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. Stringham ❑ Jeff D'Ambrosio, PA-C

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

MRN _____

Northwest ENT and Allergy Center

PATIENT CONFIDENTIALITY

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

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 $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 _____

MRN _____

Northwest ENT and Allergy Center

AGREEMENT TO RECEIVE ELECTRONIC COMMUNICATION

Patient Name: _____
Date of Birth: _____

By signing below, I agree that Northwest ENT and Allergy Center, P.C. may send the following types of emails and text messages (including automated messages) to the mobile telephone number and/or email address, as applicable, that I have provided to (insert clinic name):

- appointment confirmations and reminders;
- other practice communications such as clinical care reminders and information, pre- or post-visit instructions, messages regarding my health and health plan and/or diagnoses or treatment, billing-related messages, eligibility information or questions, and occasional practice updates such as office moves or weather closings;
- updates on available treatment offerings and services, services and programs that may be of interest to me, refill reminders, promotions, and innovations in ENT products and care.

Electronic communication authorization options:

Initial below to indicate consent.
___ Email
___ Text Messaging

I understand that I have the right to opt-out of receiving certain such communications by following the instructions provided in an applicable message. However, I understand that if I choose to opt out, I may experience an impact in my experience with the service(s) that rely on communications via text messaging and/or email communications. I also understand that I may continue to receive certain time-sensitive messages that do not require consent (such as emergency notifications) even after opting out or unsubscribing.

I agree that Northwest ENT and Allergy Center, P.C. may send me messages by text or email (as selected above that are unsecure. Text messages and email communications have inherent privacy risks, including that unencrypted text messages and email communications are not secure and could be accessed by an unauthorized party, intercepted, or altered without my knowledge or authorization.

_____	_____	_____
(Signature of patient/authorized representative)	(Print name if other than patient)	(Date)

By opting-in to email communication from (insert clinic name), you agree to receive the types of emails described above. You can revoke your consent to receive emails at any time by using the unsubscribe link found at the bottom of every email.

By opting-in to SMS messages from (insert clinic name), you agree to receive automated promotional messages. This agreement isn't a condition of any purchase. We will send no more than four (4) msgs/month. Msg & Data rates may apply. Reply STOP to end anytime after receiving your initial confirmation message.

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 name and address: _____

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:

_____

_____

Northwest ENT
and Allergy Center

PATIENT HEALTH HISTORY

MRN _____

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

❑ Allergies	❑ Diabetes	❑ Rashes
❑ Arthritis	❑ Headaches	❑ Seizures
❑ Asthma	❑ Hearing loss	❑ Strep Throat
❑ Cancer	❑ Hypertension	❑ Other
❑ Chronic Lung Disease	❑ Ear infections	_____

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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. Current Tobacco Use Yes ❑ No ❑
   Mark your tobacco use: ❑ Smokeless Tobacco ❑ Cigarettes ❑ Cigars

   Former Tobacco Use Yes ❑ No ❑

   Mark your Former Use: ❑ Smokeless Tobacco ❑ Cigarettes ❑ Cigars

   When did you quit? _____

   How many packs per day? _____
6. Do you Vape? Yes ❑ No ❑

   Start Date: _____ How often do you vape? _____
7. Do you drink alcoholic beverages? Yes ❑ No ❑
8. Do you use recreational drugs? Yes ❑ No ❑

IF A FAMILY MEMBER HAS BEEN DIAGNOSED WITH ANY OF THE FOLLOWING PLEASE TELL US WHOM:

❑ Cancer _____	
❑ Diabetes _____	❑Stroke _____
❑ Heart failure _____	❑Thyroid disease _____
❑ Hypertension _____	❑Seizures _____
❑ Rheum arthritis _____	❑Migraines _____
❑Osteoarthritis _____	❑Rashes _____
	❑Other_____

Northwest ENT
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PATIENT HEALTH HISTORY

MRN _____

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

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

Patient Feedback:

We're constantly working on improving each patient's experience in our office and would appreciate it if you could share any feedback, good or bad, from your visit today to help. You'd receive a simple, 2-question survey that won't take you longer than a minute. Your feedback lets us know what we are or aren't doing well, and is invaluable in helping us improve patient experience to provide you with the best experience possible. Please sign below if you'd like you'd like to participate.

_____ _____

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