Washington Ear, Nose and Throat

80 Landings Drive, Suite 207
Washington, PA 15301
(724) 225-8995

Last Name: _____ First Name: _____

Home Phone: _____

Mobile Phone: _____

Work Phone: _____

Email Address**:** _____

May we contact you through e-mail/text (test results, appointment confirmation)? ○ Yes ○ No

Patient Address: _____

City: _____ State: _____ Zip Code: _____

Gender: ○ M ○ F ○ O Birth date: _____

Emergency Contact: _____ Phone: _____

Primary Care Physician: _____

Referring Physician (if different from Primary Care): _____

Employer: _____ Occupation: _____

Insurance Information

Primary Insurance: _____

Secondary Insurance: _____

Guarantor Information

Same as above ○ Yes ○ No

If information is different from above, please answer below:

Person responsible for account: _____ Relation to patient: _____

Birth date: _____ Phone: _____

Address (if different from patient): _____

City: _____ State: _____ Zip Code: _____

Employer: _____ Occupation: _____

Is this the result of an injury? ○ Yes ○ No

If yes, please answer below:

Date of accident: _____ Employment related: Y/N

Type of accident: _____

Additional Information

Pharmacy Name: _____ Phone: _____

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with the above noted insurance company and assign directly to Washington Ear, Nose and Throat all insurance benefits. I understand I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment. I authorize the use of this signature on all insurance submissions.

Signature: _____ Relationship: _____ Date: _____

FINANCIAL POLICY

Insurance
If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

You will be asked to update your demographic and insurance information periodically, including providing our office with copies or your insurance card(s). We are required to obtain your signature for permission to release information to your insurance carrier annually. Our failure to obtain these updates could result in criminal and civil penalties and/or expulsion from your insurance plan. Please assist us in complying with your insurance requirements.

We will gladly submit fees for your covered medical services to your insurance company. However, we expect payment of all services within 60 days. It may become necessary for you to pay your account in full if your insurance company fails to pay for services within 60 days. It is your responsibility to understand your coverage and benefits, including pre-certifications, referral and authorization requirements. We will, however, assist you to ensure all plan requirements are met.

Payment for Services
Payment for services, including co-payment and deductible amounts, is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. Our failure to collect these amounts may be a violation of our contract with your insurance company and may result in civil and criminal penalties and/or expulsion from your insurance plan. In addition, your failure to pay the required co-amounts is a violation of your financial responsibility for coverage and we may report your refusal to pay these amounts to your employer and/or insurance company representative.

We accept cash, checks, MasterCard, and VISA. Returned checks will be subject to a $30 fee. Balances older than 60 days, and failure to pay account balances as promised may be subject to external collection and additional collection fees, including attorney and other court fees. We may investigate your credit record to determine your ability to pay your debt.

Cancelled Appointments
Charges may be made for broken, confirmed appointments and appointments cancelled without 24 hours advance notice. Your cooperation in canceling your scheduled appointment well in advance of the appointment allows us the opportunity to offer your appointment to another person who needs medical care.

General
We will gladly discuss your proposed treatment and answer any questions relating to your insurance. It is important to understand, however that:

We participate in many of the local insurance plans. Your insurance, however, is a contract between you, your employer and the insurance company. We are, often, not a party to that contract. We are very sensitive to keeping health care costs affordable to our patients. As a result, we take great care to insure than our fees are consistent with the charges in this geographic region. Your insurance company may not use “reasonable charge information” specific to this region and specialty of Otolaryngology. In fact, many carriers purchase non-specific data and/or do not update their information on an annual basis. Most reputable insurance companies consider our fees usual, customary and reasonable.

Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to outpatients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask at the front desk.

Thank You.

My signature below constitutes acknowledgement and acceptance of this policy.

Signed: _____ Date: _____
Patient or Guarantor

Washington Ear, Nose and Throat

Acknowledgement of Receipt of Notice of Privacy Practices

Washington Ear, Nose and Throat has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning this information. You may review our current notice prior to signing this acknowledgement.

We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effectiveness of the change. You may obtain a revised notice by submitting a request to our Privacy Officer.

