



Patient Information

Reason for visit: _____

Referring Physician: _____ Marital Status: M S W D
Name
Last: _____ First: _____ MI: _____

Date of Birth: _____ Male or Female SS#: _____

Address: _____ Zip Code: _____

Home Phone: _____ Work phone: _____

Cell phone: _____ Email: _____

Emergency Contact: _____ Phone#: _____

Employer: _____ Job Title _____
Employment Status: Full Time Part Time Retired Self-Employed Unemployed

Guarantor, Insured or Responsible Party (person with patient today)

Name
Last: _____ First: _____ Middle: _____

Date of Birth: _____ Male or Female SS#: _____

Address: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Primary Insurance: _____ Insured: _____
Date of Birth (Policy holder) _____ SS#(Policy Holder): _____
Policy#: _____ Group#: _____
Insurance Address: _____
Insurance Phone: _____

Preferred Pharmacy

Name: _____

Address: _____

Telephone Number: _____

Southern Crescent ENT, P.C.

1101 Hospital Drive, Suite 100A
Stockbridge, GA 30281

1265 Hwy 54 W, Suite 304
Fayetteville, GA 30214

Michael A. Avidano, M.D.
Blanca I. Durand, M.D.

Keith A. Kowal, M.D.
Harold W. Moss, M.D.

Office Policy on Managed Care Insurers

In order to accommodate the needs and requests of our patients, we participate in numerous managed care insurance programs.

While we are pleased to be able to provide this service to you, it is extremely difficult for us to keep track of all the individual requirements of the plans. Each one has different stipulations regarding how often services may be rendered and even more importantly where those services may be performed. Even with the same insurance company, the plans differ, depending upon the type of contract your employer has negotiated.

Providing quality medical care for our patients is our primary concern. We are willing to provide care within your insurance contract guidelines, if you let us know at the time of service what they are. If you are unsure of your insurance benefits and coverage for services, including deductibles and co pays, you should contact your insurance company prior to being treated.

Unfortunately, if you do not inform us of any special requirements in your contract, and we subsequently order services such as lab work, x-rays, surgery, sleep tests, or hospitalization that are not covered, we or the selected medical facility will have no choice, but to bill you directly for those charges. Payment for those charges is then your responsibility. In the event that services are provided and your coverage is not in effect on the day, the few submitted will be denied by your carrier and will become your responsibility.

With your cooperation and help, you should be able to receive all of the benefits offered to you. We will be able to concentrate on caring for your medical needs.

I have read and understand the office policy stated above and agree to accept responsibility for payment of services as discussed above.

Patient or Guardian

Date

Southern Crescent ENT, P.C.

I authorize the use/ disclosure of protected health information about me as described below.

Patient's name: _____

Patient's date of birth: _____

I give permission for Southern Crescent ENT to provide information to:

1. I understand that I may revoke this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying Southern Crescent ENT, P.C. in writing.
2. I understand that I can refuse to sign this authorization and the refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).
3. I may inspect or copy any information used or disclosed under this agreement.
4. I understand that if the person or organization that receives the information is not a healthcare provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations.

Patient's Signature or Patient's Representative

Date

Printed name of Patient's Representative

Relationship to patient