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VALLEY ENT
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Patient Profile

PATIENT INFORMATION

Name: _____

Address: _____

_____

City,State Zip: _____

Alternate: _____

Address _____

City,State Zip:_____

Home Phone: _____ [ ] preferred

Cell Phone: _____ [ ] preferred

Work Phone: _____ [ ] preferred

Is it ok for ValleyENT to contact you by Email?[ ]Y [ ]N

Email:_____

Contact By: [ ]Home Phone [ ] Cell [ ] Text Messaging*
*Text messaging may contain risks as to possession of, or access to patient's phone

PATIENT EMPLOYMENT

[ ] Employed [ ] Retired [ ] Unemployed [ ] Student

Employer:_____

PRIMARY INSURANCE

Insurance Name: _____

Policy ID#: _____Group#: _____

Policy Holder:_____

Date of Birth: _____

Relationship to Patient: [ ] Self [ ] Spouse [ ] Parent

SECONDARY INSURANCE

Insurance Name: _____

Policy ID#: _____Group#: _____

Policy Holder:_____

Date of Birth: _____

Relationship to Patient: [ ] Self [ ] Spouse [ ] Parent

Gender: [ ] M [ ] F
Date of Birth: _____Age:_____

Marital Status: [ ] Married [ ] Single [ ] Other: _____
Preferred Language: [ ] English [ ] Other _____
Race: [ ] Caucasian [ ] Black/African American

[ ] Asian [ ] Native American [ ] Hispanic

[ ] Other_ _____

Referring Physician:_____

Phone:_____

Fax: _____

Primary Care Physician:_____

Phone:_____

Fax: _____

Please list any other specialists currently seeing below:

Specialist:_____ Specialty:_____

Phone:_____

Specialist:_____ Specialty:_____

Phone:_____

EMERGENCY CONTACT

Name:_____

Number:_____

Relation:_____

PHARMACY INFORMATION

Pharmacy Name: _____

Address or Street Location: _____

_____

City:_____State:_____ Zip: _____

Phone: _____

Fax:_____

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VALLEY ENT, PC

BILLING AND FINANCIAL POLICY INFORMATION

Every attempt is made to comply with insurance company's requirements. Since policies and benefits differ among employers and individuals participating with each insurance company, we are unable to know the specifics of your policy. Your insurance company informs all participants that it is ultimately your responsibility to verify benefits and coverage information prior to having any services rendered. Valley ENT, PC cannot guarantee the cost of services performed will be covered by your insurance. To limit the charges that you may be responsible for, please ensure that we always have up-to-date information regarding your insurance coverage.

You will be responsible for payment of all services if any of the following circumstances apply:

- If you do not have insurance;
- If you do not have a referral when required and have elected to be seen
- If you are with an insurance company we are not contracted with; or,
- If a claim denial from the insurance company is not able to be resolved.

All patients are responsible for payment at the time of service. We do not bill for co-pays. If your insurance deductible has not been met, full payment of allowed charges will be collected at the time of service. If your deductible has been met, your coinsurance amount will be collected based on allowed amount of the charges.

Non-payment of amounts due may result in your scheduled appointment being re-scheduled to a later time when you have the funds available.

If any uncollected balance is not paid in full within 90 days of receiving a statement, we reserve the right to turn your account over to a collection agency. Valley ENT offers payment plans if you cannot pay your balance in full. The responsible party or guarantor of the account will be responsible for all collection fees, including legal expenses. A $40.00 fee will be applied to all returned checks.

A fee of $25.00 will be charged to patients requesting medical records for personal use and a $25.00 fee will be charged for family medical leave (FMLA) forms and physician-dictated letters for personal reasons.

NO SHOW / CANCELLATION POLICY

Effective June 1, 2011 there will be a $50.00 fee charged for no shows or for cancelled appointments with less than 24 hour notice (AHCCCS patients will be billed $3.00 per ARS 36-2930.01).

SURGERY CANCELLATION POLICY

A scheduling deposit is required prior to any surgery. This deposit will be refunded after your insurance company has processed payment for your claim, providing you have no balances due to Valley ENT, PC. For cancelled surgery appointments, we will refund your deposit in full providing the appointment is cancelled with 72 hours (excluding weekends) notice.

By signing this form, you agree to all the information listed above, authorize the release of any medical information necessary to process your claims and authorize payment of medical benefits to Valley ENT, PC, or supplier for services rendered.

_____ _____

Signature of Patient or Responsible Party Date

_____

Print Name

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PROCEDURES IN OFFICE

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 have become aware that some insurance carrier 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.

The physicians of Valley ENT only perform these procedures when deemed medically necessary to best diagnose and treat our patients. If you are presenting with a sinus or throat/voice complaint, there is a good chance the surgeon will need to perform one of these procedures.

Examples of in-office procedures include:

•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 tissues of the nasal passages AND the pharynx and larynx.

Please speak with the office manager, MA or front desk if you would like to know what your carrier allows for these procedures prior to their completion.

