Patient Name _____
(Last) (First) (Middle Initial)

Relationship to Policy Holder: Self, Child, Spouse, Other (circle one) Policy Holder: _____

PATIENT DATA

Address: _____
Address: _____
City: _____ State: _____ Zip: _____
Soc. Sec. No. _____
Birthdate: ____/____/____ Gender: _____
E-mail Address: _____

Telephone Numbers:
Home: (____)_____
Work: (____)_____ Exten: _____
Emergency: (____)_____ Exten: _____
Contact: _____
Marital Status? _____ Smoker? _____
Pharmacy Phone #: _____

POLICY HOLDER DATA (Only if different than above)

Sex: M F Birthdate: _____ S.S.# _____
Address: _____
City: _____ State: _____ Zip Code: _____ Phone # _____

REFFERING PHYSICIAN

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____ Phone # _____

FAMILY PHYSICIAN

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____ Phone # _____

INSURANCE INFORMATION

Primary Insurance Carrier: _____
Subscriber Name: _____ Relationship: _____
ID/Plan #: _____ Group #: _____
Address: _____
Secondary Insurance Carrier: _____
Subscriber Name: _____ Relationship: _____
ID/Plan #: _____ Group #: _____
Address: _____

OTHER INSURANCE (Circle One) Motor Vehicle Worker's Comp.

Date of Accident: _____ MV/WC Company: _____
Adjuster Name: _____ Address: _____
****VERY IMPORTANT**** Claim #: _____ Policy #: _____
Policy Holder Name (if other than patient): _____

Attorney Information (if you are involved in or contemplating litigation to which this visit may be relevant)

Name: _____ Phone #: _____

EMPLOYER

Name: _____ Phone #: _____ Status: FT, PT, Ret (circle one)
Address: _____

If any of the above information changes, please contact us. This will help you and us in processing insurance forms and mailing forms to your doctors and attorneys. Thank you for your help.

Date: _____ Signature: _____

ROBERT T. SATALOFF, M.D., D.M.A., F.A.C.S.
KAREN M. LYONS, M.D.
ROBERT J. WOLFSON, M.D., F.A.C.S.
THOMAS C. SPALLA, M.D.
HELEN YOO BOWNE, M.D.

Education/Research
Drexel University College of Medicine
American Institute for Voice and Ear Research

Clinical Care
Philadelphia, Ear, Nose & Throat Associates, L.L.C.

1721 Pine Street
Philadelphia, PA 19103
(215) 545-3322
Fax: (215) 790-1192

E-mail: Office@PhillyENT.com
www.PhillyENT.com

219 N. Broad Street, 10th Floor
Philadelphia, PA 19107
(215) 762-5530
Fax: (215) 762-5540

Appointment Date: _____

Re: Appointment Cancellation Policy

Due to the demand for the specialized services that the practice provides, a 48-hour cancellation policy has come into effect. As of October 15, 2007, if the office has not been notified a minimum of 48 hours prior to the scheduled appointment date, a fee of $50.00 will be charged to established patients and a fee of $100 will be charged to new patients who do not appear for a scheduled appointment with a doctor or member of the speech and voice team. Patients who have audiology appointments and do not appear for the appointment or cancel at least 48 hours in advance will be charged $50 **per test**. This fee will also be charged for patients who have not complied with medication restrictions and have to have balance testing rescheduled. Please be sure to obtain and read instructions for testing. If you have any problems or concerns, please do not hesitate to contact one of our audiologists, nurses or physicians.

Signature: _____ Date: _____

Witness: _____

**** Please note that all questionnaires and forms MUST be completed in advance of your appointment or you may experience a significant delay in your wait time to see our physicians. Thank you for your cooperation.**

**** Please be aware that "no show" fees are out-of-pocket expenses and will not be covered by your insurance company. Please try to keep your scheduled appointments or cancel at least 48 hours in advance.**

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PATIENT'S PAYMENT RESPONSIBILITY

I, the guarantor, understand that I am fully responsible for all fees payable to Drs. Robert Thayer Sataloff, Karen M. Lyons, Robert J. Wolfson, Helen Yoo Bowne, Amanda Hu and/or any associate rendering medical treatment to me or the patient for whom I am financially responsible.

LEGAL, MOTOR VEHICLE, OR WORKERS' COMPENSATION CASES:
I understand that if I am involved in any of these types of cases, I must present all relevant documentation before any service with the physician. I must also present my personal health insurance coverage, in the event my accident-related coverage expires or terminates. If the appropriate information is not presented at the time of service, all balances will become my responsibility.

CLAIMS SUBMISSIONS:
Depending on my insurance carrier, the doctors' office may file directly to the insurance company for services rendered in the office. Claim submission polices for participating and non-participating insurances are located in the billing office for review. I am aware of the insurance companies with which the doctors participate. I am aware the physician I am to see participates or does not participating in my medical insurance plan. By signing this agreement, I acknowledge that I am fully aware of my co-pays, deductibles, and non-covered services. I am also aware that my co-pay is due before I leave the office at each visit. I acknowledge that the doctors' office will bill me for balances due and that I am fully responsible for all balances billed.

REFERRAL:
If my insurance company requires a referral authorization, I understand that it is my responsibility to bring a referral authorization with me at the time of each service date. If the referral is not presented prior to services being rendered, I acknowledge that I will sign a financial release form holding the guarantor personally responsible for any services that are not covered by my insurance carrier for that visit date.

NON-COVERED SERVICES:
I understand that the doctors' office provides special services which may not be covered by my insurance company. Therefore, payments for these services are my responsibility. Services that may not be covered include, but are not limited to: Objective Voice Measures, Electroglottography (laryngeal function studies) (92520), Dynamic Voice Evaluation (70371), Botulinum Toxin Injections, Speech Evaluations, and High-Performance Vocal Muscular Re-Education. In the event that I may require any of these special services, I am aware that I am fully responsible for the charges for these services.

PAYMENT PLANS AND COLLECTION:
I acknowledge that the doctors' office can submit any unpaid balance due over 121 days to a collection agency. I also acknowledge that if I am unable to pay my entire balance, I may arrange to make monthly payments with the billing office. If I am not consistent with my monthly payments, my full balance may be placed with the doctors' collection agency after one notice.

APPOINTMENT CANCELLATION NOTICE
Appointments and/or testing require 48-hours notice of cancellation. A $50.00 cancellation fee will be charged if a patient fails to show for a scheduled appointment or 48-hours notice is not given to the office in the event of cancellation. This fee is not covered by insurance companies and is the patient=s responsibility.

_____ _____
Patient/Guarantor's Signature Date