

# REGISTRATION FORM

(Please Print)

Today's date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## PATIENT INFORMATION

Last name: \_\_\_\_\_ First: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  Mr.  Miss  Gender:  M  F  
 Mrs.  Ms.

Preferred Name: \_\_\_\_\_  Married  Divorced  Single  Widowed Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Primary address: \_\_\_\_\_ SSN: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_ Home / Cell: \_\_\_\_\_

Spouse/Parent Name: \_\_\_\_\_ Spouse/Parent #: \_\_\_\_\_

Your Email: \_\_\_\_\_ Spouse/Parent DOB: \_\_\_\_\_

Indicate race:  American Indian  African American  Asian  White  Multiracial  Other \_\_\_\_\_

Indicate Ethnicity:  Hispanic  Non-Hispanic

Employer Name: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

Referred to clinic by (please check one box):

Dr.  Insurance Plan  Hospital  Family  Friend  Close to me  Internet  Other \_\_\_\_\_

## IN CASE OF EMERGENCY

Name of local friend or relative: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Relationship to patient: \_\_\_\_\_ Phone #: \_\_\_\_\_

## INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: \_\_\_\_\_ SSN (responsible party): \_\_\_\_\_

Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone #: \_\_\_\_\_

Is this person a patient here?  Yes  No

Insurance Name: \_\_\_\_\_ Member #: \_\_\_\_\_ Group: \_\_\_\_\_

Policy Holder name: \_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient's relationship to policy holder:  Self  Spouse  Child  Other \_\_\_\_\_

Name of secondary insurance: \_\_\_\_\_ Member #: \_\_\_\_\_ Group #: \_\_\_\_\_

Patient's relationship to policy holder:  Self  Spouse  Child  Other \_\_\_\_\_

I authorize the physician(s) of North Texas ENT to treat me. I authorize any physician/agent of North Texas ENT to release my medical records or medical information to any physician, hospital or other medical provider or supplier who may participate in my medical care. I authorize any physician, hospital, or other supplier to release my medical records and information to the physician(s) of North Texas ENT. I authorize any physician/agent of North Texas ENT to release my medical records and/or information to my insurance carrier to determine my benefits. I authorize my insurance carrier(s) to pay the medical benefits directly to the physician(s) of North Texas ENT. I understand that I am financially responsible for any balance. I agree that a photocopy of this agreement will be considered the same as the original.

Patient/Guardian signature \_\_\_\_\_ Date \_\_\_\_\_

## Insurance Disclaimer

Dr. Brent A. Metts

I, (print name of patient/guarantor) \_\_\_\_\_, understand that if my insurance does not pay for my office visit, or any services performed in the office, I will be responsible for any or all procedures.

### **Please be aware!!!**

**\*\*\*Please be aware** that when a patient requires a visit to a specialist, there are diagnostic procedures required for appropriate care that cannot be done by primary care physicians. These procedures may be done during the normal course of the exam by the specialist. Although necessary as part of routine exams, insurance companies often categorize these as "in-office procedures/surgeries". The possible procedures which often are performed in this practice during your visit may include, but are not limited to:

Nasal Hemorrhage Control  
Tympanostomy/Myringotomy  
Nasal Endoscopy with/without Debridement  
Audio- Comprehensive  
Laryngoscopy  
Tympanometry  
Otoacoustic Emissions  
Complete Endoscopic Exam  
Cerumen (ear wax) Removal  
Binocular Microscopy  
Foreign Body Removal  
Nasopharyngoscopy with Endoscope  
Epley

Depending on your insurance policy provisions, these procedures and others may fall under a separate benefit other than your office copay, such as your deductible and/or co-insurance. In most cases, exact insurance benefits cannot be determined until the insurance company receives and processes the claim. Therefore, any quote for services will be considered an estimate and any payment will be considered a partial payment until the insurance company has processed your claim. Your insurance is a contract between you and your insurance carrier; payment is ultimately your responsibility. Payment will be mandatory the day of your appointment, we do not do payment plans and we will not wait until after insurance processes your claim to bill you. We here at Dr. Brent A. Metts' office feel that it is very important for you to know and understand your coverage.

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## Dr. Brent A. Metts' Office Financial Policy

In order to make your experience with us a positive event, please review the following policies of our office.

1. We accept the following: Credit Cards, Debit Cards, Care Credit and cash.
2. We also accept checks, however a \$30.00 fee will be charged if returned or canceled and you will not be able to see the doctor until all charges are paid for in-full.
3. This office accepts most insurance plans. If we do not accept your insurance, you are welcome to privately pay for your visit (with the exception of Medicaid) and services performed during your visit. Otherwise, your full amount of the copay, deductible or co-insurance is to be paid in-full at the time of service.
4. We will submit the office visit and any procedures/surgeries done to insurance, but **the patient will be responsible for any and all charges not covered by the insurance company.**
5. Medicare assignments are also accepted here and we will be happy to file for you... however, it is the patient/guarantor's responsibility to make sure it automatically crosses over to your secondary insurance carrier if you have more than one health insurance.
6. In order to ensure prompt payments from your insurance, it is important that you (the patient/guarantor) inform this office of all changes with providers, new insurance cards and any changes in your coverage. Otherwise, you may be charged the full amount for services rendered. Please be sure to update each year, along with your medication list and any allergies that may have changed since your previous visit.
7. Please be aware that the office of Dr. Brent A. Metts reports unpaid bills to a Collection Agency. If your account is transferred to collections, any and all fees assessed by the agency will be added to the balance of your account. Any patient sent to collections forfeits any future appointments.

