1) Complete each line entirely or indicate N/A 2) Print clearly 3) Complete ALL pages

PATIENT INFORMATION

Name: ____

Address: ____

____

City,State Zip: ____

Home Phone: ________________________ [ ] preferred

Cell Phone: __________________________ [ ] preferred

Work Phone: _________________________ [ ] preferred

Can We Leave Detailed Phone Messages?
Please Mark All That Apply: [ ] Home [ ] Cell [ ] Work

Email:____

Preferred Method of Contact:
[ ] Home Phone [ ] Cell Phone [ ] Text Messaging [ ] Email

Gender: [ ] M [ ] F **Date of Birth:** ___________________

Marital Status: [ ] Married [ ] Single [ ] Other ___________

Preferred Language: [ ] English [ ] Other ______________

Race: [ ] White [ ] Black/African American
[ ] Asian [ ] Other____________________

Ethnicity: [ ] Non-Hispanic [ ] Hispanic [ ] Other________

PATIENT EMPLOYMENT

Employer/School:_______________________________
[ ] Employed [ ] Retired [ ] Unemployed [ ] Student

Emergency Contact:_____________________________

Phone:____

Relation:_______________________________________

Pharmacy Name:______________________ **Address/Or Street Location**: ______________________________________

Phone:______________________________ **Fax**:________________________________

Referring Physician:___________________________________**Phone**:______________________**Fax**:________________
Is Your Referring Physician The Same As Your Primary Care Physician? [ ] Y [ ] N

Primary Care Physician:________________________________**Phone**:______________________**Fax**:________________

Please List Any Other Specialists You Currently See

Specialist:___________________________ **Phone**:___________________________ **Specialty**:_____________________

Specialist:___________________________ **Phone**:___________________________ **Specialty**:_____________________

Primary Insurance: ________________________________ **Policy ID**:________________________ **Group#**:_____________

Policy Holder:__________________________________ **Date Of Birth**: _____________________
Relationship To Patient: [ ]Self [ ]Spouse [ ]Parent [ ] Other: _________________________

Secondary Insurance:______________________________ **Policy ID**: ________________________ **Group#**:____________

Policy Holder:_________________________________ **Date Of Birth**:_______________________
Relationship To Patient: [ ]Self [ ]Spouse [ ]Parent [ ] Other: __________________________

Patient Name:__________________________________**DOB**___________

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BILLING AND FINANCIAL POLICY

Every attempt is made to comply with insurance company's requirements. Since policies and benefits differ among every type of insurance and the plans within them, we are unable to know the specifics of your policy. Insurance companies inform all participants that it is ultimately the patient's 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.

______**Initial** All patients are responsible for payment at the time of service. This includes co-pays, and any other patient responsibility such as deductibles, and /or any coinsurance amount if it applies. We collect based off the contracted allowed amount we have with your insurance.

______**Initial** Patients are responsible for billed amounts due in the event that we are not contracted with their insurance plan, they do not have insurance, there is not a valid referral on file, or if there is a claim denial from the insurance company that we are unable to resolve.

______**Initial** Please be aware that certain procedures performed in our office are not included under the standard office visit. These procedures are billed separately and in addition to office visit charges. Some insurance companies will classify these procedures as "surgery". At times these charges will go towards the deductible, and not be covered under a copay. The physicians of Valley ENT only perform these procedures when deemed medically necessary to best diagnose and treat our patients. It is ultimately the patient's responsibility to know how their insurance benefits are applied. These procedures can consist of Nasal or Throat endoscopes, Hearing exams, Ear Cleanings, Microscope exam, and many other procedures. If you have any question regarding what may be done during your visit or the procedure codes, please don't hesitate to ask the front office or medical assistant.

______**Initial** Non-payment of past due amounts may result in your scheduled appointment being re-scheduled to a later time when you are able to bring your account to current, or make payment arrangements.

______**Initial** 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.

______**Initial** A $40.00 fee will be applied to your account should your check be returned by the bank as unpaid.

______**Initial** There is a $25.00 fee for FMLA forms that need to be completed outside of having surgery and any physician dictated letters for personal use. Attorney fees may vary in price per request.

______**Initial** NO SHOW/ CANCELLATION POLICY: There will be a $50.00 fee charged for no shows or cancelled appointments with less than a 24hour 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 AUTHRORIZE PAYMENT OF MEDICAL BENEFITS TO Valley ENT, PC OR SUPPLIER FOR SERVICES RENDERED.

