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EAR, NOSE & THROAT
head and neck surgery

PATIENT INFORMATION

LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____

SSN _____ HOME PHONE _____ MOBILE PHONE _____

AGE _____ DOB _____ GENDER _____

PATIENT ADDRESS _____ APT/UNIT _____

CITY _____ STATE _____ ZIP CODE _____

RACE _____ ETHNICITY _____ LANGUAGE SPOKEN _____ EMAIL ADDRESS _____

EMERGENCY CONTACT _____ EMERGENCY ADDRESS _____

TELEPHONE _____ RELATIONSHIP _____

RESPONSIBLE PARTY

GUARANTOR NAME (LAST, FIRST, M.I.) _____ DOB _____ GENDER _____ SSN _____

GUARANTOR'S COMPLETE ADDRESS _____ TELEPHONE _____

REASON FOR VISIT _____ REFERRING PHYSICIAN _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

INSURANCE INFORMATION

(1) PRIMARY INSURANCE COMPANY _____ TELEPHONE _____

POLICY HOLDER'S NAME _____ RELATIONSHIP TO PATIENT _____

DOB _____ SSN _____

POLICY NUMBER _____ GROUP NUMBER _____ EFFECTIVE DATE _____

(2) SECONDARY INSURANCE COMPANY _____ TELEPHONE _____

POLICY HOLDER'S NAME _____ RELATIONSHIP TO PATIENT _____

DOB _____ SSN _____

POLICY NUMBER _____ GROUP NUMBER _____ EFFECTIVE DATE _____

PHARMACY INFORMATION

PREFERRED PHARMACY _____ PHONE NUMBER _____ ADDRESS/CROSS STREET _____

The above information is complete and correct. I hereby authorize the release of information necessary to file a claim with my insurance company, and I assign benefits otherwise payable to the doctor or group indicated on the claim. I understand that I am financially responsible for all charges for medical services rendered, regardless of insurance coverage. A copy of the signature is as valid as the original. A $25.00 fee will be charged if I do not call 24 hours prior to canceling my appointment. A $50.00 fee will be charged for no-show appointments.

Patient/Guardian Signature _____ Date _____

Guarantor Signature _____ Date _____

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PEDIATRIC HISTORY

Please answer each question by filling in the appropriate circle fully.

Patient accompanied by: ○ Mother ○ Father ○ Care Provider

Is the patient over the age of 18? ○ Yes ○ No

Is the patient accompanied by a guardian? ○ Yes ○ No

Do you have any medical problems?

- ○ ADHA
- ○ Anemia
- ○ Asthma
- ○ Other lung problems
- ○ Anxiety/Depression
- ○ Developmental delay
- ○ Diabetes
- ○ Dizziness
- ○ Down's syndrome
- ○ Heart murmur
- ○ Irregular heartbeat
- ○ Migraine headaches
- ○ Mitral valve prolapse
- ○ Vision problems
- ○ Sinusitis
- ○ Allergies
- ○ Genitourinary problems
- ○ Seizures
- ○ Thyroid problems
- ○ Blood cancer
- ○ Skin cancer
- ○ Other, please list: _____
- ○ None

Please list all medications that you are currently taking: _____

_____

_____

Please list all allergies to medications and the reaction you have to them: _____

_____

_____

Please list all surgeries: _____

_____

_____

Please answer each question by filling in the appropriate circle fully.

Did the patient's mother receive prenatal care? O Yes O No

Did the patient's mother have or use any of the following during pregnancy?

O Infection O High blood pressure O Diabetes
O Alcohol O Tobacco O Drugs

Was the patient born within two weeks of their due date? O Yes O No

Did the patient have any complications during their newborn nursery stay?

O No
O Breathing problems
O Jaundice requiring treatment
O Infection
O Birth injury
O Birth defect

Does anyone in the family (brothers, sisters, father, mother) have...?

O Ear problems O Hearing loss O Head and neck cancers
O Allergies O Sinus problems O Other: _____

Does the patient...?

