address of insurance carrier prior to your visit. If this information is not provided, you may be asked to either reschedule your appointment or agree to the terms of our Self-Pay Policy.

Missed appointments and appointments cancelled without 24 hours notice may result in a $40 fee charged to your account. Excessive abuse of scheduled appointments may result in discharge from the practice.

We accept cash, checks, money orders, Visa and MasterCard. Returned checks will result in a $25 fee charged to your account. Any and all payment arrangements must be approved in advance by the office or billing manager.

All delinquent accounts will be charged an interest rate of 1.5% (18% per annum). In the event any balance is not paid as agreed, the undersigned agrees to pay a collection fee up to 40% of the unpaid balance. In the event of a lawsuit to collect the unpaid balance, the undersigned further agrees to pay court costs and attorney's fees.

I acknowledge that I have read, understand and agree to the terms of the Patient Financial Policy.

Patient/Responsible Party
Signature_____**Date**_____

Patient Name (Please Print)_____**Date**_____

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