### **\*\*ATTENTION\*\***

#### **A \$30.00 fee will be charged for each of the following events:**

1. Completion of **ANY FORMS** (i.e. FMLA paperwork, Disability forms, other forms to be completed by the doctor, or copies of financial or medical records).
2. Not showing up for appointment, or appointments **NOT** canceled **PRIOR** to the appointment arrival time. We are committed to making you an appointment at your earlier convenience; likewise, we request a courtesy call in advance if you are unable to keep your appointment to allow other patients to be seen. A \$30.00 may apply if such notice is not received. Multiple missed appointments may result in our request for you to find another specialist.

We thank you for helping us make this office more efficient for you. Please sign & date below. Your signature states that you agree and will be in compliance with the above policies.

Thank you, office of Dr. Brent A. Metts.

Signature \_\_\_\_\_

Date \_\_\_\_\_

# Medical Information Release Form

(HIPAA Release Form)

Name: \_\_\_\_\_ Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

## Release of Information

\_\_ I authorize the release of information including the diagnosis, records; examination rendered to me and the claims information. This information may be released to:

Relation \_\_\_\_\_ Name \_\_\_\_\_ Phone# \_\_\_\_\_

\_\_\_\_\_ **Information is not to be released to anyone except the doctor**

TO ANY PHYSICIAN, HOSPITAL, CLINIC OR THEIR REPRESENTATIVE

You are hereby authorized and requested to deliver and furnish to:

Dr. Brent A. Metts

7801 Lakeview Pkwy, Suite 120, Rowlett, TX 75089

972-475-9151 - Fax: 972-475-1757

\_\_ Date: \_\_\_\_\_ to \_\_\_\_\_ OR \_\_\_\_ all past, present and future periods

Signed: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## Consent for Text (SMS) Messaging

With your consent, North Texas ENT would like to send text (SMS) messages to your mobile number.

By providing your informed consent where indicated, you acknowledge that you have understood the information below and agree to participate in our text (SMS) messaging service.

Purpose and Description: North Texas ENT's text (SMS) messaging service is designed to provide you with helpful information, reminders, and notifications via text messages sent to your mobile phone. We may use text (SMS) messages to communicate with you for a variety of purposes, including:

- Appointment reminders
- Missed appointment notifications
- Office closures

I consent to receiving text (SMS) messages from North Texas ENT

\_\_\_\_\_  
Mobile number

I do NOT consent to receiving text (SMS) messages from North Texas ENT

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient/Guardian Name

\_\_\_\_\_  
Relationship to Patient

Do you have any of the following symptoms **right now**? Please check all that apply.

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

[General]

- Chills
- Fatigue
- Fever
- Weight Loss
- Weight Gain
- Night Sweats
- Body Aches
- None of the above**

[HEENT]

- Blurred vision
- Snoring
- Double vision
- Hearing loss
- Ear pressure/fullness
- Ear Pain
- Ear Discharge
- Ringing in Ears
- Vertigo
- Ear Swelling
- Nasal Congestion
- Nasal Discharge
- Runny nose
- Nasal Obstruction
- Nose Bleed
- Nose/Sinus Pain
- Sinus/Facial Pressure
- Trouble swallowing
- Lump in Throat
- Hoarseness
- Throat Clearing
- Oral ulcers/Spots
- Enlarged tonsils
- Sore Throat
- Thyroid Mass
- Neck Mass
- Loss of smell or taste
- None of the above**

[Cardio]

- Chest pain
- Irregular beats
- Syncope
- None of the above**

[Respiratory]

- Chronic cough
- Cough
- Short of Breath
- Wheezing
- Apneas
- None of the above**

[GI]

- Nausea
- Constipation
- Diarrhea
- Heartburn
- Loss of Appetite
- Vomiting
- None of the above**

[GU]

- Possible Pregnancy
- Trouble Urinating
- None of the above**

[Integ]

- Contact Allergy
- Dry skin
- Itching
- Rash
- Skin Lesion
- None of the above**

[Endo]

- Sensitive to Cold
- Sensitive to Heat
- Hair loss
- None of the above**

[Immuno]

- Sinus allergies
- Dermatitis
- None of the above**

[Psych]

- Anxiety
- Depression
- Difficulty sleeping
- None of the above**

[Neuro]

- Poor Concentration
- Poor Memory
- Seizures
- Headache
- Numbness
- Fainting
- Tingling
- Dizziness
- Weakness
- None of the above**

[Muscul]

- Muscle Pain
- Joint Pain
- None of the above**

[Heme]

- Easy bleeding
- Easy Bruising
- Lymph Nodes
- None of the above**

Are you on hospice?  Yes  No

\_\_\_\_\_  
Initial Here