

Diseases of the Ears, Nose and Throat, Inc.

Patient Information

Doctor you are seeing today: Timothy Nash, D.O. Timothy Drankwalter, D.O. Audiology

Name: First _____ Last _____ MI _____

Date of Birth: _____ Age: _____ Sex: M/F Social Security Number: _____

Marital Status: Single/ Married/ Divorced/ Widowed (please circle one)

Race: American Indian/Alaska Native Native Hawaiian/Other Pacific Islander Check box if patient declined
 Asian White
 Black/African American Other Race _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown Check box if patient declined

Email: _____

Street Address: _____

City/State/Zip: _____

Place of Employment: _____

Spouse: _____

Please check one box to indicate preferred number

Home Phone _____

Cell Phone _____

Work Phone _____

If patient is a child, both parents' names: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Family Doctor: _____

Insurance Information

Insurance Company: _____ Subscriber Name: _____

If patient is not the subscriber, complete below:

Subscriber's relationship to patient _____ SSN: _____ DOB: _____

Subscriber's place of employment: _____

I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION, OR ITS INTERMEDIARIES OR CARRIERS, OR MY PRIVATE INSURANCE CARRIER ANY INFORMATION NEEDED FOR THIS OR A RELATED CLAIM. I PERMIT A COPY OF THE AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT. I AUTHORIZE THE DOCTOR TO BILL ALL SERVICES AND ALLOW MY INSURANCE CARRIER TO ISSUE INDEMNITY PAYMENTS DIRECTLY TO THE PHYSICIAN. I UNDERSTAND THAT ANY SERVICES NOT COVERED BY INSURANCE ARE THE OBLIGATION OF THE RESPONSIBLE PARTY.

SIGNATURE OF PATIENT, PERSONAL REPRESENTATIVE, PARENT OR GUARDIAN (IF PATIENT IS MINOR)

DATE

Diseases of the Ears, Nose and Throat, Inc.

Medical History

Patient Name: _____ Today's Date _____

DOB: ___/___/_____ Age: _____ Referring Physician: _____

Reason for your visit: _____

Preferred Pharmacy _____ Pharmacy Phone # _____

Patient Medications

Please list ALL MEDICATIONS, (including over-the-counter) that you are currently taking below:

I am not currently taking any medications (including over-the-counter, herbals, etc.)

Name:	Dose:	Times a Day:	Reason you take it:

Patient Medication Allergies

Are you allergic to latex? Yes ___ No ___

Are you allergic to medical tape? Yes ___ No ___

Do you have any known drug allergies? Yes ___ No ___

If yes, please list medications you are allergic to below:

Medication Name	Reaction

Past Surgical History

tonsil
 ear tubes
 ear surgery
 nasal/sinus surgery
 thyroid
 (see list)

Other Surgeries	Year	Comments

Past Medical History

Allergies/Hayfever	Ear Infections	High Blood Pressure
Anemia	Emphysema	Immune System Disorder
Anxiety Disorder	GERD/Reflux	Migraines
Asthma	Headaches	Neurologic Disorder
Bleeding Disorder	Hearing Loss	Sleep Disorder
Cancer	Heart Attack (MI)	Speech Delay
COPD	Heart Disease	Stroke
Depression	Heart Problems	Thyroid Problems
Diabetes	Hepatitis	
Dizziness or fainting	High Cholesterol	

Patient Family History

Disease	Family Member (Please indicate maternal or paternal)	Comments
Heart Disease		
Asthma		
Diabetes		
COPD		
Hepatitis		
Stroke		
Bleeding Problems		
High Blood Pressure		
Other:		

Patient Social History

1. Do you ever drink alcohol? Yes ___ No ___
1a. If Yes, how often? Occasionally Weekly Daily
2. Do you smoke? Yes ___ No ___
2a. If Yes, ___ packs a day for ___ years ?
3. Are you exposed to second hand smoke? Yes ___ No ___
4. Do you use any other tobacco products? Yes ___ No ___
5. What is/was your occupation: _____
6. Have you been exposed to excessive noise (explain)? _____

Patient Name _____

DOB: _____

Review of Systems

Please check all problems that you CURRENTLY have OR Please check "NONE"

Constitutional: none

fatigue fever significant weight loss significant weight gain

Eyes: none

blurred vision double vision itching burning eye pain

Ear: none

difficulty hearing ear pain vertigo tinnitus ears feel pressured discharge from ears

Nose: none

frequent nosebleeds nasal congestion nose/sinus problems rhinorrhea (runny nose)
 sinus pressure blockage/obstruction

Mouth/Throat: none

sore throat bleeding gums snoring dry mouth oral abnormalities mouth ulcer
 teeth abnormalities difficulty swallowing post nasal drip hoarseness mouth breathing

