



# PATIENT INFORMATION

MRN \_\_\_\_\_

Northwest ENT  
and Allergy Center

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. Stringham  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



<b>PATIENT CONFIDENTIALITY</b>
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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	Emergency Contact Y/N

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:**

- **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 \$50.00 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 \_\_\_\_\_



# 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 name and location: \_\_\_\_\_

REASON FOR TODAY'S VISIT: \_\_\_\_\_

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

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

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:

\_\_\_\_\_  
\_\_\_\_\_



## PATIENT HEALTH HISTORY

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

- |   |   |                                       |
|---|---|---------------------------------------|
| <input type="checkbox"/> Allergies            | <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Rashes       |
| <input type="checkbox"/> Arthritis            | <input type="checkbox"/> Headaches      | <input type="checkbox"/> Seizures     |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Hearing loss   | <input type="checkbox"/> Strep Throat |
| <input type="checkbox"/> Cancer               | <input type="checkbox"/> Hypertension   | <input type="checkbox"/> Other        |
| <input type="checkbox"/> Chronic Lung Disease | <input type="checkbox"/> Ear infections | _____                                 |

- 
- |   |                              |                             |
|---|------------------------------|-----------------------------|
| 1. Are you pregnant?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 2. Have you had pneumonia vaccine?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 3. Do you wear hearing aids or have known hearing loss?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 4. Are you retired?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 5. Tobacco Use:   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Mark your tobacco use: <input type="checkbox"/> Smokeless Tobacco <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars |                              |                             |
| 6. Do you drink alcoholic beverages?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 7. Do you use recreational drugs?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

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

- |  |  |
|--|--|
| <input type="checkbox"/> Cancer          | <input type="checkbox"/> Stroke          |
| <input type="checkbox"/> Diabetes        | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Heart failure   | <input type="checkbox"/> Seizures        |
| <input type="checkbox"/> Hypertension    | <input type="checkbox"/> Migraines       |
| <input type="checkbox"/> Rheum arthritis | <input type="checkbox"/> Rashes          |
| <input type="checkbox"/> Osteoarthritis  | <input type="checkbox"/> Other _____     |



## PATIENT HEALTH HISTORY

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

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Activity change          | <input type="checkbox"/> Trouble swallowing       | <input type="checkbox"/> Food allergies                   |
| <input type="checkbox"/> Appetite changes         | <input type="checkbox"/> Voice changes            | <input type="checkbox"/> Immunocompromised                |
| <input type="checkbox"/> Chills                   | <input type="checkbox"/> Eye itching              | <input type="checkbox"/> Dizziness                        |
| <input type="checkbox"/> Sweating                 | <input type="checkbox"/> Eye pain                 | <input type="checkbox"/> Headaches                        |
| <input type="checkbox"/> Fatigue                  | <input type="checkbox"/> Eye sensitivity to light | <input type="checkbox"/> Light headedness                 |
| <input type="checkbox"/> Irritability             | <input type="checkbox"/> Sleep apnea              | <input type="checkbox"/> Numbness                         |
| <input type="checkbox"/> Unexpected weight change | <input type="checkbox"/> Choking                  | <input type="checkbox"/> Seizures                         |
| <input type="checkbox"/> Congestion               | <input type="checkbox"/> Cough                    | <input type="checkbox"/> Speech difficulty                |
| <input type="checkbox"/> Dental problems          | <input type="checkbox"/> Shortness of breath      | <input type="checkbox"/> Syncope (Fainting)               |
| <input type="checkbox"/> Ear discharge            | <input type="checkbox"/> Wheezing                 | <input type="checkbox"/> Adenopathy (Swollen lymph nodes) |
| <input type="checkbox"/> Ear pain                 | <input type="checkbox"/> Chest pain               | <input type="checkbox"/> Bruises/Bleed easily             |
| <input type="checkbox"/> Facial swelling          | <input type="checkbox"/> Leg swelling             | <input type="checkbox"/> Agitation                        |
| <input type="checkbox"/> Hearing loss             | <input type="checkbox"/> Abdominal pain           | <input type="checkbox"/> Behavior problem                 |
| <input type="checkbox"/> Mouth sores              | <input type="checkbox"/> Nausea                   | <input type="checkbox"/> Hyperactive                      |
| <input type="checkbox"/> Nosebleeds               | <input type="checkbox"/> Rectal pain              | <input type="checkbox"/> Nervous/anxious                  |
| <input type="checkbox"/> Postnasal drip           | <input type="checkbox"/> Vomiting                 | <input type="checkbox"/> Self-Injury                      |
| <input type="checkbox"/> Runny nose               | <input type="checkbox"/> Arthralgia (Joint pain)  | <input type="checkbox"/> Sleep disturbance                |
| <input type="checkbox"/> Sinus pressure           | <input type="checkbox"/> Back pain                | <input type="checkbox"/> Snoring                          |
| <input type="checkbox"/> Sneezing                 | <input type="checkbox"/> Joint swelling           | <input type="checkbox"/> Change in smell                  |
| <input type="checkbox"/> Sore throat              | <input type="checkbox"/> Neck pain                | <input type="checkbox"/> Change in taste                  |
| <input type="checkbox"/> Ringing in the ears      | <input type="checkbox"/> Environmental allergies  |   |