

PROLIANCE EASTSIDE EAR, NOSE, AND THROAT

PATIENT INFORMATION

Eric Pinczower, MD

1800 116th Ave. NE #102 Bellevue, WA 98004

Male Female Single Married Divorced Other _____

PATIENT'S NAME: _____

ADDRESS: _____
FIRST M.I. LAST (NICKNAME)

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK/CELL PHONE: _____

BIRTH DATE: _____ SOCIAL SECURITY #: _____

EMPLOYER: _____ OCCUPATION: _____

FINANCIALLY RESPONSIBLE PARTY / BILL PAYER (if other than patient):

NAME: _____ RELATIONSHIP TO PATIENT: _____

PHONE: _____ ADDRESS (if different than patient): _____

FINANCIAL / INSURANCE INFORMATION:

METHOD OF PAYMENT: INSURANCE (give card to front desk to copy) CASH/CHECK/VISA/MASTERCARD

PAYMENT IN FULL IS DUE ON DATE OF SERVICE UNLESS INSURANCE IS BEING BILLED **PRIMARY INSURANCE:**

PHONE: _____

NAME OF SUBSCRIBER (if not patient): _____ DOB: _____

RELATIONSHIP OF SUBSCRIBER TO PATIENT: _____ EMPLOYER: _____

INSURANCE ADDRESS: _____ CITY, STATE & ZIP: _____

SOCIAL SECURITY NUMBER OF SUBSCRIBER (for insurance purposes if different than ID#): _____

ID#: _____ GROUP#: _____ PLAN NAME: _____

SECONDARY INSURANCE: _____ PHONE: _____

NAME OF SUBSCRIBER (if not patient): _____ DOB: _____

RELATIONSHIP OF SUBSCRIBER TO PATIENT: _____

ADDRESS: _____ CITY, STATE & ZIP: _____

ID#: _____ GROUP#: _____ PLAN NAME: _____

PRIMARY CARE PHYSICIAN (PCP): _____ PHONE: _____

REFERRING PHYSICIAN: _____

PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING

Assignment, Release and Financial Agreement: I authorize treatment of person named above and agree to pay all fees for such treatment. I hereby authorize my insurance benefits to be paid directly to the provider of service and I am financially responsible for non-covered services. 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 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 company, 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.

You have been notified that there will be a \$25 charge for broken appointments unless 24 hours notice has been given.

We're pleased to offer professional services by telephone or fax. Requests for services from Dr. Pinczower may be made at:

Telephone: (425) 451-3710

Fax: (425) 451-2636

Routine medication refill charge is \$25 (if it has been over 90 days since last office visit). Other electronic services are subject to a \$25 minimum charge and are otherwise prorated at 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.

Patient/Responsible Party Signature

Date