Board Certified

# Durango ENT

Ear, Nose, and Throat
Allergy Hearing Aids

# Patient Information

Patient name:______________________ email:_________________________

Preferred name:____________________ ☐ Male ☐ Female

Date of Birth:______________________ Social Security #:_______________

Mailing Address:_________________________________________________
street city state zip

Home phone # (_____)_______________ Cell Phone # (_____)_______________

preferred contact number (circle) home cell work

Employer: __________________________ Occupation: __________________

Employer phone number:____________________________________________

Name of parent or legal guardian (If the patient is a minor):______________________

Parent or legal guardian SSN:_______________ Date of Birth: _____________

Please complete if insurance policy is under parent or spouse:

Name of primary policy holder:_____________________

Social Security # of policy owner: __________________ Date of Birth:_________

Address of policy holder: ________________________________________________

PLEASE PRESENT INSURANCE CARD(S) TO THE FRONT DESK

Assignment of insurance benefits: I hereby authorize direct payment to Philip Wiley, MD PC, 1165 S. Camino Del Rio STE #200 Durango, CO 81303 of all insurance benefits, including major medical, herein specified and otherwise payable to me, for the services rendered by the above. Payment for care rendered by the above named doctor as an inpatient is also assigned as shown above. I understand that I am financially responsible to the above named doctor until the bill is paid in full. If I have Medicaid secondary, the office will bill insurance. If Medicaid does not pay, I will be responsible for the balance. I understand if any unpaid portion of my balance becomes deliquent, it may begin to accrue interest at 18% per annum. In the event my balance becomes deliquent and further collection efforts are necessary, I agree to pay all costs and reasonable attorneys' fees incurred by Philip Wiley MD, PC, in said collection efforts. There is a $20 charge for all check returned for insufficient funds.

To provide continuity of care a copy of your visit(s) will be forwarded to your primary care physician and referring physician. Please inform the staff if you do not wish a record to be forwarded. My signature below also provides consent to release records to myself at my request.

Any patient has the right to choose the provider and facility for their health care services. Thus we would like to inform you that Animas Surgical Hospital meets the definition of a physician-owned hospital under 42 CFR 489.3 and Dr. Wiley is an owner of the hospital. As such, there is a financial incentive to order tests and perform surgeries and procedures at the hospital.

Signed:_____________________________ Date:_________
signature of patient or responsible party

1165 S. Camino Del Rio #200
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