

**Proliance Eastside Ear, Nose and Throat**

**PATIENT INFORMATION SHEET**

8301 - 161<sup>st</sup> Avenue NE #200, Redmond, WA 98052

425.869.4855 Fax 425.869.4858

**Tom Gumprecht, MD**

Patient Name: \_\_\_\_\_  
First M.I. Last

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ SS# \_\_\_\_\_ Gender: F M

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone #: ( ) \_\_\_\_\_ Work Phone #: ( ) \_\_\_\_\_

Employer Name: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Occupation: \_\_\_\_\_ Martial Status: S M D W O

Referred By: \_\_\_\_\_ M.D. Other: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_  
(Not at the same address)

**PAYMENT IN FULL IS DUE AT TIME OF SERVICE UNLESS INSURANCE CARD(S) PROVIDED**

**PRIMARY INSURANCE SUBSCRIBER INFORMATION**

**SECONDARY INSURANCE SUBSCRIBER INFORMATION**

Subscriber Name: \_\_\_\_\_  
First M.I. Last

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First M.I. Last

Subscriber ID# \_\_\_\_\_ Subscriber DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Subscriber ID# \_\_\_\_\_ Subscriber DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer Name: \_\_\_\_\_ Work Phone #: ( ) \_\_\_\_\_

Employer Name: \_\_\_\_\_ Work Phone #: ( ) \_\_\_\_\_

Ins. Co. Name: \_\_\_\_\_ Group/Local #: \_\_\_\_\_

Ins. Co. Name: \_\_\_\_\_ Group/Local #: \_\_\_\_\_

Relation to Patient: Self Spouse Father Mother

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**PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING**

**Assignment Release & Financial Agreement:** I authorize treatment of the above named person and agree to pay all fees for such treatment. I hereby authorize my insurance benefits to be paid directly to the provider of services and I am financially responsible for non-covered services. I also authorize the physician to release any information requested. I understand that my insurance may deny payment for any reason including but not limited to the following; services not authorized by Primary Care Provider, services not authorized/covered by insurance co., referral from PCP's office not at specialist's office at time of appointment. I acknowledge that failure to meet my financial obligations may result in the referral of my account to a collection agency.

Eastside ENT is pleased to now offer patients professional services by electronic means – Telephone or Fax  
Requests for services from Dr. Gumprecht may be made by:

Telephone: 425-869-4855 Fax: 425-869-4858

These services are subject at a \$25.00 minimum charge and are otherwise prorated an hourly rate of \$400/hour. You will be notified prior to a service being rendered if a charge of more than \$100 is anticipated. These charges do not apply to postoperative patients for 90 days post surgery, but otherwise are the responsibility of the patient. As a courtesy we now accept Credit Card payments: **Visa or MC.**

**WE RESERVE THE RIGHT TO CHARGE \$25.00 FOR CANCELLED, NO SHOW OR BROKEN APPOINTMENTS WITHOUT 24 HOURS ADVANCE NOTICE.**

\*\*\*\* Any unpaid balance over 60 days are subjected to late fees \*\*\*\*

\_\_\_\_\_  
Patient Signature  
(Guarantor if patient under 18 years)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date