Smoke	O Yes	O No
Have secondhand smoke exposure	O Yes	O No
Drink alcohol	O Yes	O No
Use smokeless tobacco	O Yes	O No
Use recreational drugs	O Yes	O No
Drink caffeine	O Yes	O No
Attend daycare	O Yes	O No
Have pets	O Yes	O No

Has the patient experienced any of the following in the last six months?

Weight change	O Yes	O No
Fever	O Yes	O No
Chills	O Yes	O No
Loss of appetite	O Yes	O No
Hearing loss	O Yes	O No
Sore throat	O Yes	O No
Epistaxis	O Yes	O No
Change in voice	O Yes	O No
Ringing in ears	O Yes	O No
Dizziness	O Yes	O No

Used Q-tips	○ Yes	○ No
Allergies	○ Yes	○ No
Ear pain	○ Yes	○ No
Ear drainage	○ Yes	○ No
Ear fullness	○ Yes	○ No
High blood pressure	○ Yes	○ No
Irregular heart rhythm	○ Yes	○ No
Murmur	○ Yes	○ No
Nausea	○ Yes	○ No
Vomiting	○ Yes	○ No
Diarrhea	○ Yes	○ No
Heartburn	○ Yes	○ No
Skin rash	○ Yes	○ No
Hives	○ Yes	○ No
Itching	○ Yes	○ No
Diabetes	○ Yes	○ No
Thyroid disease	○ Yes	○ No
Headache	○ Yes	○ No
Memory loss	○ Yes	○ No
Tingling or numbness	○ Yes	○ No
Blurring of vision	○ Yes	○ No
Asthma	○ Yes	○ No
Cough	○ Yes	○ No
Wheezing	○ Yes	○ No
Sinus congestion	○ Yes	○ No
Stuffy nose	○ Yes	○ No
Runny nose	○ Yes	○ No
Itchy eyes	○ Yes	○ No
Scratchy throat	○ Yes	○ No
Easy bruising	○ Yes	○ No
Anemia	○ Yes	○ No
Visual changes	○ Yes	○ No
Rheumatoid arthritis	○ Yes	○ No
Arthritis	○ Yes	○ No
Muscle aches	○ Yes	○ No

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PATIENT NOTIFICATION FOR PAYER PAYMENT POLICIES FOR CERTAIN IN-OFFICE PROCEDURES

Patient Name: _____

Please be aware that certain procedures performed in our office are not included in the standard office visit. These procedures will be billed separately and in addition to the office visit charges. We have become aware that some insurance carriers are classifying these procedures as "surgery" and applying the charges to a higher deductible amount. The result may be insurance payment for an office visit but not a procedure. In such cases, payment for the procedure will be due from the patient. Be assured that we are following accepted billing and coding guidelines and that all procedures are performed in the best interest of patient care. Please speak with our staff if you have any questions.

Examples of in-office procedures include:

Flexible laryngoscopy: This procedure involves passing a long, thin, flexible fiber-optic scope through the nasal cavity and into the throat. The fiber-optic scope enables the physician to visualize areas of the throat not readily seen using the laryngeal mirrors.

Nasal endoscopy: This procedure uses the flexible or rigid scope attached to a light source to view areas of the nasal cavities that the physician cannot see using the standard nasal speculum and head mirror.

Nasal endoscopy with debridement or biopsy: This is the same procedure as above, but it also includes the removal of crusting or tissue.

Cerumen removal: This procedure is the removal or extraction of hardened or accumulated cerumen (earwax) from the external auditory canal by mechanical means, such as debridement.

Audio testing: Some insurance carriers will only cover one test per year.

Patient/Guardian Signature _____ Date _____

ASSIGNMENT OF BENEFITS

I hereby guarantee the payment of all charges incurred at the office of Advanced Ear, Nose & Throat–Head and Neck Surgery, LLC. I hereby assign and direct to pay all benefits for medical services under this claim directly to Advanced Ear, Nose and Throat–Head & Neck Surgery, LLC. I hereby authorize the release of any medical information requested by the insurance companies with the above assignment.

Patient/Guardian Signature _____ Date _____

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FINANCIAL POLICY

Thank you for choosing us as your health care provider. Our priority is to provide you with specialized treatments that help restore your full physical health. Prior to seeing the doctor, all patients much complete this financial policy form. Please review and initial or sign where indicated.

