Patient Name:_____

DOB: _____

Ayala
ENT & Facial Plastic Surgery

NEW PATIENT REGISTRATION FORM

All patients MUST provide some form of identification

Address (Street or Box)			City		State	Zip Code	
Home Phone	Work Phone		Cell Phone		Email		
Sex (check one) □ Male □ Female	Date of Birth	Age	Social Security		Driver License		
Marital Status (check one) □ Single □ Married □ Divorced □ Widowed			Spouse's Name (if applicable)				
Employer Name			Employer Address				
Primary Care Physician Name	Phone		Referring Physician Name		Phone		
How did you hear about our physician: □ Community Event Referral □ Direct email □ ER □ Established patient □ Family/ Friend □ Hospital □ Insurance □ Internet/Website □ Location/ drive by □ Newspaper □ Physician Referral □ Radio / TV							
□ Employed □ Retired □ Unemployed □ Student □ Child □ Disabled							
Pharmacy Information Name			City		Phone		

Complete this section only if the patient is a minor (Responsible party)

Responsible Party Last Name	First Name	Middle Name	Relationship to Patient		
Address (Street or Box)	City	State	Zip		
Home Phone	Work Phone	Cell Phone			
Sex(check one) □ Male □ Female	Date of Birth	Age	Social Security	Driver License	

Insurance & Subscriber Information

Primary Insurance Company	Effective Date		**Secondary Insurance Company**	Effective Date	
Calims Mailing Address (Street or Box)			Claims Mailing Address (Street or Box)		
City	State	Zip	City	State	Zip
Policy ID Number Subscriber Name (policy holder)	Group Number Date of Birth		Policy ID Number Subscriber Name (policy holder)	Group Number Date of Birth	
Subscriber Social Security	Relationship to Patient		Subscriber Social Security	Relationship to Patient	
Subscriber Employer	Work Phone		Subscriber Employer	Work Phone	
Subscriber Employer Address (Street or Box)			Subscriber Employer Address (Street or Box)		
City	State	Zip	City	State	Zip

_____ _____

Signature of Patient, Parent or Legal Guardian Date

Address: 800 E. Dove Ave Suite F & G ● McAllen, Texas 78504 Ph: 956-631-4515 Fax: 956-627-6015

Ayala
ENT & Facial Plastic Surgery

Patient Preferences Regarding Communication of PHI & HIPAA

(Patient Health Information)

Preferred Method of Communication

: □ Home Phone □ Work Phone □ Cell Phone □ Email □ Guardian

My Preferred method of communication regarding my **medical conditions** is indicated below **(Check One):**
□ Home Phone □ Work Phone □ Cell Phone □ Email □ Mail Letter □ Guardian

If the above method of communication is by phone, please check the appropriate box below (Check one):

□ Leave a message with detailed information: □ Home Phone □ Work Phone □ Cell Phone

□ Leave a message with a call back number only: □ Home Phone □ Work Phone □ Cell Phone

We may leave a message on: □ your answering machine □ Voice Mail □Other: _____

Please note that you are responsible for any charges incurred in receiving our communications. For example; if you provide a cell phone number as a method of contact, then you are responsible for any charges by your mobile carrier for receiving calls or text messages from the clinic.

Please let our office know if you have any special instructions or requests regarding our communication with you. For example; Please let us know if you would like for us to call you at a different phone number for a particular test result or if you do not want to be called at all.

Approved HIPAA Contacts

Keeping our patient's information private is important to our Practice and by default we will only disclose information related to the patient's **Billing Account** and **Medical Conditions** to the **Patient** or **Legal Guardian**.
If you want to add additional contacts (other than the patient or Legal Guardian) That Ayala Nasal & Sinus Institute is allowed to disclose this type of information to, please complete the fields below and select the appropriate checkboxes based on your approval for each person you list. In addition, please choose the person you would like Ayala Nasal & Sinus Institute to list as your Emergency Contact in the event an emergency situation was to take place at our office.

_____	_____	_____
Contact Name	Relationship to Patient	Contact Phone Number
□ **Billing Account Information**	□ **Medical Condition Information**	□ **Emergency Contact**
_____	_____	_____
Contact Name	Relationship to Patient	Contact Phone Number
□ **Billing Account Information**	□ **Medical Condition Information**	□ **Emergency Contact**

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for health information from persons not listed on this form will require my specific authorization prior to the disclosure of any health information.