How to Contact our Privacy Officer:

Mail: Washington Ear, Nose and Throat
Privacy Officer
80 Landings Drive, Suite 207
Washington, PA 15301
Telephone: (724) 225-8995
Fax: (724) 225-9874

Acknowledgement of Receipt

I acknowledge that I have received the Notice of Privacy Practices for Washington Ear, Nose and Throat.

_____
Name of Patient

_____ _____
Signature of patient (or personal representative) Date

Personal Representative Name: _____

Relationship/Authority: _____

- -

Good Faith Efforts to Obtain Acknowledgement of Receipt

I provided the above named patient/personal representative with the Notice of Privacy Practices.

Describe how notice was provided:

- ○ Offered copy and individual refused to accept delivery
- ○ Offered copy and individual accepted delivery
- ○ Other: _____
  _____

Describe efforts to obtain signature on acknowledgement of notice form:

- ○ Patient/personal representative was asked to sign form and refused
- ○ Other: _____
  _____

_____ _____
Signature of staff member Date

Washington Ear, Nose and Throat

Consent to Disclosure of Personal Health Information to Family Members

I, _____, give my permission to the practitioners and staff of Washington Ear, Nose and Throat to release information regarding my medical care, including my medical condition, test results, appointment dates/times to the following individuals:

Name	Relationship	Telephone Number

_____
Name of Patient

_____ _____
Signature of patient (or personal representative) Date

Personal Representative Name: _____

Relationship/Authority: _____

Washington Ear, Nose and Throat

Patient History Data Sheet

Name _____ DOB _____Age_____ Date_____

Past Medical History

Do you have, or have you ever had…….

Yes ○	No ○	Heart Disease (heart attack, angina, heart surgery, arrhythmia)	Yes ○	No ○	Stroke or TIA
Yes ○	No ○	Diabetes (insulin, pills, diet control)	Yes ○	No ○	Migraine headaches
Yes ○	No ○	Lung Disease (asthma, emphysema, chronic bronchitis)	Yes ○	No ○	Seizure
Yes ○	No ○	High blood pressure	Yes ○	No ○	Anxiety Disorder
Yes ○	No ○	Thyroid problems	Yes ○	No ○	Depression
Yes ○	No ○	Gastroesophageal Reflux Disease (GERD)	Yes ○	No ○	Panic attacks
Yes ○	No ○	Kidney trouble	Yes ○	No ○	Arthritis
Yes ○	No ○	Cancer	Yes ○	No ○	Glaucoma
Yes ○	No ○	Liver problems	Yes ○	No ○	Macular degeneration
Yes ○	No ○	Head trauma	Yes ○	No ○	Use alternative medicine (please list)
Yes ○	No ○	Obstructive Sleep Apnea			

Other medical conditions: _____

Previous Surgeries
(list any prior surgical procedures):

Current Medications
(doses):

Allergies to Medications:

Social History

Occupation/Job: _____

Marital Status: Single ○ Married ○ Divorced ○ Widowed ○ Other_____

Have you used tobacco products? ○ Yes ○ No If so, please explain: _____

Have you used alcohol products? ○ Yes ○ No If so, please explain: _____

Do you use: Medical Marijuana: ○ Yes ○ No CBD Oil: ○ Yes ○ No CBD Oil with THC: ○ Yes ○ No

Do you use caffeine? ○ Yes ○ No If yes, how many cups/day: _____

Race:
- ○ American Indian/Alaskan Native
- ○ Asian
- ○ Black / African American
- ○ Native Hawaiian / Other Pacific Islander
- ○ White / Caucasian
- ○ Other: _____

Ethnicity:
- ○ Not Hispanic or Latino
- ○ Hispanic or Latino
- ○ Other:_____

Language:
- ○ English
- ○ Spanish
- ○ Other:_____

Washington Ear, Nose and Throat

Name: _____

Family History

Have any family members had the following diseases? If so, please circle and indicate which relative.