It is the patients' or policy holder's responsibility to know the terms of their health insurance plan and to be aware of deductibles, co-payments and/or co-insurance. You have an obligation to determine whether your doctor is in-network or if your visit with our practice requires a referral from your primary care physician. Recognize, as you make decisions about your care, that if your doctor is out-of-network, you may incur higher out-of-pocket costs. All insured patients are required to sign the assignment of benefits for payment from the insurance company.

Please initial _____.

Beginning 2/1/2023, a credit card will be mandatory for appointment scheduling. You may elect to use the card to pay for services (co-payment, deductibles and fees) or present another form of payment at our office. We accept MasterCard, Visa, Discover or American Express, in addition to cash or check. A 3.5% convenience fee will be added to each credit card transaction.

Please initial _____.

All co-pays and deductibles are due at the time of service. Failure to do so will result in a **$25** charge added to your bill. Self-pay patients must remit full payment on-site unless a payment plan is established.

Please initial _____.

Standard penalty fees will be charged to patients who do not cancel an appointment or procedure with sufficient notice. This financial policy authorizes Advanced Ear, Nose & Throat-Head and Neck Surgery, LLC to charge the card on file **$50** for each missed appointment, whether a complete no-show where the patient fails to call ahead or if less than 24 hours' notice is given. Canceled or rescheduled surgical procedures without at least five (5) days' notice are subject to a $300 charge. In case of an emergency, please contact us as soon as possible to avoid the late cancellation fee.

Please initial _____.

Our contract with your insurance company requires us to collect all co-pay deductibles prior to services being rendered. If they haven't paid your balance in full within 30 days, contact the carrier directly to facilitate their processing of your outstanding claim(s). If a service is deemed non-covered by your plan, you will be responsible for the complete charge. Payment is due upon receipt of an invoice from our office.

All returned checks will be subject to a $35 NSF fee.

All accounts will be considered delinquent if unpaid after 90 days and turned over to an attorney and/or collection agency without notice. You will remain responsible for paying the full outstanding balance plus any subsequent fees charged to our practice by the collection agency.

Patient/Guardian Signature _____ **Date** _____

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you, and that relates to your past, present or future physical or mental health condition and related health care services.

Uses and Disclosures of Protected Health Information:

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice and any other uses required by law.

Treatment:

We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment:

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations:

We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities included, but not limited to, quality assessment activities, employee review activities, training of medical students, licensing and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law; Public Health issues as required by law; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners; Funeral Directors and Organ Donors; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures. Under the law, we must make disclosures to you and, when required by the Secretary of the Department of Health and Human Services, investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken action in reliance on the use or disclosure indicated in the authorization.

Your Rights:

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under Federal Law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding, and protected health information that is now subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit the use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another health care professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

You have the right to obtain a paper copy of this notice from us upon request, even if you have agreed to accept this notice alternatively, i.e., electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us, and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints:

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2023.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at (702) 360-3838.

The signature below is only an acknowledgment that you have received this Notice of Privacy Practices:

PRINT NAME: _____ **SIGNATURE:** _____ **DATE:** _____

Permission to release health information to: _____ Relationship: _____

Permission to release health information to: _____ Relationship: _____

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REQUEST FOR RECORDS

Patients: Please list any previous providers so we may retain medical records.

Date: _____

Physician: _____

Specialty: _____

Phone: _____

Fax: _____

☐ Copies of blood work in the last _____ months

☐ Medical records in the last _____ months

☐ All radiology reports in the last _____ months

I, _____ hereby authorize you to release all the above records to Advanced Ear, Nose & Throat-Head and Neck Surgery, LLC. This request expires 12 months from the date signed.

I, _____ hereby authorize you to release all the above records to Advanced Ear, Nose & Throat-Head and Neck Surgery, LLC. This request expires 12 months from the date signed.

Print Patient Name: _____ **Date of Birth:** _____

Patient or Guardian Signature: _____ **Relationship to Patient:** _____

****** FAX RECORDS TO (702) 834-5752.******