Chevy Chase ENT Associates, LLC

Thomas P. Winkler, M.D. & Leslie F. Hao, M.D.
Maria Capobianco, Au.D. & Candace Thorp, Au.D.
Patient Registration Form

Patient Name: ____
Last First M.I Title/Occupation

Address: ____
Street City State Zip Code

____
Home phone Work phone Cell phone E-mail Address

____
Birth date Age Sex Marital Status Social Security No

EMERGENCY CONTACT: ____
Name Phone No. Relationship

Referring Physician: ____________________ **Primary Care Physician:**____________________

Primary Insurance: ____
Subscriber's ID No. Group

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Subscriber's Name Subscriber's Date of Birth Relationship to Patient

Secondary Insurance:____
Subscriber's ID No. Group

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Subscriber's Name Subscriber's Date of Birth Relationship to Patient

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Insurance Authorization and Assignment Agreement of Insurance Benefits

Chevy Chase ENT Associates, LLC provides medical and surgical services by Thomas P. Winkler, M.D., and Leslie Fan Hao, M.D. I hereby authorize Chevy Chase ENT Associates, LLC to apply for benefits on my behalf for covered services rendered by Chevy Chase ENT Associates, LLC. I certify that the information I have reported regarding my insurance coverage is correct and current. I further authorize the release of any necessary information, including medical information, for this or any related claim. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked at any time, in writing.

I understand that payments are due at the time of service and that any reimbursement will come directly to me. The only exception will be for those patients who are enrolled with Traditional Medicare as their primary insurance. I understand that Chevy Chase ENT Associates, LLC does not participate with any insurance plans on a contractual basis (except Medicare) **Patient Initials**______

If you miss your appointment, cancel or change your appointment with less than 24 hours notice, you will be charged $25. **Patient Initials**______

HIPPA Privacy Notice Statement

I further acknowledge that I have been presented and have had the opportunity to read the Privacy Notice for Chevy Chase ENT Associates, LLC. I understand that a copy is available to me upon my request.

Signature ____ **Date**__________________
Patient or Guardian