MIDWESTENTCENTRE
Breathe better. Hear better. Live better.

Patient Registration

Account #_____ KEB RRM MC BMC MPP

Date of Birth: _____/_____/_____ Name: _____ Gender: M/F
Last First M.I

Phone #: (____) _____ May we leave a detailed message? Y or N

Cell #: (____) _____ May we leave a detailed message? Y or N

Work #: (____) _____ May we leave a detailed message? Y or N

Email Address_____

Primary Doctor: _____ Referring Doctor: _____

EMERGENCY CONTACT:_____ Phone #:_____ Relationship:_____

RELEASE OF PROTECTED HEALTH INFORMATION

I give consent for the medical or billing staff of Midwest ENT Centre to discuss my healthcare information with the following person(s):

_____ _____
Name Relationship to patient Name Relationship to patient

AUTHORIZATION OF RELEASE OF INFORMATION / CONSENT TO TREATMENT / FINANCIAL RESPONSIBILITY

- I understand that I am responsible for my insurance copay at the time of service. If uninsured, I understand that I am responsible for all charges incurred at the time of each visit. I further understand that if my account is sent to collections, an additional 25% fee will be charged.
- I authorize Midwest ENT Centre to keep my credit card information and signature securely on file, and to charge the card for any outstanding balance deemed my responsibility by my insurance company after the claim is fully processed and the explanation of benefits (EOB) form is sent. Copays and incurred fees will be charged at the time of service. A receipt will be emailed after each transaction.
- I understand that there may be certain exams and services necessary for my diagnosis and treatment that are classified as *office-based procedures* by my insurance company, and that these may be subject to additional copay/coinsurance/deductible amounts as dictated by my insurance plan. Such procedures include but are not limited to audiologic testing, imaging, endoscopic examinations and treatments, and other minor surgical procedures.
- I authorize Midwest ENT Centre to send me text appointment reminders, limited educational and/or marketing information. I understand such contact will be kept to a minimum and that my information will not be shared.

I have read, understand and agree to each of the preceding on my and/or on behalf of those under my care. I further understand that I may revoke this authorization in writing at any time.

X _____ _____
Patient or Guardian Signature **Date**

COPY OF NOTICE OF PRIVACY PRACTICES AVAILABLE AT FRONT DESK RECEPTION

Thank you for choosing Midwest ENT Centre for your ear, nose and throat specialty care.

9/11/20

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MEDICATION LIST

Account #_____ KEB RRM MC BMC MPP

Patient Name: _____Date:_____

Please list each medication on a separate line.

MEDICATION NAME	DOSAGE	HOW OFTEN DO YOU TAKE IT?
Example: Penicillin	*1 tablet*	*2x a day*

LIST ANY ALLERGIES TO MEDICATIONS:

_____