Heart Disease ☐	Migraine ☐	Mental Illness ☐	Epilepsy ☐
Diabetes ☐	Thyroid ☐	Voice Problems ☐	Bleeds Easily ☐
Hearing Loss ☐	Stroke ☐	Dizziness ☐	Cancer ☐

Malignant Hyperthermia/Anesthesia Complications

☐ Other hereditary diseases that run in the family: _____

Review of Systems

Recently have you had any of the following symptoms or problems:

General
- Yes ○ No ● weakness or fatigue
- Yes ● No ● recent weight loss

Eyes
- Yes ● No ● blurred vision
- Yes ● No ● double vision

Ear, Nose, Mouth and Throat
- Yes ● No ● trouble hearing
- Yes ● No ● tinnitus or ringing in ears
- Yes ● No ● ear pain
- Yes ● No ● ear infection or drainage
- Yes ● No ● dizziness, vertigo, or unsteadiness
- Yes ● No ● stuffy nose
- Yes ● No ● sinus trouble
- Yes ● No ● frequent nose bleeds
- Yes ● No ● frequent sore throats
- Yes ● No ● pain near teeth or mouth
- Yes ● No ● hoarseness or voice change
- Yes ● No ● difficulty with swallowing
- Yes ● No ● lumps in neck
- Yes ● No ● pain in the neck

Cardiovascular
- Yes ● No ● heart trouble
- Yes ● No ● palpitations
- Yes ● No ● high blood pressure

Respiratory
- Yes ● No ● cough
- Yes ● No ● asthma or wheezing
- Yes ● No ● shortness of breath

Hematologic
- Yes ● No ● easy bruising or bleeding
- Yes ● No ● anemia

Comments

Allergic
- Yes ● No ● hay fever or dust/mold allergy
- Yes ● No ● food sensitivity or intolerance
- Yes ● No ● chemical sensitivity
- Yes ● No ● latex allergy or sensitivity

Gastrointestinal
- Yes ● No ● heartburn or acid reflux
- Yes ● No ● nausea or vomiting
- Yes ● No ● diarrhea
- Yes ● No ● ulcers
- Yes ● No ● frequent use of antacids

Genitourinary
- Yes ● No ● kidney problems

Musculoskeletal
- Yes ● No ● joint pain or stiffness

Integumentary
- Yes ● No ● skin rashes

Neurological
- Yes ● No ● headaches
- Yes ● No ● numbness in face, legs, or arms
- Yes ● No ● seizures
- Yes ● No ● weakness of arms of legs
- Yes ● No ● blackouts or fainting
- Yes ● No ● trouble speaking
- Yes ● No ● confusion or memory loss

Psychiatric
- Yes ● No ● nervousness or increased stress
- Yes ● No ● sleep problems
- Yes ● No ● excessive moodiness or worry

Endocrine
- Yes ● No ● thyroid trouble
- Yes ● No ● diabetes

Comments

_____ROS, PMHx, FHx, SHx Completed by patient and reviewed by M.D. _____
Physician

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 are aware that some insurance carriers are classifying these procedures as "surgery" and applying the charges to your calendar year deductible. 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.

Our physicians will only perform these procedures when deemed medically necessary to best diagnose and treat our patients. If you are presenting with a sinus, swallowing problem, throat/voice complaint, symptoms of allergies, cancer or hearing loss, there is a good chance the physician will need to perform one or more of the following procedures.

- **CPT-31575 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 laryngeal mirrors.

- **CPT-31231 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.

- **CPT-31237 Nasal Endoscopy with Debridement or Biopsy:** This is the same procedure as above with removal of crusting or tissue.

- **CPT-92511 Flexible Nasopharyngoscopy:** This involves examining both the tissue of the nasal passages, the pharynx and larynx.

- **CPT-31579 Stroboscopy:** This procedure uses synchronized flashing light passed through a flexible or rigid scope that visualizes vocal fold vibration.

- **CPT-69420 Myringotomy:** This is a procedure to create a hole in the ear drum to allow fluid that is trapped in the middle ear to drain out.

- **CPT-69433 Tube Placement:** This is a procedure where a small hole is made in the eardrum and a tube is inserted to remove fluid and re-establish equal air pressure on both sides of the eardrum.

The following codes are used for audiology services.

- **CPT-92567 Tympanometry** *(This is used to tell the pressure of the ear drums.)*
- **CPT-92557 Audiometry and CPT-92588 Otoacoustic Emissions (OAE) (***This is considered a basic hearing test that is used to tell if hearing is normal.)*

Please contact your insurance provider to verify benefits and coverage information prior to having any services rendered.

_____ _____

Patient/Parent/Legal Guardian Signature Relationship

_____ _____

Print Name Date