Allergy, Ears, Nose and Throat Associates of Texas
Tariq Yunus, MD
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DrYunus@AllergyENT.net

INSURANCE/PAYMENT INFORMATIONS

Primary Insurance Name ____________________

Policy Number ____________________ Group No ____________________

Subscriber Name ____________________ Subscriber Date of Birth ____________________

Subscriber's Employer ____________________ Relationship to Patient ____________________

Secondary Insurance Name ____________________

Policy Number ____________________ Group No ____________________

Subscriber Name ____________________ Subscriber Date of Birth ____________________

Subscriber's Employer ____________________ Relationship to Patient ____________________

Worker's Compensation Yes No

Claim Address

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Injury No. ____________________ Date of Injury ____________________

If present condition is accident related, please provide date of injury. ____________________

MEDICARE PATIENTS ONLY

Medicare will only pay for services that it determines to be reasonable and necessary under 1862(a)(1) of the Medicare law. If Medicare determines that a particular service is not "reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service.

If Medicare denies payment, I personally agree to be fully responsible for payment.

____________________ ____________________
Signature of Patient/Guardian Date

PAYMENT POLICY

I irrevocably authorize my insurance benefits to be payable directly to Dr. Yunus and/or the attending physician on my behalf. I understand that I am responsible for all co-insurance and non-covered charges. I understand that payment is due in full at time of service and if not I am responsible to make the appropriate financial arrangements. I consent to the release of information from my medical record as necessary for the collection of services being rendered by this establishment. I also understand that I am responsible for the payment of reasonable attorney fees and collection expenses if required for the collection of the account.

____________________ ____________________
Signature of Patient/Guardian Date

Referring Physician's Name ____________________ Office Phone No ____________________

Primary Care Doctor's Name ____________________ Office Phone No ____________________

If other than referring physician, please tell how you learned of our office. ____________________

Preferred Pharmacy (include location/cross street) ____________________