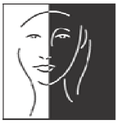


ENT & Facial Plastic Surgery
Registration Form

How did you hear about our office? ° Yellow Pages ° Emergency Room ° Family/Friend ° Patient ° Managed Care Plan/Insurance Company ° Physician ______________

PATIENT INFORMATION Please Print					
First Name		MI	Last Name	Date of Birth	Social Security Number
Address		Apt #	City	State	Zip
Home Phone	Work Phone		**E-Mail Address (for confirming appointments)**		Sex: Male Female (Circle One)
Name & Address of Employer			Marital Status: Single Married Divorced Widow(er) (Circle One)		
Occupation			Emergency Contact (Name & Phone Number)		

RESPONSIBLE PARTY/BILLING INFORMATION **Same As Above** ☐					
First Name		MI	Last Name	Date of Birth	Social Security Number
Address		Apt #	City	State	Zip
Home Phone	Work Phone		Sex: Male Female Relationship to patient:		
Occupation			Name & Address of Employer		

PRIMARY INSURANCE INFORMATION			
Effective Date of Plan	Name of Company	Copay Amount	Phone Number (on card)
Group Number	Policy Number	Name of Insured/Policyholder (on card)	

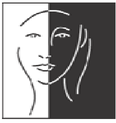
SECONDARY INSURANCE INFORMATION **None** ☐		
Effective Date of Plan	Name of Company	Phone Number (on card)
Group Number	Policy Number	Name of Insured/Policyholder (on card)

Unless otherwise instructed, ENT & Facial Plastic Surgery will assume that if you are married, we are authorized to disclose information about your care and benefits to your spouse (or parents, if you are a dependent child). If you disagree, please inform us immediately

Signature ____ Date ____/____/____

______________________________**1year Sign off from 1st Appointment**______________________________

I agree that all information on this sheet is current and accurate: ____________________________Date:____/____/_____



ENT & Facial Plastic Surgery

6845 Elm Street Suite 303
McLean, VA 22101

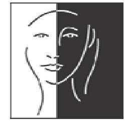
Ednan Mushtaq, MD PC

Patient Financial Responsibility

We are committed to providing you with the best possible care, and we will help you receive your maximum allowable insurance benefits. We need your assistance and understanding of our payment policy. All of our company's billing services are handled by an outside company (Professional Accounts Management Services). Please understand that not all services or procedures are covered by insurance companies. If you have any questions regarding the coverage of the services provided, please call your insurance carrier.

If we do not participate with your insurance plan or if we are an out-of-network provider, you can still see Dr. Mushtaq; however, payments for all services rendered that are not covered by your insurance and/or other out-of-network charges will be your responsibility and payment is expected at the time of service. For your convenience, we accept checks, cash, and credit cards payments. A fee of $25.00 will be charged for all returned checks. For any balance that is over 30 days late there may be additional collection fees. Please call the billing department promptly for assistance in managing your account. We are here to help you and will be happy to answer any questions that you may have about insurance coverage.

There will be a $20.00 fee for all missed or changed appointments when a 24 hour notice was not provided. This fee is the patient's responsibility and not the responsibility of the insurance company.



Patient Financial Agreement

I, ____________________, hereby authorize ENT & Facial Plastic Surgery to apply for benefits on my behalf for services rendered. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize that payment of benefits be made payable to Dr. Ednan Mushtaq, MD PC on my behalf.

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. I have read the above Patient Financial Responsibility and have provided ENT & Facial Plastic Surgery with true and correct insurance information. I authorize the release or any medical information necessary to process my insurance claims. I will notify you of any changes to my health insurance coverage.

____
Printed Name of Patient, Policy Holder or Legal Guardian

_______________________________________ ____________________
Signature of Patient, Policy Holder or Legal Guardian Date