

Coastal ENT Medical Group

William S. Halsey, M.D, F.A.C.S.

9834 Genesee Ave., Suite 416, La Jolla CA 92037

858-458-1287 (voice)

858-452-9160 (fax)

Patient Registration

PERSONAL

Name _____ Date of Birth _____ Age _____ M ___ F ___

Address _____ Email _____

City _____ State _____ Zip _____ Social Security # _____

Phone () _____ Cell() _____ Fax() _____

EMPLOYMENT

Employer _____ Phone () _____

Address _____ Occupation _____

City _____ State _____ Zip _____

IN CASE OF EMERGENCY-Nearest Relative to contact. (Other than responsible party)

Name _____ Relationship _____ Phone _____

Address _____ Work Phone _____

PERSON RESPONSIBLE FOR PAYMENT

Name _____ Relationship _____ Home Phone _____

Address _____ Work Phone _____

Employer _____ DOB _____ Social Security # _____

INSURANCE--Please present cards to receptionist

Cash Medicare PPO WC Other _____

Primary Insurance Name _____ Subscriber _____

Secondary Insurance Name _____ Subscriber _____

REFERRAL – We are interested in who referred you to our office? _____

Yellow Page Insurance Book Physician Friend ScrippsHealth Internet Other _____

Please initial each line below:

_____ I give my permission for treatment by Coastal ENT Medical Group physicians and staff.

_____ I allow release of information to my insurance carriers.

_____ I allow electronic submission of prescriptions.

_____ I give my permission for photography necessary for my treatment and care.

What are your expectations for today's visit? _____

Signed _____ **Date** ____ / ____ / ____

Coastal ENT Medical Group

Office Financial Policy

- I authorize treatment and agree to pay for such treatment.
- I authorize my insurance benefits to be paid directly to the provider of service (Assignment of Benefits).
- I am financially responsible for “not covered” services.
- If using **Point of Service (POS)**, please be aware that you are responsible for any out of pocket fees related to POS benefits, as we are not HMO providers.
- I also authorize the physician to release any information required to the insurance company.
- I agree that I will not withhold or delay payment if my insurance company denies payment on any of my charges.
- I understand that my insurance company may deny payment for any reason including but not limited to services not authorized by them. (Insurance Waiver)
- I acknowledge that failure to meet my financial obligations may result in the referral of my account to a collection agency.
- In the event of a returned check, we will charge you **\$35** and ask for another form of payment. If the account is not satisfied, you will be turned over to collection agency.
- I understand that my eligibility for coverage by my insurance company cannot be confirmed at this time and since I wish to receive medical service from **Coastal ENT Medical Group** and **William Halsey, MD**, I understand that if I am not eligible, I will be responsible for payment of all services provided.

Personal Health Records (PHR)

We participate in an electronic prescription system and may use it for your Rx needs.

What is your preferred **LOCAL** pharmacy? _____

What is their address or phone? _____

What is your **MAIL ORDER** pharmacy _____

Red Flag-We are committed to curtail identity fraud and as such we will ask you for 2 types of identification in order to treat.

CA Medical Board Notice-We offer this NOTICE TO CONSUMERS: Medical doctors are licensed and regulated by the Medical Board of California (800/633-2322 or www.mbc.ca.gov).

Appointment Cancellation Policy

In respect for others, please give at least 48 hours notice to cancel your appointment.

A \$25.00 charge may be enforced for an appointment not cancelled within TWO working days, which will then be billed to you, not the insurance company.

Name

Date