____ ____________________

Signature of Patient or Responsible Party Date

____

Print Name of Above

Patient Name:_________________________________**DOB**___________

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PHI ACKNOWLEDGEMENT

______**Initial** I acknowledge that I have been offered a copy (available at front desk) of the Privacy Rules from Valley ENT, PC, 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 along with any referring, or primary care physicians listed on the patient information sheet 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

______**Initial** 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 health care provider if any information has changed.

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

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.

____ ___________________
Signature of Patient or Responsible Party Date

____
Print Name of Above

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:___________________________________**DOB**___________

PATIENT REVIEW OF SYSTEMS

Please check **YES** or **NO** to each section if you **CURRENTLY** have or do not 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 breathe through nose			Hoarseness		
Itchy nose			Nose bleeds		
Lump in neck					

Neurologic	**Yes**	**No**	**Cardiovascular**	**Yes**	**No**
Headaches			Chest pain		
Numbness			Palpitations		
Weakness			Shortness of breath		
Blurred vision					
Double vision					

Respiratory	**Yes**	**No**	**Gastrointestinal**	**Yes**	**No**
Cough			Nausea		
Shortness of breath			Vomiting		
Wheezing			Diarrhea		
			Blood in stool		

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

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Patient Name:___________________________________**DOB**____________

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Medical History

Please check all that apply

Medical Problems (Illnesses)	
High blood pressure	
Atrial fibrillation	
Asthma	
Sleep apnea	
Acid reflux	
Heart attack (MI)	
Coronary artery disease	
Bleeding Disorder	
Diabetes	
Stroke	
Kidney failure	
DVT	
HIV	
Hepatitis B or C	
Cancer(Please write in):	
Other medical problems not listed:	

Past Surgeries (Operations)		Year
Ear tubes		
Tympanoplasty		
Mastoidectomy		
Sinus surgery		
Septoplasty		
Rhinoplasty		
Tonsillectomy		
Adenoidectomy		
Thyroidectomy		
Cardiac stents		
Cardiac bypass		
Gastric bypass or banding		
Skin cancer		
Kidney transplant		
Other surgeries:		

Social History

Please check all that apply

Employment	
Student	
Not employed	
Employed	
Occupation:	

Alcohol use	
Never	
0-2 drinks/day	
3 + drinks/day	

Tobacco			
Never		Currently smoke	
Former: Yr Started_________		< 1 pack/day	
Yr Quit___________		1-2 packs/day	
Vaping: Yr Started_________		3 + packs/day	
Yr Quit ___________			

Family History

Please check all that apply

Family History		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		

Patient Name:___________________________________DOB____________

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Current Medications

☐ NO Current Medications Date:________________________

Please include over the counter medications and supplements

Name of Drug	Strength	Frequency	What condition do you take this for?

Drug Allergies

☐ NO Known Drug Allergies

Name of Drug	Reaction

VALLEY ENT

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

TO REQUEST RELEASE OF MEDICAL INFORMATION PLEASE COMPLETE AND SIGN BELOW.

I, ____________________________________, hereby voluntarily authorize the disclosure of information from my health records.
(Name of Patient)

Patient Name: ____ Patient's Date of Birth: ____________________

Patient's Address______________________________ City ___________________ State ___________ Zip Code ___________

Home Phone ________________________________ Cell or Work Phone ____

Information Requested:

_______The complete medical records pertaining to my treatment and care *(Excludes Psychotherapy Note)
Psychotherapy Notes must be on a separate request form.

_______Specific test, labs, notes or date of service ____

Purpose of Release: ____,
(Patient's request, dispute, referral, other)

The information is to be provided to:

Name of Person/Organization/Facility:____

Address____________________________________ City ___________________ State ___________ Zip Code ___________

Phone Number:____

1. I understand that this authorization will expire on (insert date) ________________________.
2. I understand that I may revoke this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying Valley ENT P.C. in writing.
3. I understand that I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).
4. I may inspect or copy any information used or disclosed under this agreement.
5. I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be re-disclosed and would no longer be protected by these regulations.

____ ________________________________
Patient's Signature or Patient's Representative Date

____ ________________________________
Print Name of Patient Representative Relationship to Patient

YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM