CHEVY CHASE
ENT & AUDIOLOGY

Patient Registration Form

Patient Name: _____
Last First M.I. Title/Occupation

Address: _____
Street City State Zip Code

_____
Home Phone Work Phone Cell Phone Email Address

_____
Birth Date Age Sex Marital Status Social Security No.

Emergency Contact: _____
Name Phone No. Relationship

Referring Physician: _____ Primary Care Physician: _____

Primary Insurance: _____
Subscriber's ID No. Group

_____
Subscriber's Name Subscriber's Date of Birth Relationship to Patient

Secondary Insurance: _____
Subscriber's ID No. Group

_____
Subscriber's Name Subscriber's Date of Birth Relationship to Patient

Insurance Authorization and Assignment Agreement of Insurance Benefits

Chevy Chase ENT Associates LLC provides medical and surgical services by Thomas P. Winkler, M.D., and Leslie Fan Hao, M.D. I hereby authorize Chevy Chase ENT Associates LLC to apply for benefits on my behalf for covered services rendered by Chevy Chase ENT Associates LLC. I certify that the information I have reported regarding my insurance coverage is correct and current. I further authorize the release of any necessary information, including medical information, for this or any related claim. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked at any time in writing.

I understand that payments are due at the time of service and that any reimbursement will come directly to me. The only exception will be for those patients who are enrolled with Traditional Medicare as their primary insurance. I understand that Chevy Chase ENT Associates LLC does not participate with any insurance plans on a contractual basis (except Medicare).

Patient Initials: _____

If you miss, cancel or change your appointment with less than 24 hours' notice, you will be charged $25.

Patient Initials: _____

HIPAA Privacy Notice Statement

I further acknowledge that I have been presented with the Privacy Notice for Chevy Chase ENT Associates LLC and have had the opportunity to read it. I understand that a copy is available upon request.

Signature: _____ Date: _____
Patient or Guardian