Neuro: none

fainting frequent headaches seizures numbness weakness migraines restless legs
 loss of consciousness

Cardiovascular: none

chest pain heart murmur dyspnea (shortness of breath) on exertion edema (swelling)
 palpitations light headed on standing

Respiratory: none

wheezing shortness of breath hemoptysis (coughing up blood) sputum production
 sleep apnea

GI: none

vomiting heartburn painful swallowing no appetite increased appetite

Hematologic/Lymphatic: none

swollen glands easy bruising excessive bleeding

Psychiatric: none

anxiety depression restless sleep other _____

Urinary: none

urinary retention frequent urination difficult urination hematuria (bloody urine)
 incontinence painful urination

Musculoskeletal: none

joint pain muscle aches

Skin: none

rash itching dry skin growth/lesions

Endocrine: none

increased thirst increased hunger diabetes

Allergic/Immuno: none

sneezing runny nose

I certify the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

(signature if over 18)

(Date)

If you are not the patient:

(please print your name)

(Relationship to Patient)

Patient Policies for Diseases of the Ears, Nose and Throat, Inc.

Thank you for choosing Diseases of the Ears, Nose and Throat, Inc. as your healthcare provider. To continue offering high quality care and service, we adhere to the following policies. The patient/responsible party has the responsibility to assure that all obligations for the health care received is fulfilled. We ask that you read and sign this statement prior to seeing the doctor.

Insurance: We are contracted with most insurance plans. If you are not covered by a plan that we do business with or are uninsured, payment in full is expected at each visit. Patients with insurance are expected to pay any personal balance due, immediately after their insurance remits payment. If insurance does not remit payment within 30 days, the patient is responsible for payment in full. If you receive an insurance payment at your home on an outstanding bill with us, that payment must be forwarded to us immediately. It is the responsibility of the patient to know their insurance benefits. Please contact the insurance company with any questions regarding coverage.

Co-Payments & Deductibles: All co-payments and deductibles must be paid at the time of service. This arrangement is part of the patients' contract with their insurance company. Failure on our part to collect co-payments and deductibles can be considered fraud by your insurance company. Please, help us uphold the law by paying your co-payment at each visit.

In-Office Procedures: Please be advised that during your visit, the doctor may need to perform an in-office procedure. This can include the use of an endoscope to look at your nasal passages or throat. These procedures are medically necessary for the doctor to accurately diagnose your condition. Employing the use of these exams and procedures is the standard of care for providing complete and comprehensive otolaryngology services in an office setting.

Insurance companies will consider all of these procedures as “surgical.”: We do not have control over how endoscopies are interpreted by insurance companies. Diagnostic endoscopies are always considered, “surgical,” despite the fact that no surgical instruments are used. We notify you of this issue in advance, so you are not surprised when you receive an explanation of benefits from your insurance company that states that a “surgical service” was provided. Also, surgical services may be reimbursed or paid at a different rate than an office visit and may be applied towards a deductible.

_____ (Please initial and date)

Non-Covered services: Please be aware that some and perhaps all of the services you receive may be non-covered or not considered reasonable or customary by Medicare and other insurance carriers. These services must be paid for at the time of your visit. In addition, some medications prescribed by the doctor may require prior authorization or may not be covered at all by your insurance company. If prior authorization is needed we will assist you in any reasonable manner to obtain medication coverage. However, insurance coverage for your prescriptions is ultimately beyond our control.

Account Balances: We will require that patients with self-pay balances do pay their account balances to zero prior to receiving further services by our practice. Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to our practice manager with whom they can review their account and concerns.

Referrals: Patients are requested to provide staff with sufficient notice to complete any referral forms, precertification's or other forms required by your insurer to process payment for services. Retroactive referrals will be completed for emergency care only. The patient is responsible for acquiring a referral if required by their insurance company. The patient will be responsible for any financial penalty incurred by failure to secure the proper referral.

Proof of Insurance: All patients must complete our patient information form prior to seeing the doctor. We must have a copy of your current insurance card in order to bill your insurance. We ask that you bring your card with you to each visit. If you fail to provide us with current insurance information you will be responsible for the balance of your claim at the time of service.

Insurance Claim Submission: We will be happy to submit both your primary and secondary insurance claims on your behalf provided that you have supplied us with the necessary billing information. We will assist you in any reasonable manner to get claims paid. Your insurance company may on occasion ask you to provide them with additional information. It is your responsibility to comply with that request. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract.

Insurance Coverage Changes: If you have an insurance change, please let us know prior to your next visit. This enables us to make the appropriate changes and help you achieve your maximum insurance benefit.

