



Please Note: All information is confidential and will become part of your medical record
Do not leave any boxes empty, mark N/A for not applicable or None if appropriate. PLEASE PRINT CLEARLY.

Patient Name: Date of Visit:
Date of Birth: Email: Preferred Phone:

Referring MD: Primary Care MD: Pharmacy Preference:
Name: Name: Name:
Phone Number: Phone Number: Phone Number:
Address: Address: Address/Cross streets:

Reason For Visit: Height Weight

Medications (Name, dosage) Do you have problems in any of the following areas?
Fevers/Chills/Weight: Eyes: Ear, Nose, Mouth, Throat: Cardiovascular: Respiratory: Gastrointestinal: Musculoskeletal: Genitourinary: Skin: Neurological: Endocrine: Blood/Lymphatic: Immunologic: Psychiatric:

Allergies (Medication, Food, Environmental, Etc. Please include what the reaction you had)
What other Medical Problems do you have? Do you smoke? Do you drink? Did you quit? How many per week?

PAYMENT POLICY FOR IN-OFFICE PROCEDURES
For Patients with deductibles and co-insurance

The following procedures are billed as a distinct procedure from the office visit. Your insurance plan may deem these procedures to be surgical in nature and may apply the fees for the service to your deductible or co-insurance: FLEXIBLE LARYNGOSCOPY: The passing a fiberoptic scope through the nasal cavity and into the throat; NASAL ENDOSCOPY: The passing a fiberoptic or rigid scope through the nasal cavity; NASAL ENDOSCOPY WITH DEBRIDEMENT OR BIOPSY: A nasal endoscopy with the removal of crusting or tissue, usually performed after nasal surgery; CERUMEN REMOVAL (EAR WAX): The removal of wax from the ear canals. I understand that I am responsible for payment for the above services including any amounts not paid by my insurance carrier such as copayments, deductibles, and non-covered services.

The information is accurate and complete to the best of my knowledge.
I will not hold the physician or his staff responsible for any error or omission that I may have made completing this form.
Signature: Date:



REFERRING PHYSICIAN, MEDICATION AND PHARMACY INFORMATION FORM

Patient's Name:	Date:
Name and Address of Internist or Referring Doctor:	
Physician's Name:	
Address:	
Telephone:	Fax:

MEDICATIONS

Do you have any allergies to medications? No Yes (Please List):

Please list all medications that you are taking (including over-the-counter medication, such as eye drops, aspirin, Motrin, nasal sprays, vitamins, herbal remedies, birth control pill, etc.)

MEDICATIONS	DOSAGE (mg, teaspoon, etc)	FREQUENCY

VACCINATION HISTORY

Date of most recent Flu Shot (ages 6 mos +)	Date of most recent Pneumonia Shot (ages 65+)
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PHARMACY INFORMATION

In order to expedite prescription service, if required, we would like to have your pharmacy information on file

Pharmacy Name:
Address
Telephone: Fax:
Patient's Signature:



OTOLARYNGOLOGY (ENT)

PAYMENT POLICY FOR IN-OFFICE PROCEDURES

In addition to an office visit, consultation and examination, your care may also involve office procedures that are routinely performed in the evaluation and treatment of Ear, Nose and Throat conditions. As per customary practice with medical insurance carriers, these office procedures are billed as a distinct procedure from the office visit. Your health plan may categorize these procedures as **surgical** and apply the fees for these services to you as a copay, co-insurance, deductible and/or out-of-pocket charge. This is based on your contract with your insurance carrier.

These procedures include, but are not limited to, the following:

- **Nasal Endoscopy: Examination of the nasal and paranasal sinus cavities with a fiberoptic endoscope.**
- **Nasal Endoscopy with debridement or biopsy: Includes a nasal endoscopy and additionally includes removal of crusting or tissue.**
- **Flexible Laryngoscopy: Examination of the throat with a fiberoptic endoscope.**
- **Laryngeal Stroboscopy: Examination of the larynx and vocal cords under stroboscopic light.**
- **Cerumen removal: Removal of wax from the ear canals.**

By signing this form, you acknowledge that you are aware of this policy and understand that you are responsible for any of the associated fees.

Patient Name:

(Print)

Signature:

(Patient or Responsible Party)

Date:



Financial Policy

Welcome to the Department of Otolaryngology-Head & Neck Surgery.

The following is a statement of our financial policy. We hope this gives you a better understanding of how our billing works.

Financial Policy

Patients have many different types of insurance and payment options for services rendered. Also, not all physicians in the practice accept the same type of insurance. The three most common scenarios are outlined below. Please read the following and if you have any question or concerns please call the office of the physician you are seeing.

Participating Plans

In this scenario the physician you will see participates with your insurance plan. It is your responsibility to ensure your physician is in fact currently a provider in that plan. At the time of service you will be responsible for all co-payments and co-insurances as outlined by your plan coverage. We will collect your co-insurances and deductibles in advance if you are having a procedure in the office or hospital. The Medical College will then forward a bill to your insurance carrier who will confirm if any additional payments are due from you. You will receive written notification of such decision and may ultimately be responsible for such payments as determined by your insurance company. If your plan requires a referral, please present the referral at the time you check-in. If you do not have a referral you may have to reschedule your appointment.

Non-Participating Plans

In this scenario the physician you will see does not participate in your insurance plan. Payment of services is due at the time of the visit. We can submit the claim directly to your carrier or a claim can be mailed directly to you.

Medicare

For any of our providers that participate with Medicare, we will bill Medicare directly for your service and Medicare will send payment directly to the physician. You will be responsible for any deductible or co-insurance. If your physician does not participate with Medicare you will be responsible for payment at the time of service, and your claim will then be forwarded to Medicare and they will reimburse you directly.

Usual and Customary Rates

Your insurance policy is a contract between you and your insurance company. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Payment

Cash, Check, MasterCard, Visa, Discover and American Express card are recognized forms of payment.

We hope this information is helpful; Again, if you have any questions or concerns, please contact your physician's office.

Signature of Patient or Responsible Party

Date