Last Name_____ **First Name**_____
Address_____
City_____ **State**____ **Zip**_____
Home Phone: _____ **Work Phone:** _____
Mobile phone: _____ **E-MAIL:** _____

Date of Birth ___-___-_____ **Social Security #**_____

Sex M/F_____ **Marital Status S M D** ____ **Student Status FT/PT**

Referring Dr._____ Phone#_____
Primary Care Physician_____ Phone#_____

Pharmacy: _____**Phone:**_____

Primary Insurance Co. _____ID#_____
Ins. company's phone #_____ Group # (if any) _____
Ins. Co. Address_____
Insured person's Name _____
Date of Birth_____ Relation _____ SS#:_____

Secondary Insurance Co. _____ID#_____
Ins. company's phone #_____ Group # (if any)_____
Ins. Co. Address_____
Insured person's name_____
Date of Birth_____ Relation_____ SS# _____

I have read my HIPAA rights and Financial Policy (as affixed to clipboard)

L.I. Center for ENT / Advanced Otolaryngology

I give authorization for them to:

a. **Request and receive and share any and all information in relationship to my medical condition, to be able to bill and get paid for services provided.**
b. **Share my health information with my all my family members Except** _____

I also give my consent to use my signature as authorization on all insurance forms and billing requests so they may receive payment for their services. I am aware that I am responsible for any and all services not covered by my insurance company.

I accept responsibility for payment of my account, as well as additional fees that may accrue should my account fall into arrears and is not paid within a timely manor.

_____ _____
Signature of Patient/Parent **Date**

My signature is valid indefinitely, unless otherwise requested in writing to withdraw my approval.