

# ENT and Allergy Associates, LLC

# 2012

160 Hawley Lane, Trumbull, CT 06611  
tel 203.380.3707 fax 203.380.3711

## Billing Information Sheet

Patient Name (last, first, MI)	Date of Birth (mm/dd/yyyy)	Social Security Number
Street Address	Home Telephone	Work Telephone
	Cell Phone/Pager	Marital Status
City State Zip Code	E-mail Address	
Primary Care Physician	PCP's Office Location	
Employer	Employer Address	

How much is your annual deductible?	Is your deductible within a Health Savings Account?	Yes No
-------------------------------------	---	--------

Primary Health Plan		Secondary Health Plan	
Plan Address		Plan Address	
Group # ID#	Group # ID #		
Name of Policy Holder (last, first, MI)		Name of Policy Holder (last, first, MI)	
Policy Holder Address		Policy Holder Address	
Policy Holder's Employer		Policy Holder's Employer	
Telephone Number	Date of Birth	Telephone Number	Date of Birth
Social Security Number	Work Phone	Social Security Number	Work Phone

Whom may we thank for referring you to us?	Relationship
--	--------------

**If patient is a minor, please complete the following parental information:**

Circle Parental Marital Status:	Single	Married	Divorced	Widowed
Father's Name		Mother's Name		
Father's Date of Birth		Mother's Date of Birth		
Social Security number		Social Security number		
Employer		Employer		
Employer Address		Employer Address		
Employer Telephone Number		Employer Telephone Number		

**Emergency information**

Name of nearest relative not living with you	Relationship
Address	Telephone Number
Whom may we contact in case of an emergency?	Relationship
Address	Telephone Number

I have reviewed the completed information on the Billing Information Sheet and the information contained is accurate and true. I also have read and understand the Financial Policy statement. I know that the HIPPA Notice of Privacy Practices is posted on the public website at [www.entallergymd.com](http://www.entallergymd.com) and that I may request a copy from this office.

I hereby authorize ENT and Allergy Associates to furnish information concerning illnesses and treatments of the above named patient to any third party payor with whom the patient is under contract. I hereby authorize payment of benefits directly to ENT and Allergy Associates otherwise payable to me for medical and/or surgical services rendered.

I acknowledge that I am responsible for payment of any non-covered service, co-payment or deductible. I recognize that I am responsible for obtaining any and all referrals from my primary care physician and that I am responsible for payment of any denied service resulting from lack of referral. I also recognize that I am responsible for payment of any denied service resulting from misrepresentation of the information contained within the Billing Information Sheet. I am aware that delinquent accounts will be charged interest and I agree to pay any costs of collections including reasonable attorney fees.

I hereby permit the doctor or his assistant to take photographs or other digital images of the above named patient. I understand that these images are for legal documentation or presentation at professional meetings and discussions, and I give permission to use them as such.

Signature	Date
-----------	------