Steven Peskind MD
EAR • NOSE • THROAT • ALLERGY
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Patient Information:

Last Name _____ First Name _____ Middle I. _____
Date of Birth _____ Sex _____ Marital Status _____ Social Security # _____
Address _____ City _____ State _____ Zip Code _____
Primary Phone # _____ Secondary Phone # _____ Work # _____
Email Address _____
Ethnicity: ☐ Hispanic Race: ☐ Anglo ☐ Black ☐ Am Indian ☐ Asian ☐ Other ☐ Native Hawaiian ☐ Unknown
Preferred Language _____
Emergency Contact _____ Phone # _____
Relationship to Patient _____

Primary Insurance:

Please Provide Information of the Insured/Person Who Provides the Insurance:

Name of Insurance Co. _____
Policy/ Subscriber #/ ID# _____ Group/Account # _____
Name of Insured _____ Primary Phone # _____
Date of Birth _____ Social Security # _____ Patient's Relationship to Insured _____

Secondary Insurance (Medicare Patients Only):

Please Provide Information of the Insured/Person Who Provides the Insurance:

Name of Insurance Co. _____
Policy/Subscriber #/ID # _____ Group/Account # _____
Name of Insured _____ Primary Phone # _____
Date of Birth _____ Social Security # _____ Patient's Relationship to Insured _____

If Patient is a Minor:

Father's Name _____ Primary Phone # _____ Secondary Phone # _____
Address if Different From Patient _____
Father's Date of Birth _____ Social Security # _____

Mother's Name _____ Primary Phone # _____ Secondary Phone # _____
Address if Different From Patient _____
Mother's Date of Birth _____ Social Security # _____

Responsible Party if Different Than Parent:

Name _____ Relationship to Patient _____
Address _____ Primary Phone # _____ Seconday Phone # _____
Social Security # _____ Email _____

Referring Physician Name _____ Phone # _____
Primary Care Physician Name _____ Phone # _____

Pharmacy Name _____ Address _____ Phone # _____

Consent to Treat:

I give permission to the physician and whomever he may designate as his assistant(s) / associate(s) to administer such treatment as deemed necessary, and to perform any medical care or procedures as are considered therapeutically necessary based on the findings during examination or treatment.

Authorization to Release Information:

I authorize Steven Peskind, M.D. and Associates, P.A. to release any medical information pertaining to the examination, treatment, history, prescription or medication and medical expenses of the above patient to any physician, hospital, clinic, insurance company and all other agencies deemed necessary in order to process insurance claims. This authorization also includes the release of any pertinent medical information to any specialist or other medical facility the physician may refer the patient to for medical treatment or evaluation.

Assignment of Benefits:

I authorize payment of medical benefits to Steven Peskind, M.D. and Associates, P.A., for services rendered. I understand that I am financially responsible for any copays or deductibles required by my insurance company. I also understand that I am responsible for charges that are not covered by my insurance company.

MEDICARE Limited Coverage/Waiver of Liability (Medicare patient ONLY)

Please be advised that Medicare will only pay for services that it determines to be "reasonable and necessary" under Section 1862 (a)1 of the Medicare Law. If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service.

Beneficiary Agreement:

I have been notified by my physician/supplier that he or she believes that, in my case, Medicare is likely to deny payment for some services for the reasons stated. If Medicare denies payment, I agree to be personally and fully responsible for payment.

Patient Record of Disclosures

The HIPAA privacy rule gives individuals the right to request a restriction on the uses and disclosures of their health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as sending correspondence to the individual's office instead. I understand that I may be contacted by any phone number that I have listed on this form.

Financial Policy:

As a courtesy to our patients, we will file insurance claims to the insurance carriers with which we participate. Any deductible or copays your insurance company requires you to pay is due at the time of service.

I understand that I am financially responsible for any copays or deductibles requires by my insurance company. I also understand that I am responsible for charges that are not covered by my insurance company. If I am covered by a Managed Care Plan that requires a referral from my Primary Care Physician (PCP), I understand that it is my responsibility to obtain the necessary referral before my appointment. If I choose to be seen by the physician, without the appropriate referral, I understand that I will be responsible for 100% of the charges incurred.

Notice to Patients of Financial Interests:

You are informed by this Notice that Dr. Peskind holds a financial interest in Texas Health Center for Diagnostics & Surgery and Cook Children Pediatric Surgery Center. You have the option, at your discretion, to use an alternate health care facility.

By my signature I agree to comply with the Financial Policy, Consent to Treat Policy, Authorization to Release Information, Assignment of Benefits, Patient Record of Disclosures, and Notice to Patients of Financial Interests.

There will be a charge of $25.00 for NSF checks.

Insured or Authorized Person's Signature _____Date_____

PLEASE PRINT, SIGN AND DATE AND BRING WITH YOU TO YOUR APPOINTMENT