SHERIDAN
Ear, Nose & Throat
Scott N. Bateman, MD

330 W Dow Street
Sheridan, WY 82801
Phone: 307672-0290
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Patient Information & Financial Agreement

Personal Information:

Today's Date: _____

First Name: MI: Last: Maiden Name:

Date of Birth: Sex: M F SSN: Marital Status:

Billing Address: Home Phone:

City, State, Zip: Cell Phone:

Employer: Work Phone:

Email address:

Spouse's Name: Phone:

Emergency Contact: ☐ *Check here if emergency contact is same as spouse*

Name: Phone: Relationship to patient:

How did you hear about us? ☐Radio ☐TV ☐Newspaper ☐Phone Book ☐Internet ☐Facebook ☐Doctor referral ☐Word of mouth

If Patient is a Minor:

Guardian 1: Relationship to patient: DOB:

Address: Home Phone:

City, State, Zip Cell Phone:

Employer Work Phone:

Guardian 2: Relationship to patient: DOB:

Address (if different form above): Home phone:

City, State, Zip Cell Phone:

Employer Work Phone:

Payment and Insurance Information: *(Please present your insurance card(s) and photo ID to the front desk)*

How do you plan on paying for today's services? ☐Cash ☐Check ☐Credit Card ☐Money Order

Primary Insurance: Policy #: Group #:

Name of Insured: DOB: Relationship to Patient:

Secondary Insurance: Policy #: Group #:

Name of Insured: DOB: Relationship to Patient:

HIPAA, Disclosure of Medical Information, Insurance Authorization & Financial Policies:

Full payment is expected at time of service unless proof of insurance is provided or other mutually agreed upon arrangements have been made with the billing department. **ALL CO-PAYS ARE DUE AT TIME OF SERVICE.** We accept cash, checks, money orders, and all major credit cards

We accept Medicare, Medicaid, Tricare/Champus, and most commercial insurance carriers (network participation varies between carriers and/or individual plans). Payment of your charges will be based on your individual insurance plan and any amount applied to your plan Co-pay, deductible, and/or coinsurance will be your responsibility. Any procedures performed in addition to your office visit may be applied to your insurance plan deductibles and/or coinsurance. Cosmetic procedures or any other procedures deemed not medically necessary by your insurance will also be your responsibility. *Insurance is a contract between you and your insurance carrier; therefore, you are responsible for making sure your insurance is current and up to date and for understanding the details of your own individual policy*. We are not a party to this contract and therefore cannot be involved in disputes regarding deductible, coinsurance, co-payments, covered charges, coordination of benefits, or allowable amounts.

Past due balances may be subject to finance charges or late fees. Patient responsible balances over 120 days past due will be considered for collection procedures and any insufficient checks will be subject to a $35 re-processing fee. Any insurance payments made directly to the member for our services or supplies must be turned over within 30 days to avoid penalty. Holding those funds for personal use is insurance fraud and carries legal consequences.

We are committed to providing you with the best available medical care. Please don't hesitate to ask if you have any questions regarding our fees, financial policy, or the claim filing process. A clear understanding will enhance the doctor-patient relationship and provide you with a better overall experience.

Sheridan Ear, Nose & Throat is in compliance with the Health Information Portability and Accountability Act (HIPAA). A copy of our HIPAA Policy can be provided to you upon request. W**e WILL require your consent as the patient or guardian (in the case of a minor) to discuss medical treatment information with family members, spouses, or health care providers not directly involved in your care.** You will be given the opportunity to list those parties whom we may disclose your medical information with in the lines below. Consent must be given in writing and will remain effective until written notice is received stating otherwise.

I authorize Sheridan Ear, Nose & Throat to disclose my medical and treatment information to the following parties:	
Name:	Relationship to Patient:
Name:	Relationship to Patient:

I have read and agree to the above terms and understand that by signing below I become responsible for timely payment of services provided to the above named patient. The information I have provided is true and correct to the best of my knowledge. I authorize Sheridan Ear, Nose & Throat to submit claims and initiate disputes to the insurance named above on my behalf. I authorize the release of any information pertinent to my case to any insurance carrier, collections agency, attorney, etc. I acknowledge that you have been given the opportunity to review the HIPAA policy and give your consent to disclose medical and treatment with only those listed in this section.

Signature:_____ **Date:**_____ **Relationship to patient:**_____