SAN FRANCISCO EARS NOSE THROAT & ALLERGY

490 POST STREET #1230 SAN FRANCISCO, CA 94102
PHONE: (415) 392-3833 FAX: 415-986-6115

DATE: _______________ NAME: _____________________ _____________________ _______________________
First Middle Last

DATE OF BIRTH: _________________ ☐ Male ☐ Female SSN ______ - _______ - ______

Address: ____
Street City State Zip

Home Phone: (_____) ________________________ Cell Phone: (_____) __________________________

Occupation: ________________________________ Employer: __________________________________

Email: ____

Emergency Contact: _____________________ Relationship: __________________ Phone: _____________________

Primary Insurance Information	**Secondary Insurance Information**
Insurance Name:	**Insurance Name:**
Insurance ID:	**Insurance ID:**
Group or Policy Number:	**Group or Policy Number:**
Policy Holder Name:	**Policy Holder Name:**
Policy Holder Relationship to Patient:	**Policy Holder Relationship to Patient:**
Policy Holders SSN & DOB:	**Policy Holders SSN & DOB:**

Primary Care Physician: ____

Referring Physician: ____

DO YOU HAVE ANY DRUG ALLERGIES? ____

BILLING POLICY / AUTHORIZATION TO PAY PHYSICIAN

Our office policy is to bill your insurance company directly for all physician charges. We ask that you pay your copayment amount and deductible, if it has not been met, at the time of service. You will be billed for charges not covered by your insurance plan. If you do not have insurance, payment is due at the time of service. Payment arrangements are available for unusual circumstances.

I (print name), _________________________________, hereby authorize my insurance company to make payments for all medical surgical benefits directly to IVOR A. EMANUEL, M.D.

Signature: ___________________________________ Date: _____________________________

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CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

NAME: ______________________________ DATE OF BIRTH: ______________________________

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

☐ I request the following restrictions to the use or disclosure of my health information:

____
____
____

______________________________________ ______________________________
Signature of Patient or Legal Representative Date

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OFFICE PAYMENT POLICY
AUTHORIZATION / FINANCIAL AGREEMENT

I HEREBY AUTHORIZE, the release of any and all information, acquired in the course of my examination / treatment, to my insurance company. This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as the original.

Signature: ______________________________ Date: ______________________

I UNDERSTAND that I am personally responsible for ALL charges incurred during the course of my examination / treatment.

Signature: ______________________________ Date: ______________________

AUTHORIZATION TO TREAT MINOR

As the parent / guardian of ____

I HEREBY GIVE PERMISSION to Ivor A. Emanuel M.D. to treat the above child/minor. I also agree to be responsible for any charges associated with the treatment deemed necessary by the physician. This permission is granted and effective from the date signed and may be revoked by written notice sent to the physician's address.

Signature: ______________________________ Date: ______________________