Northwest ENT and Allergy Center

PATIENT INFORMATION

MRN _____

PATIENT NAME: Last _____ First _____ MI _____

Date of Birth ___/___/___ Patient's Age _____ Male ❑ Female ❑ MARITAL STATUS ❑ S ❑ M ❑ D ❑ W

Street Address: _____ Social Security # xxx-xx-_____ (last 4 digits only)

City _____ State _____ ZIP Code _____

Home/Cell Phone _____ Work Phone _____

Email Address _____

Which Doctor Are You Seeing Today? ❑Dr. Locandro ❑Dr. Parikh ❑Dr. Kauffman ❑Dr. Ingley

❑Dr. Antunes ❑Jeff D'Ambrosio, PA-C ❑Claudette Corey, NP

Name of Physician that requested today's consult/visit: _____

Primary Care Physician, if different than above: _____ Phone No. _____

How did you hear about us?

❑NW ENT Website ❑ Physician ❑ ZocDoc ❑Insurance ❑Internet search ❑Friend ❑Relative ❑Media/TV

❑ (Check if self and skip this section)

RESPONSIBLE PARTY NAME: Last _____ First _____ MI ___Date of Birth ___/___/____

Male ❑ Female ❑ Home Phone (_____) _____ Work Phone (_____) _____Ext_____

Street Address___ _____

ZIP Code _____ City _____ State _____

Primary Insurance Co. _____ Policy Holder _____

Policy ID# _____ Group No. _____

Secondary Insurance Co. _____ Policy Holder_____

Policy ID# _____ Group No. _____

If Policy Holder is not the Patient, We Must Have the Following Information to File Your Claim

POLICY HOLDER: Last _____First _____ MI _____Date of Birth ___/___/_____

GENDER ❑ Male ❑ Female PATIENT'S RELATIONSHIP TO POLICY HOLDER ❑ Spouse ❑ Child ❑ Other _____

Street Address _____City _____State_____ Zip _____

Subscriber's Employer _____

PAYMENT OF ALL CO-PAYMENTS, DEDUCTIBLES, AND ANY OTHER PATIENT RESPONSIBILITY FEES ARE DUE WHEN SERVICES ARE RENDERED. IF YOU HAVE A QUESTION ABOUT FEES, PLEASE CHECK WITH US.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Northwest ENT and Allergy Center to diagnose and treat me. I also authorize Northwest ENT and Allergy Center to release medical and/or any other information to my insurance carrier, and/or Centers for Medicare and Medicaid Services or its intermediaries or carriers, any information needed for payment on Medicare/Insurance Company Claims for services rendered by Northwest ENT and Allergy Center and/or its physicians. I permit a copy of this authorization to be used in place of the original, and request assignment of payment of medical insurance benefits either to Northwest ENT and Allergy Center and/or its physicians. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for treatment. (Section 1128B of the SS Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information). I have also been informed of my rights to privacy via posters and handouts contained within this office as mandated under the current federal HIPAA laws. I also acknowledge receipt and understanding of the Northwest ENT and Allergy Center Financial Policy and Patient Notification for Payer Payment Policies for Certain In-Office Procedures.

_____ _____

Patient or Legal Guardian Signature (If patient under 18 years old) Date

Northwest ENT and Allergy Center

PATIENT HEALTH HISTORY

MRN _____

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.** It is important for your doctor to know you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcome to a copy of the report if you wish.

PATIENT NAME: Last _____ First _____ MI _____

Male _____ Female _____ Date of Birth: _____ Height: _____ Weight:_____

Pharmacy Preference (include location): _____

REASON FOR TODAY'S VISIT: _____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

Name of Medication	Dosage	Taken For (Medical Condition/Problem)

LIST OTHER CONDITIONS FOR WHICH YOU MAY NOT BE TAKING MEDICATIONS: _____

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? ____Yes ____No. If yes, please list below:

Name of Medication	Type of Reaction

SURGERIES AND HOSPITALIZATIONS

Have you ever had any problems with anesthesia (being numbed or put to sleep)? ____Yes ____No

If yes, please explain: _____

List any surgeries you have had (including dates):

_____

_____

Have you ever been hospitalized for non-surgical reasons? ____Yes ____No

If yes, list reasons for hospitalizations: _____

_____

CURRENT OR MOST RECENT OCCUPATION: _____

Northwest ENT and Allergy Center

PATIENT HEALTH HISTORY

MRN_____

MARK IF YOU HAVE EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING:

