Proliance South Seattle Otolaryngology, a Division of Proliance Surgeons Inc., PS

Registration form

Patient Name: _____
First Middle Last Suffix
Birthdate: _____Age: _____ SS#: _____ Gender: _____

PLEASE PROVIDE PO BOX and HOME ADDRESS

Mailing Address: _____City:_____ ST:_____ Zip: _____

Home Phone #: _____ Day/Work/Cell Phone #: _____

(If Minor, PARENT INFORMATION)

Name: _____ Relationship: _____ Phone: _____

Referred By: _____ M.D. PCP/Other: _____

Emergency Contact: _____ Phone #: _____

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

Primary Insurance Subscriber Information
Subscriber Name: _____
Relation to Patient: _____
Insurance Co. Name: _____
Subscriber ID#: _____ DOB: _____
Subscriber Group: _____

Secondary Insurance Subscriber Information
Subscriber: _____
Relation to Patient: _____
Insurance Co. Name: _____
Subscriber ID#: _____ DOB: _____
Subscriber Group: _____

PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING

By my signature below I acknowledge receipt of the South Seattle Otolaryngology, a division of Proliance Surgeons Inc PS Privacy Practices.

_____ _____ _____
Signature Relationship Date

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 the non-covered services. I also authorize the physicians 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 company, referral from PCP's office at specialist office at time of appointment. I acknowledge that failure to meet my financial obligations my result in the referral of my account to a collection agency. I also understand that any unpaid patient balances over 60 days are subject to late fees.

South Seattle Otolaryngology is please to now offer patients professionals services by electronic means – Telephone and Fax Request for Dr. Peter Maurice. Dr. David Santos, Dr. David Green may be made by telephone or fax.

These services are subject at a $15.00 minimum charge and are otherwise prorated at an hourly rate of. You will be notified prior to a service being rendered in the charge of more than $100.00 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/MC).

Missed Appointments/Cancellations

Broken appointments represent a cost to us, to you and to the other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. A fee may be charged associated with missed or late-canceled appointments.

_____ _____/_____/_____

Patient Signature of Legal Guardian DOB Date