New Patient Packet

Please print and complete the following 6 pages.
Bring the completed forms to your scheduled appointment.
Thank you!

Washington Ear, Nose and Throat
80 Landings Drive, Suite 207
Washington, PA 15301
(724) 225-8995

Washington Ear, Nose and Throat

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

Today's Date: _____ Home Phone: _____

Name: _____ Work Phone: _____

Social Security Number: _____ Cell/Pager: _____

May we contact you through e-mail? Yes _____ No _____ (Test results, Appointment confirmation)

Email Address**:** _____

Primary Care Physician: _____

Referring Physician (if different from Primary Care): _____

Patient Address: _____

City: _____ State: _____ Zip Code: _____

Sex: M/F Age: _____ Birth date: _____ Marital Status: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone: _____

Insurance Information
Primary Insurance: _____

Secondary Insurance: _____

Guarantor Information
(If information is different from above)
Person responsible for account: _____ Relation to patient: _____

Birth date:_____ Phone:_____ Social Security Number: _____

Address (if different from patient): _____

City: _____ State: _____ Zip Code: _____

Employer: _____ Occupation: _____

Is this the result of an injury?
Date of accident: _____ Employment related: Y/N

Type of accident: _____

Additional Information
Pharmacy Name: _____ Phone: _____

Assignment and Release

I, the under signed 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 insure 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 $25 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. Failure to show for a scheduled confirmed appointment may result in a $20 cancellation fee.

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 out patients, 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:_____Patient or Guarantor Date:_____

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 _____ Age_____ Date_____

Current Medications (doses):

Allergies to Medications:

Previous Surgery:

Review of Systems

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

			Comments
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	

			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	

			Comments
Hematologic			
Yes	No	easy bruising or bleeding	
Yes	No	anemia	

			Comments
Endocrine			
Yes	No	thyroid trouble	
Yes	No	diabetes	

Washington Ear, Nose and Throat

Past Medical History

Do you have, or have you ever had…….

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

Social History

Occupation/Job:_____

Marital Status: Single_____ Married_____ Divorced_____ Widowed_____

Children (age):

Yes No Do you use tobacco (_____ packs/_____day;_____years) Quit_____years ago
Yes No Do you use alcohol (_____drinks/day/week/weekend/month)
Yes No Do you use coffee, tea, or caffeine containing beverages (_____cups/day)

Race:
____American Indian/Alaskan Native
____Asian
____Black African American
____Native Hawaiian/ Other Pacific Islander
____White
____Other: _____

Ethnicity:
____Not Hispanic or Latino
____Hispanic or Latino
____Other:_____

Language:
____English
____Spanish
____Other:_____

Family History

If any blood relative has had any of the following, 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

Hereditary Disorder:_____

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