Owens
ear center

WELCOME TO OUR OFFICE

Hearing & Balance Disorders Facial Nerve Disorders Skull Base Surgery Allergy

Plano Office: 6509 W. Plano Pkwy, Plano, TX 75093 972-781-1462 (Fax) 972-378-4125
Fort Worth Office: 9545 N. Beach St., Ste. 155, Fort Worth, TX 76244 817-562-3140 (Fax) 972-378-4125

DEAR _____ **DATE**_____

Thank you for calling our office. Your appointment details are as follows:

Date:_____ **Time:**_____ **Office** Ft. Worth ⬭ Plano ⬭

With: ⬭ Dr. Robert Owens ⬭ Lori McGee, FNP

Enclosed you will find forms to be completed. Please return them to our office before your visit or bring them with you 15 minutes before your scheduled appointment time.

1. Patient Information
2. Office Policy
3. Patient Health History

Please bring the following items with you to your appointment:

1. Insurance card(s) & Driver's License

2. Copies of all your hearing tests. We are required by law to keep all copies you bring. Please make duplicate copies for yourself before your visit.

3. X-Ray Images. Please bring the actual CT Scan and MRI Images (films) with you so we can personally review them at the time of your visit.

4. Referral Form. (If your insurance policy requires this) If you insurance requires that you obtain a referral, we **MUST** have this **PRIOR** to your appointment. If you come without your referral , according to the strict 'no exceptions' term of your insurance policy, your appointment may have to be rescheduled because your insurance will not reimburse us for a visit without a valid referral.

5. Your completed enclosed forms (if you have not mailed them to us previously). If you forget your forms, you will need to fill out a new set in our office and this may delay your appointment.

Please call if you have any questions concerning your appointment.

If you fail to keep this appointment there is a charge of $75 dollars. If you need to cancel or reschedule your appointment we require you call 24 hours in advance.

Thank you for your cooperation and we look forward to seeing you!

PATIENT INFORMATION – Please Print Clearly

Last Name:_____ First Name: _____ MI _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Phone: Home_____ Work _____Ext_____Cell_____
Email:_____
□ Male □ Female □ Single □ Married □ Widowed □ Divorced
Date of Birth: _____ Social Security Number_____

Occupation: _____ Are you retired? □ Yes □ No
Employer's Name:_____
Employer's Address: _____

Referring Physician: _____
Reason for seeing Doctor:_____

Person to notify in case of an emergency: _____
Phone: Home_____ Work _____Ext_____ Cell_____
Relationship to patient: □ Spouse □ Mother □ Father □ Other_____

INSURANCE – PLEASE PROVIDE INFORMATION FOR BOTH INSURANCES

Primary Insurance	**Secondary Insurance**
Company:_____	Company:_____
Address:_____	Adress:_____
City:_____State:_____Zip:_____	City:_____State:_____Zip:_____
Policyholder ID No.:_____	Policyholder ID No.:_____
Group ID No.:_____	Group ID No.:_____
Name of Policyholder:_____	Name of Policyholder:_____
SSN:_____	SSN:_____
Date Of Birth:_____	Date Of Birth:_____
Policyholder Employer: _____	Policyholder Employer: _____
Relationship to Patient:_____	Relationship to Patient:_____

I consent to be examined by the Physicians of Owens Ear Center at each office visit. I agree to allow them to release to my insurance carrier or its representatives any information necessary to determine my benefits entitlement. I also assign payment of benefits to Owens Ear Center in the case payment is not made at the time of service or in the case of Medicare. I understand that payment is required at the time of service unless otherwise agreed to previously with our billing department. I understand that I am financially responsible for all charges incurred regardless of any problems which may arise with my insurance company.

Patient's Signature_____ **Date:** _____