Cynthia Go, MD, PhD, FACS
1011 State St., Suite 120
Lemont, IL 60439

Lemont ENT, S.C.

(630) 243-4505
www.lemontent.com
drgo@lemontent.com

PATIENT REGISTRATION FORM

Today's Date: _____

Who Recommended You to see Dr. Go: _____

Patient's Name: _____
Last First M.I.

Home Address: _____

City: _____ State: _____ Zip: _____

Age: _____ Date of Birth: _____ Gender: ____ Male ____Female

Home Phone # _____

Cell Phone # _____

Email address _____

Employer Name _____ Work Address _____

City, State, Zip _____ Work Phone # _____

Primary Insured's Name _____

Primary Insured's Birthdate: _____

Insurance Company _____

Insured ID no. _____ Group no. _____

Emergency Contact Name & Phone # _____

Preferred Pharmacy Name & Phone # _____

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SIGNATURE PAGE
Acknowledgement of Office Policies, Email Policy, and Privacy Policy

I have read the information about email procedures and privacy and have received answers to all of my questions about using email to communicate with Dr. Go. I understand that Lemont ENT is not responsible for information loss or delay, or for breaches of confidentiality, due to technical factors beyond the Practice's control.

I understand that email is never appropriate for urgent or emergency situations.

I understand that emails sent to Dr. Go from any email address are considered unsecure and I assume all responsibility for any misuse or misdirection of personal health information contained in such emails.

I have read and agreed to the Office Policies of Lemont ENT and have received answers to all of my questions regarding the contents therein.

I have read and agreed to the Notice of Privacy Practice for Protected Health Information of Lemont ENT and have had all my questions answered regarding the contents therein.

Signature: _____Date: _____

Print Name: _____Date of Birth: _____

Contacts: Please list other persons that we may inform about your health information.

At which **phone numbers** and/or **email**, may we leave information about appointment, financial and/or medical conditions? (check all that apply)

☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email ☐ Voicemail

Would you like to be enrolled to have access to your Patient Health Record? ☐ Yes ☐ No
If so, please give your email address and an access code will be sent to you. _____

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Please read this notice prior to signing the Financial Responsibility Form

The amount that your insurance company will pay for your office visit to see Dr. Go may not be 100% covered which is often the case when you see your primary care doctor. **Because you are seeing a specialist, the costs of your visit may not be paid by your insurance company and can be applied entirely to your deductible, even if you have a copay.**

In addition, any procedures that may be performed in the office to help diagnose your problem are often applied to your deductible and you are responsible for paying this amount yourself. Examples of procedures that may be performed to diagnose and treat your condition include (but are not limited to):

1. Nasal endoscopy (scope used to evaluate your sinuses)
2. Flexible Laryngoscopy (scope used to evaluate your throat and vocal cords)
3. Biopsy
4. Ear wax removal
5. Use of the microscope to evaluate the ear drums

Your visit will be billed to your insurance company first. However, after any contracted discounts for in-network benefits are applied, the resulting amount will be your responsibility to pay completely. Lemont ENT, SC will bill you this amount and by signing the Financial Responsibility Form, you are agreeing to pay the amount that is your deductible. Further, the office may be able to predetermine the amount that you may owe for this visit before you leave and we will expect payment at the conclusion of your visit. There may still be an additional amount owed even after this payment and you will be billed for this amount.

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PATIENT FINANCIAL OBLIGATION

I authorize the provider to act as my agent in helping me obtain payment from my insurance companies. I understand the provider does not accept responsibility of collecting my insurance claims or for negotiating a settlement on disputed claims.

I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered. I understand I will receive a total of two statements for any balance due by me before a mandatory full payment letter is initiated by Lemont ENT, SC at 30 days after the first statement was sent.

I agree to pay an unpaid balance due and owing on my account within THIRTY (30) DAYS from the date of the initial statement.

Further, I agree than any portion of my account which remains unpaid after the passage of SIXTY (60) DAYS from the date of the first monthly statement shall be considered "delinquent" for the purposes of collection and shall bear interest at a rate of FIFTEEN PERCENT (15%) per annum until paid in full.

If any portion of my account becomes delinquent and it becomes necessary for the provider to refer this matter to an attorney for collection, **I agree to pay the reasonable attorney fees, costs and expenses incurred through and/or other efforts to collect the delinquent sums.**

I understand that a $25.00 charge will be applied for any no-show appointments or if cancellation of my appointment was made less than 24 hours of the appointment.

_____ _____

Patient Signature Date

_____

Name of Parent or Guardian (if applicable)

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PAYMENT AUTHORIZATION AGREEMENT

In an effort to provide better service, we are constantly looking for ways to be more efficient while we try to hold down our expenses. We will be asking you to provide us with your credit card information at the time of service. This information will be held securely until your insurance has paid their portion of the charges. Our office and your insurance company will notify you first what your remaining balance will be. At that time, you may pay your balance with a check or credit card within 30 days of receiving your statement. If no payment is received after that time, the remaining balances will be charged to your credit card and a copy of your payment will be mailed to you.

This will be an advantage to you since you will no longer have to write out and mail us checks. It will be an advantage to us as well since it will greatly decrease the number of statements that we have to generate and send out. The combination will benefit everybody in helping keep the cost of health care down.

This in no way would compromise your ability to dispute a charge or question your insurance company's determination of the visit charges.

Co-payments will be due at the time of the visit. If you have any questions about this payment method, please do not hesitate to ask at the time of your appointment.

I, _____ _____
Patient name DOB

Hereby authorize Lemont ENT, SC to keep my credit card on file for payment and to initial appropriate payment entries against the above referenced credit card as amounts are owed by me on my patient account. I acknowledge that the initiation of all such entries to make payments on my patient account must comply with the provisions of US law and any applicable state laws. I understand and agree that these entries may be made to my credit card account periodically to pay amounts owed by me on my patient account. I also agree to notify Lemont ENT, SC if my credit card information changes for any reason. This information shall remain in effect until I communicate with Lemont ENT, SC in writing. I acknowledge a receipt copy of this authorization form.

_____ _____
Patient Signature Date

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