



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. Van Deusen Dr. Dharamsi Dr. Antunes

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



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: _____

Name of Primary Care Physician: _____

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: _____



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

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

Ethnicity

- Hispanic
- Not Hispanic
- Decline to State

Language

- English
- Spanish
- Other

Preferred method of receiving information from office

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



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:

Patient Initials _____

- **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 _____