Patient Name (please print) :

_____

Patient/Guardian

Signature:_____ **Date:**_____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:_____ **Relationship:**_____

Signature:_____ **Date:**_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement but was unable to do so as documented below.

Date:
Reason:

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Patient Name: _____

Date of Birth: _____ **Account:** _____

PHI Acknowledgement

I have received a copy of the Privacy Rules from Valley ENT, P.C., and authorize the following list of people who may receive my Protected Health Information. I understand that I may revoke this authorization at any time by giving written notification to the office.

These people may receive my Protected Health Information:

Name: _____ Date of Birth: _____ Phone Number: _____

Relationship to Patient: ☐ Spouse ☐ Child ☐ Parent ☐ Other

Name: _____ Date of Birth: _____ Phone Number: _____

Relationship to Patient: ☐ Spouse ☐ Child ☐ Parent ☐ Other

Name: _____ Date of Birth: _____ Phone Number: _____

Relationship to Patient: ☐ Spouse ☐ Child ☐ Parent ☐ Other

Please check all that apply:

___May leave a message on voicemail at home #: ( ) _____

___May leave a detailed message on cellular phone #: ( ) _____

___May leave a detailed message on voicemail at work #: () _____

___May leave information with spouse or parent (name): _____

___May leave information with other family members/friends (names): _____

_____

___May leave a detailed message at different location #: ( ) _____

With my signature below, I acknowledge and understand that the information provided will be kept in my confidential medical record and abided by until revoked by me in writing or in person at Valley ENT.

It is my responsibility to notify my healthcare provider should I change one or more of the telephone numbers or names listed above.

Signed: _____ Date: _____

(Patient or parent/legal guardian if patient is minor

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Valley ENT Review of Systems

Name:_____ Date: _____

Please check *yes or no* if you **currently** have the following symptoms: ☑

ENT	Yes	No		Yes	No
Hearing loss			Facial pain		
Ringing in the ears			Loss of smell		
Room spinning dizziness			Postnasal drip		
Ear pain			Snoring		
Ear discharge			Difficulty swallowing		
Runny nose			Pain with swallowing		
Hard to breath through nose			Hoarseness		
Itchy nose			Nose bleeds		
Lump in neck			Bloody Sputum		

Neurologic	Yes	No	Cardiovascular	Yes	No	Respiratory	Yes	No
Headaches			Chest pain			Persistent cough		
Numbness			Palpitations			Wheezing		
Weakness			Shortness of breath					
Blurred vision								
Double vision								

Genitourinary	Yes	No	Musculoskeletal	Yes	No
Frequent urination			Joint pain		
Nocturnal urination			Joint swelling		
Painful urination			Limited mobility		

Integumentary	Yes	No	Psychiatric	Yes	No
Dry skin			Sadness		
Changing of mole			Abnormal mood		
Itchy skin			Insomnia		
			Anxiety		

General	Yes	No	General	Yes	No
Fever			Anorexia		
Weight loss					
Night sweats					
Fatigue					

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Patient Name:_____ DOB:_____

Medical Problems (Illnesses): check all that apply ☑

☐ High blood pressure	☐ Heart attack (MI)	☐ Stroke
☐ Atrial fibrillation	☐ Coronary artery disease	☐ Kidney failure
☐ Asthma	☐ Bleeding disorder	☐ DVT
☐ Sleep apnea	☐ COPD/ chronic bronchitis	☐ HIV
☐ Acid reflux	☐ Diabetes	☐ Hepatitis B or C
☐ Cancer (please write in):	☐ Other medical problems not listed:	

Past Surgeries (operations): check all that apply ☑

☐ Ear tubes	☐ Tympanoplasty	☐ Mastoidectomy
☐ Septoplasty	☐ Rhinoplasty	☐ Sinus surgery
☐ Tonsillectomy	☐ Adenoidectomy	☐ Thyroidectomy
☐ Cardiac stents	☐ Cardiac bypass	☐ Gastric bypass or banding
☐ Skin cancer	☐ Kidney transplant	
☐ Other surgeries:		

Social history: check all that apply ☑

Tobacco:	☐ Never	☐ Former: Year started _____ Year quit	
☐ Currently smoke:	☐ < 1 pack/day	☐ 1-2 packs/day	☐ 3 or more packs/day
Alcohol use:	☐ Never	☐ 0-2 drinks/day	☐ 3 or more drinks/day
Employment:	☐ Student	☐ Employed Occupation: _____	☐ Not employed

Family History: check all that apply ☑

	Family member		Family member
☐ Asthma		☐ Sinusitis	
☐ Hearing loss		☐ Thyroid goiter	
☐ Bleeding disorder		☐ Anesthesia problems	
☐ Stroke before 60		☐ Heart attack before 60	
☐ Meniere's disease		☐ Thyroid cancer	

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Valley ENT Medical History Form **Date:** _____
Name:

Current Medications: (please include over the counter medications and supplements)

Name of Drug	Dosage (Strength)	Frequency (times per day)

Drug Allergies:

Name of Drug	Reaction