Returned Checks: If your check is returned for insufficient funds there will be a \$25 fee added to your account, in addition to the amount the check was for. These fees must be paid in full prior to any future appointments.

Nonpayment: If your account is over 90 days past due it will be referred to a collection agency. By signing this agreement, you are authorizing us to release all information needed to secure payment.

Late to Appointment Policy: If you are an established patient and you arrive 15 minutes late or more to your appointment you will likely be asked to reschedule unless the physicians schedule can still accommodate you. Priority will be given to the patients who arrive on time and you may have to be worked in between them. This may mean you will have a considerable wait. If this is not convenient for you, you may choose to reschedule. One or two late patients cause the entire daily schedule to fall behind. This is an inconvenience to everyone. We strive to see every patient as close to their appointment time as possible.

The registration process and filling out of the forms for a new patient can take more than 15 minutes. If you arrive at the scheduled appointment time and not the arrival time as instructed, you may be asked to reschedule.

Missed Appointments: We reserve the right to charge \$35 for missed office visits and \$125 for missed in-office surgeries. These charges will be billed to you directly and must be paid in full prior to additional visits.

Prescription Refills: Please call your pharmacy for all prescription refills. They will contact our office for necessary information. Please allow 24-48 hours for all requests. Also, note that an additional 48 hours is necessary if prior authorization is required by your insurance company. Be sure that all refill requests are received by 4:00pm on Thursdays; the on-call physician will not refill prescriptions over the weekend.

On-call Physicians: Our practice is covered 24 hours a day, 7 days a week by a group of 3 Ear, Nose and Throat physicians for emergencies only. Please understand that routine prescription refills, appointment scheduling and billing questions are not issues that the on-call physician can help you with. Please call during regular business hours with all non-urgent inquiries.

We accept cash, personal checks and credit cards (Visa, Mastercard, Discover and Care Credit).

We understand that temporary financial problems may affect timely payment. We encourage you to communicate any such problems so that we can assist you in the management of your account.

Thank you for your understanding and cooperation with this policy. It is our privilege to provide you with your medical care.

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I have read, understand and agree to the above Patient and Financial Policy. I understand that charges that are not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility.

Responsible Party

Date

Patient name if different from Responsible Party _____

HIPAA Form

Health Insurance Portability and Accountability Act

Consent for Purposes of Treatment, Payment and Healthcare Operations

By signing this form, I consent to the use or disclosure of my protected health information by **Diseases of the Ears, Nose and Throat, Inc.** for the purpose of providing treatment to me, obtaining payment for my health care bills or to conduct Diseases of the Ears, Nose and Throat Inc. health care operations. I understand that I have the right to revoke this consent, in writing, at any time, except to the extent that Diseases of the Ears, Nose and Throat Inc. has taken action in reliance on my prior consent.

My "protected health information" means any of my written and oral health information, including my demographic data that can be used to identify me, that has been created or received by Diseases of the Ears, Nose and Throat Inc., and that relates to my past, present or future physical or mental health or condition.

I understand that I have a right to review Diseases of the Ears, Nose and Throat Inc. Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of our health care operations. The Notice of Privacy Practices also describes my rights and Diseases of the Ears, Nose and Throat Inc. duties with respect to my protected health information. The Notice of Privacy Practices is posted in the lobby at the Diseases of the Ears, Nose and Throat location.

Diseases of the Ears, Nose and Throat Inc. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Diseases of the Ears, Nose and Throat Inc. and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I understand I have the right to request restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations. Diseases of the Ears, Nose and Throat Inc. is not required to agree to the restrictions that I may request, but if it does, it is bound by its agreement.

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I understand that diagnosis or treatment of me by Diseases of the Ears, Nose and Throat Inc. may be conditioned upon my consent as evidenced by my signature on this document.

Responsible Party

Date

Patient name if different from Responsible Party _____

(Over)

HIPAA Form Continued

Health Insurance Portability and Accountability Act

Home/ Daytime contact phone number: _____

Do we have permission to call your home? Yes No

May we leave a message with other residents? Yes No

To whom at your residence may we talk to about your medical treatment?

Name:_____ Relationship:_____

Home#:_____ Cell#:_____ Other phone:_____

Is this person your emergency contact also? Yes No If not, please list emergency contact below:

Name:_____ Relationship:_____

Home#:_____ Cell#:_____ Other phone:_____

Do we have your permission to call you at work? Yes No

Work phone #:_____

May we leave a message on your work voicemail? Yes No

May we leave a message at work requesting only that you return our call? Yes No

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If any of the above information changes, it is the Patient / Parent / Legal Guardian responsibility to contact our office.

Responsible Party

Date

Patient name if different from Responsible Party _____