❑ Breast Cancer	❑ High/Elevated Cholesterol	❑ Hepatitis
❑ Lung Cancer	❑ Heart Attack	❑ Stomach Ulcer
❑ Skin Cancer	❑ High Blood Pressure	❑ Prostate Enlargement
❑ Throat Cancer	❑ Anxiety	❑ Renal Failure
❑ Prostate Cancer	❑ Depression	❑ Stroke
❑ Other Cancer	❑ Asthma	❑ Diabetes
❑ Migraine Headaches	❑ Chronic Bronchitis	❑ Thyroid Dysfunction
❑ Nasal Allergies	❑ Emphysema	❑ Anemia
❑ Sleep Apnea	❑ Tuberculosis	❑ Hemophilia
❑ Blood Clots/DVT	❑ Gastrointestinal Reflux	❑ HIV

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1. Are you pregnant? Yes No
2. Have you had pneumonia vaccine? Yes No
3. Do you wear hearing aids or have known hearing loss? Yes No
4. Are you retired? Yes No
5. Tobacco Use: Yes No
   Mark your tobacco use: ❑ Smokeless Tobacco ❑ Cigarettes ❑ Cigars
6. Do you drink alcoholic beverages? Yes No
   A drink is 1 shot of liquor, 1 glass of wine or 1 bottle/can of bear:
   ❑ less than 12/yr ❑ 4-13 drinks/mo ❑ 4-14 drinks/wk ❑ >2 drinks/day
7. Do you use recreational drugs? Yes No
8. Do you drink caffeine? (*coffee, tea, chocolate, cola, other caffeinated drinks)* Yes No
   Mark your caffeine use: ❑ 1 per day ❑ 2-3 per day ❑ 4 or more
9. Are you exposed to second hand smoke? Yes No
10. Does the patient attend daycare? Yes No
11. Home living situation?
    Mark all that apply. ❑ Alone ❑ w/children ❑ w/spouse

Northwest ENT and Allergy Center

PATIENT HEALTH HISTORY

MRN_____

IF A FAMILY MEMBER HAS BEEN DIAGNOSED WITH ANY OF THE FOLLOWING:

- ❑ Problems with Anesthesia
- ❑ High Blood Pressure
- ❑ Bleeding Clotting Problems
- ❑ Heart Disease
- ❑ Diabetes

PLEASE MARK IF YOU NOW HAVE OR HAVE YOU RECENTLY HAD ANY OF THE FOLLOWING:

- ❑ Fever
- ❑ Sleeping problems
- ❑ Unintentional weight loss
- ❑ Unintentional weight gain
- ❑ Blurred vision
- ❑ Itchy Eyes
- ❑ Loss of vision
- ❑ Painful eye
- ❑ Dizziness
- ❑ Ear drainage
- ❑ Hearing loss
- ❑ Ear pain
- ❑ Ringing in the ears
- ❑ Nasal congestion
- ❑ Frequent nosebleeds
- ❑ Post-nasal drainage
- ❑ Belching sour material into throat
- ❑ Hoarseness or other voice changes
- ❑ Mouth ulcers
- ❑ Partials or dentures
- ❑ Blacking out or fainting
- ❑ Chest pain
- ❑ Heart murmur
- ❑ Irregular heartbeats
- ❑ Leg Cramps
- ❑ Swelling of ankles
- ❑ Hives
- ❑ Sneezing
- ❑ Frequent non-productive cough
- ❑ Frequent productive cough
- ❑ Shortness of breath
- ❑ Snoring (excessive)
- ❑ Wheezing
- ❑ Abdominal pain
- ❑ Diarrhea
- ❑ Heartburn
- ❑ Nausea
- ❑ Trouble swallowing
- ❑ Painful swallowing
- ❑ Vomiting
- ❑ Painful Joints
- ❑ Stiffness in joints
- ❑ Swelling of joints
- ❑ Change in sense of smell
- ❑ Change in sense of taste
- ❑ Headaches
- ❑ Severe face pain
- ❑ Seizures
- ❑ Tremor
- ❑ Appetite is increased
- ❑ Fatigue
- ❑ Cold Feeling
- ❑ Bleed excessively after injury
- ❑ Bruise easily
- ❑ Masses (lumps) in armpit
- ❑ Masses (lumps) in neck
- ❑ Masses (lumps) in groin

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE.

