DR. EDWARD TOMANENG
Ear, Nose and Throat Clinic
San Marcos, Texas

Edward Tomaneng, MD
Otolaryngology-Head & Neck Surgery-Allergy
2000C Medical Parkway
San Marcos, TX 78666

Acknowledgement of Privacy Practices for the office of Edward Tomaneng, MD

I have Reviewed this office's Notice of Privacy Practices, Which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Patient Name:_____

Signature of Patient or Personal Rep._____Date:_____

Witness:_____

Please sign and read front and back of this page

San Marcos ENT - Edward Tomaneng, MD

Financial Policy and Agreement

Insurance: We participate in the with your managed care plans as well a Medicare and traditional Medicaid and we will file your claim for you. If we do not participate with you managed care plan, payment in full is required at the time of service, unless other arrangements have been made in advance. Knowing you insurance benefits - including eligibility, covered benefits, and medically necessary procedures is your responsibility; please contact customer services at your insurance company for questions you may have regarding your coverage. All patients are responsible for verifying that Dr. Tomaneng is a participating provider in their plan. Please note that it may be necessary for the doctor to perform certain procedures (nasal endoscopy or a laryngoscopy) in your evaluation and treatment. According to the American Medical Association the procedures are classified as in office procedure/surgery.
Insurance Companies sometimes apply these procedures to coinsurance and or deductible. Therefore, you may owe more than just your office co-payment. You are responsible for any charges not covered by your plan.

Referrals: Dr. Tomaneng is a specialist provider and some insurance plans require proof authorization before an office visit or any services rendered. You are responsible for obtaining necessary referral prior to your visits or follow up appointments.

Proof of insurance: You must furnish valid and up-to-date proof of insurance coverage and a copy of your driver's license. If you provide false or expired insurance information you will be responsible for the balance of the claim. **Please notify us of any changes in the insurance coverage prior to time of service**. Insurance denials for termination of coverage will be automatically billed to you.

Copayments and deductibles: all co-payments and unsatisfied deductibles must be paid at the time of service. For your convenience we accept cash, check, debit ,or credit card (Mastercard, Discover, Visa and American Express).

Collections: Any remaining balance after insurance payment is the patient's responsibility. Our office will send out 3 consecutive monthly statements after we receive the explanation of benefits from your insurance. If no payment or arrangements for the balance due have been received within 30 days after the final statement the account will be handed over to a collection agency. Should your account be sent to a collection agency, you will be financially responsible for all collection and legal fees our office incurs through the process utilized to collect the delinquent balances. We want to avoid this and are willing to make arrangements with you.

Medicare: we will accept Medicare assignment for our medicare patients. If you do not have a medicare supplement, we expect you to pay your deductible if not met at the time, as well as your 20%
Release information: I hereby authorize Edward Tomaneng, MD to furnish medical information concerning my illness or injury, including hepatitis and HIV information to my family physicians), referring physicians, and insurance companies.

Consent

I hereby authorize evaluation and treatment by Edward Tomaneng, MD. I certify that I and or my dependent have insurance coverage and assign directly to Edward Tomaneng , MD all insurance benefits for services rendered, I understand that I am responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions and to be used for the release of medical records. I have read and understand the consent, financial policy and agreement.

_____ _____

Patient/Parent/Guardian Signature Date

San Marcos ENT - **Edward Tomaneng, MD**

Patient Information Date:_____

Last Name:_____ First Name: _____MI:_____

Date of birth:_____ Age:_____ Sex: M / F

Social Security:_____ Driver's License:_____

Address:_____ City:_____ Zip:_____

Home Phone:_____ Cell:_____ Work:_____

Marital Status:(Circle one) Married / Single / Divorced / Widowed

Race: African American / Asian / White / Other Ethnicity: Hispanic, Latino / Not Hispanic, Latino

Preferred Language: English / Spanish / Other_____

Employer Name:_____

Address:_____

Emergency Contact:_____ Phone:_____

Relationship:_____ Contact Method: Home Phone / Cell / Text / Email

Email Address:_____

Parent or Legal Guardian if patient is a minor

Last Name:_____First Name:_____MI:____

Sex: Female / Male Relationship:_____

Address:_____City:_____Zip:_____

Home Phone: _____Cell Phone: _____Work Phone:_____

Birth Date: _____ Social Security Number: _____

Reason for Visit: _____

Referred by: _____

Insurance Policy Holder Information:

Primary Insurance

Insurance Name: _____

ID #: _____ Group:_____

Policy Holder's Name: _____ Birth Date: _____

Address: _____City:_____ Zip:_____

Phone: _____ Social Security #: _____

Relationship: _____

Secondary Insurance

Insurance Name: _____

ID #: _____ Group:_____

Policy Holder's Name: _____ Birth Date: _____

Address: _____City:_____ Zip:_____

Phone: _____ Social Security #: _____

Relationship: _____