MONTROSE EARS, NOSE AND THROAT CENTER
Charles E. Harper, M.D. FACS
231 S. Nevada Avenue, Suite A
Montrose, Colorado 81401
Phone: 970-249-3800 Fax: 1-970-785-7270
Web Address: www.mentc.com
E-mail: info@mentc.com

Date ______________________________

Last Name		First Name		Middle Name	Birth Date
Mailing Address Physical Address		City		State	Zip
Home Phone		Cell Phone		Work Phone E-Mail Address:	
Social Security #	Sex M F	Marital Status M S D W	Occupation		
Primary Care Physician			Referred by (circle): Physician Advertising Friend Family		
Emergency Contact		Relationship		Emergency Contact Phone	
Primary Insurance: (present Card with each visit)			Secondary Insurance (must present card at each visit)		
Employer Name:			Employer Address		
Fill out the following only if the patient is not the insurance policyholder					
Policyholder's Last Name		First Name		Middle Name	Birth Date
Policyholder's Employer's Name			Policyholder's Employer's Phone		
Fill out the following only if the patient is not the person responsible for payment					
Responsible Party Last Name		First Name		Middle	Birth Date
Responsible Party Mailing Address		City		State	Zip
Responsible Party Home Phone		Responsible Party Cell Phone		Responsible Party Work Phone	

PATIENT'S AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND CLAIM PAYMENT

I hereby authorize Montrose Ears, Nose, and Throat Center to release medical information necessary to file this and future insurance claims and to allow a photocopy of my signature to be used to file insurance.

______________________________________ ____________________

Signature of patient or legally authorized individual Date

I hereby authorize and direct my Insurer to issue payment check(s) for these and future services to Montrose Ears, Nose, and Throat Center. Regardless of my insurance benefits, if any, I understand I am financially responsible for the fees for services rendered.

______________________________________ ____________________

Signature of patient or legally authorized individual Date

Revised April 2015

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MONTROSE EARS, NOSE, AND THROAT CENTER'S FINANCIAL POLICY

Patient Name: ____

It is our office policy to inform you of our patient payment procedure. Please review and check the section below that is applicable to you.

____ **Medicare and/or Medicaid** – Must present current Medicare/Medicaid card each visit. Our office will submit your Medicare/Medicaid charges to Medicare/Medicaid and your secondary insurance if appropriate. You are responsible for deductibles, copays, and any noncovered services.

____ **Insurance (Participating Provider)** – Must present current insurance cards at each visit. Our office will submit your charges to your insurance company. You are responsible for deductibles, copays, noncovered services, coinsurance, and items considered "not medically necessary" by your insurance company. Please pay co-payments and coinsurance amounts as services are rendered.

____ **Insurance (Nonparticipating Provider)**
If your insurance company has not preauthorized this visit, you are responsible for services rendered. Please make payment for your care at each patient visit.

____ **No Insurance**
Please make payment for your care at each patient visit.

If, 60 days after billing, you fail to pay any balance due on your account or fail to honor your established financial agreement, your account is subject to a $5.00 per month rebilling fee and/or may be sent to a collection agency. If your account is sent to collection, you are responsible for all amounts due plus costs of collection.

I have read and agree to the Financial Policy of Montrose Ears, Nose, and Throat Center.

____
Signature of patient or legally authorized individual — Date

____
Name of legally authorized individual (please print) — Relationship to Patient

____
Address of legally authorized individual — Phone

Patients Medical History

Referring physician________________________ **Primary physician**______________________________

Reason for today's visit:____

____

Have you been treated for any of the following? (please circle)

Stroke	Yes	No	When?:
Heart attack	Yes	No	When?:
Heart failure	Yes	No	When?:
High blood pressure	Yes	No	
Diabetes	Yes	No	
Bleeding problem	Yes	No	When?:
Anesthetic reaction	Yes	No	When?:
Kidney failure	Yes	No	When?:
Asthma	Yes	No	
Migraine	Yes	No	

Do you smoke?	Yes	No
Have you smoked?	Yes	No

Any blood relatives with:

Early hearing loss?	Yes	No
Allergies?	Yes	No
Asthma?	Yes	No
Cancer of the mouth or throat?	Yes	No

Preferred pharmacy___________________________________

Medications/dosage _______________________ ____

____ ____

____ ____

____ ____

____ ____

____ ____

Drug allergies/side effects__________________

____

____

____

____

Other current medical problems____________________________

____

____

____

____

Previous Surgeries/When?___________________

____

____

____

____

Previous severe illnesses_________________________________

____

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____

Phone number(s) which we may call with medical information or test results_____________________________________

May we leave a message on voicemail or on an answering machine?__________

Please list any others with whom we may discuss your medical information______________________________________

____

Please sign here to confirm that we made available a copy of our privacy policy to read and/or take-home _________________________________**Date:**____________