Northwest ENT and Allergy Center

PATIENT CONFIDENTIALITY

MRN _____

Northwest ENT and Allergy Center follows HIPAA guidelines to ensure the integrity of your privacy. We need your help in ensuring your privacy by providing us with the following information.In the event that I, _____ cannot be reached personally, Northwest ENT and Allergy Center may leave any test result, lab result, appointment information, or other confidential medical or financial information to the following designated individuals:

Name	Relationship to Patient	Date of Birth (mm/dd)	Contact Phone

Release of your protected health information (PHI) to anyone other than the patient or parent/legal guardian will be restricted to those individuals listed above or individuals otherwise listed on the Notice of Privacy Practices.

PATIENT SIGNATURE:_____ **DATE:** _____

Standardization of Health Care Quality Improvement

Ensuring the delivery of high-quality, patient-centered care requires understanding the needs of the populations served. The nation's health care data infrastructure does not provide the necessary level of detail to understand which groups are experiencing health care disparities or would benefit from targeted quality improvement efforts. These questions are recommended in order to standardize an approach to eliciting race, ethnicity, and language data. Please answer the below questions in order to assist in the gathering of this data.

Race

- o American Indian or Alaskan Native
- o Asian
- o Black or African American
- o Native Hawaiian or Other Pacific Islander
- o Other Race
- o White or Caucasian
- o Decline to State

Ethnicity

- o Hispanic
- o Not Hispanic
- o Decline to State

Language

- o English
- o Spanish
- o Other

Preferred method of receiving information from office

- o Cell Phone
- o Home
- o Mail
- o Opt Out
- o Other Phone
- o Patient Portal
- o Work Phone

Northwest ENT and Allergy Center

FINANCIAL POLICY

MRN: _____

As our office strives to hold down the cost of patient care, it is important for you to understand your financial responsibility for your medical care, specifically what your insurance policy covers and does not cover. **Our office performs "in office" procedures that your insurance company considers a surgical procedure.** In some cases **they will apply** "outpatient benefits" in which case, you may have to meet a deductible or pay an additional co-insurance amount. ***Please check your insurance benefits book for coverage information. If you have questions regarding your insurance, please call the member services department listed on your insurance card.***

IN OFFICE PROCEDURES: 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 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.

In-office procedures may 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 cannot be viewed by the physician using the standard nasal speculum and head mirror.
- **Nasal endoscopy with debridement or biopsy**: This is the same procedure as above with removal of crusting or tissue. This procedure is always performed on 3 different visits after any sinus surgery.
- Audiology Hearing Services
- Other procedures include: CT's, Balloon Sinuplasty, Base of Tongue Ablation and/or Ultrasounds and Biopsies

MANAGED CARE PATIENTS: It is your responsibility to obtain all necessary referrals and/or authorization from your Primary Care Physician. You will be responsible for all services if insurance denies due to no authorization.
All co-payments are due at the time of service

COMMERCIAL INSURANCE PATIENTS: We will file your medical services to your insurance company for you. As a courtesy, we will also file any secondary insurance policies that you may have. However, you are fully responsible for all charges incurred especially any charges denied as non-covered by your insurance company. Your insurance may have its own "Usual, Customary, and Reasonable (UCR)" fee schedule

SELF-PAY PATIENTS: You are responsible for payment of services on the day you are seen.

WORKER'S COMPENSATION: You are responsible for assisting us in obtaining authorization from your case manager or adjuster for all office visits. We will bill your employer or worker's compensation insurance plan. You are only responsible for payment if your claim is controverted.

MEDICARE PATIENTS: We are participating with Medicare. We will bill Medicare for you. Please note Federal Law requires us to collect your yearly deductible and co-insurance amounts. If you have a secondary insurance we will bill your secondary insurance after Medicare pays.

STATE ASSISTED PATIENTS: We participate with the Georgia State Medicaid program and will bill Medicaid. Medicaid benefits are valid month to month; therefore, it will be necessary to present your Medicaid certificate to us each month. We will collect all co-payments at the time of service. Please note, if there is a lapse in your monthly Medicaid coverage (i.e. you are not eligible for Medicaid benefits) you will be considered a Self-Pay patient.

NO SHOW FEE: Your account will be charged $50.00 for each visit that is considered a no show.

PAYMENT POLICY

All co-payments, coinsurance amounts, deductibles and/or other patient due balances must be paid in full at the time of your visit. Failure to make payment on your account **will result in your dismissal** from the practice and your account will be turned over to an outside collection agency for payment**.** Please note that we have a $12.00 returned check fee on all checks returned to us from our bank for non-sufficient funds which will be charged to your patient account and responsible to pay. All patients who provide email account information will be automatically enrolled to receive email billing statements.

Patient Signature _____ Date _____