312 Westside Drive, Douglas, GA 31533
(912) 384-2200 phone (912) 383-7992 fax

2016 Pineview Avenue, Tifton, GA 31794
(229) 391-3440 phone (229) 386-2082 fax

**Jeffrey L. Silveira, MD**

Cell Phone: ________________________
Pharmacy: ________________________ Email: ________________________________________

## Patient Information

Last Name: ____________________________ First Name: _____________________MI: ___ SSN#:____________________

Address: ___________________________ City: ________________ State: ___ Zip Code: _________ Home #: ______________

Sex: M ___ F ___ Age: ____ Birthday: ________________ Single: ___ Married: ___ Widowed: ___ Separated: ___ Divorced: ___

Employer: ____________________________ Occupation: _______________________ Business Phone#: _________________

Whom may we thank for referring you? ______________________________________________________________________

Personal Primary Care Physicians (s): ______________________________________________________________________

## Primary Insurance

Insurance Company: _______________________________________ Address: ______________________________________

Insurer's Name: ____________________________________ Relation to Pt: ________________ Insurer's Sex: ____________

Insurer's DOB: ____________________ SSN/ID Number: ____________________________ Group Number: ______________

Policy Holder Address: __________________________________ Phone #: ____________ Employer: _____________________

## Secondary Insurance

Insurance Company: _______________________________________ Address: ______________________________________

Insurer's Name: ____________________________________ Relation to Pt: ________________ Insurer's Sex: ____________

Insurer's DOB: ____________________ SSN/ID Number: _____________________________Group Number: _____________

## Emergency Information

Emergency Contact: ________________________________ Relationship: ___________________Phone#: _________________

## Assignment of Benefits and Billing Terms

**I hereby authorize direct payment of surgical/medical benefits to Jeffrey L. Silveira, MD, for services rendered by him or under his supervision. I realize I am responsible for any deductibles or co-insurance as set forth in the financial agreement. I hereby authorize Jeffrey L. Silveira, MD, to release any medical or incidental information that may be necessary for either medical care or in processing applications for insurance benefits.**

Signature of Pt (or Responsible Party): _________________________________________ Date: ___________________________

## Financial Agreement

We are going to do our very best to provide you the finest health care available. We will do this with little emphasis on payment; but without payment we would be unable to continue to provide health care. It is important to both of us that you have a clear understanding of our financial policy.

By signing below, I understand that the Ear, Nose, and Throat Clinic of Coffee County, PC will file a claim with my insurance carrier (if applicable) on my behalf. I will provide documentation of correct proof of insurance. If insurance benefits are not paid within 60 days of rendered services, I understand that my account is immediately due and payable to me. I agree to pay those unpaid amounts in a timely fashion.

I understand that should my account become delinquent and require the services of a collections agency or attorney, I agree to pay all reasonable collections fees and/or court costs for said collection. A finance charge of 1 ½ % per month (18% annum) on all past due accounts on the unpaid amount will be assessed. The Ear, Nose, and Throat Clinic of Coffee County, PC will not be involved in disputes regarding deductible, co-payments, secondary insurance, etc.

Signature of Patient (or Responsible Party) ____________________________________________

Relationship: ______________________________ Date: ______________________________

## Medigap Assignment Authorization

I request that payment of authorized Medigap benefits to be made on my behalf to Jeffrey L. Silveira, MD. I authorize any holder of medical information to release to ________________________ any information needed to determine these benefits.

Signature of Patient (or Responsible Party) ____________________________________________

Relationship: ______________________________ Date: ______________________________

## Beneficiary Agreement for Non-Covered Services

Medicare requires us to inform you of services that are non-covered. These include:

Hearing Aids

Ear Plugs

I have been notified by Jeffrey L. Silveira, MD. and staff that the above listed services are non-covered services. I agree to be responsible for payment.

Signature of Patient (or Responsible Party) ____________________________________________

Relationship: ______________________________ Date: ______________________________