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: _____

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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 ○ Diabetes (insulin, pills, diet control)
Yes ○ No ○ Lung Disease (asthma, emphysema, chronic bronchitis)
Yes ○ No ○ High blood pressure
Yes ○ No ○ Thyroid problems
Yes ○ No ○ Gastroesophageal Reflux Disease (GERD)
Yes ○ No ○ Kidney trouble
Yes ○ No ○ Cancer
Yes ○ No ○ Liver problems
Yes ○ No ○ Head trauma
Yes ○ No ○ Obstructive Sleep Apnea

Yes ○ No ○ Stroke or TIA
Yes ○ No ○ Migraine headaches
Yes ○ No ○ Seizure
Yes ○ No ○ Anxiety Disorder
Yes ○ No ○ Depression
Yes ○ No ○ Panic attacks
Yes ○ No ○ Arthritis
Yes ○ No ○ Glaucoma
Yes ○ No ○ Macular degeneration
Yes ○ No ○ Use alternative medicine (please list)

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