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 by 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 aby 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 need 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 my 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 tot eh 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 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 ____

I have read, understand and agree to the above 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 ____________________________________