_____

Patient Name (Please Print)

_____ **_____**

Signature of Patient, Parent, or Legal Guardian **Date**

Patient Name:_____

DOB: _____

Ayala
ENT & Facial Plastic Surgery

Consent to Treat & Financial Responsibility
Please read and sign the following Statements

I hereby authorize employees including Physicians, Physician assistants and other employees/staff members to render medical treatment(s) and evaluations and care for the patient indicated below. I hereby authorized by signing the patient treatment and procedures consent form and any other forms that may be deemed necessary. I hereby authorize all benefits and payments from my insurance company (companies) for services provided and rendered to be paid directly to **Carlos Ayala, M.D. and Ayala ENT & Facial Plastic Surgery, PLLC.** I further understand that I am responsable for any charges not covered by my insurance company and/or companies , including Medicare. I also hereby authorize the reléase of any information concerning my health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I permit a copy of this authorization to be used in place of my original consent and signature. The duration of this consent is indefinite and continues until revoked in writing.

I understand that my insurance plan(s) **MAY NOT** cover the total cost of treatment(s) due to the nature of the insurance plan or that some treatment(s) **MAY NOT** be considered medically necessary by the insurance Company and that I am responsable for any co-payment, deductible and other charges not covered by primary or secondary insurance plan(s).

MEDICARE PATIENTS: I understand that I am responsable for the deductible and the co-payment applied to my medicare insurance coverage.

_____
Patient Name (Please Print)

_____ _____
Signature of Patient, Parent, or Legal Guardian **Date**

Complete this section ONLY if the patient is a minor

I consent for _____ to authorize evaluation and treatment for the patient identified above when I am not available. I understand that this authorizes the foregoing person(s) to consent to medical and surgical procedures for the patient. The duration of this consent is indefinite and continues until revoked in writing.

_____ _____
Signature of Patient, Parent, or Legal Guardian **Date**

Ayala
ENT & Facial Plastic Surgery

Financial Policy and Responsibility

In order to ensure insurance benefit coverage for any services rendered, it is imperative that the patient provide a current insurance card at each office visit. If insurance verification and coverage cannot be determined prior to the visit, payment will be requested at the time of service. Please be advised that the eligibility and benefit information supplied by your insurance company is only an estimate and is not a guarantee of payment by the insurer. Actual benefits are subject to all plan terms, definitions, limitations and exclusions in effect on the date of service. **Ayala ENT & Facial Plastic Surgery and Ayala Nasal Sinus Institute/Ayala Plastic Surgery Institute** will submit your claim/bill to your insurance company for services performed by our Medical providers or at our medical facilities; however, it is ultimately the patient's responsibility to pay for any and all services provided.

If the patient's insurance plan requires a referral from the patient's primary care physician (PCP), it is the patient's responsibility to secure the referral. In addition, please be aware that not all medical facilities participate in each patient's insurance policy; therefore, the patient should verify facilities participation with their insurance prior to scheduling diagnostic, ancillary or specialty care conducted outside of **Ayala ENT & Facial Plastic Surgery and Ayala Nasal Sinus Institute/Ayala Plastic Surgery Institute.**

Ayala ENT & Facial Plastic Surgery and Ayala Nasal Sinus Institute/Ayala Plastic Surgery Institute, is not responsible for verifying benefits for hospitals, anesthesia or any other outside ancillary services or facilities.

Co-payments and deductibles are due at time of service. For your convenience, payments can be made via cash, money order, Visa, MasterCard, Discover or American Express. When necessary, our business office is happy to assist patients in making special payment arrangements for unexpected and emergency services.

State law requires that insurance companies pay most claims within 45 days of submission. If there is difficulty processing any claim(s) submitted, we may ask for your assistance working with your health care plan provider. It is very important that you respond promptly to any inquiries from your insurance company since failing to do so could result in a delay of claim coverage.

You may have a credit balance on your account after your insurance processes payment for today's visit. This would occur if you overpaid your deductible and/or coinsurance. By signing below you are allowing for us to retain any amount less than $10.00 to be applied to future visit or service payments.

Financial Responsibility

I hereby authorize payment of medical benefits directly to **Ayala ENT & Facial Plastic Surgery and Ayala Nasal Sinus Institute/Ayala Plastic Surgery Institute** and /or the attending physician for services rendered. Authorization is hereby granted to release information contained in the patient's medical record to the patient's medical insurance company (or its employees or agents) as may be necessary to process and complete the Patient's medical Insurance claim. I understand that this authorization may include release of information regarding communicable diseases, such as Acquired immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). I understand that I am financially responsible for the total charges for services rendered which may include services not covered by the patient's insurance companies. I agree that all amounts are due upon request and are payable to **Ayala ENT & Facial Plastic Surgery and Ayala Nasal Sinus Institute/Ayala Plastic Surgery Institute.**

_____

Patient Name (Please Print)

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**