SCOTTSDALE
EAR, NOSE & THROAT

Patient Profile

Date:_____

Name First: _____ Last: _____ Preferred:

DOB: _____ Marital Status:_____ ☐ Male ☐ Female

Social Security #: _____ Age: _____

Address Street: _____ Apt: _____

City: _____ State:_____ Zip: _____

Phone Home: _____ Cell: _____ Work: _____

Email: _____ @ _____

Referring Physician: Name: _____

Phone: _____ Fax: _____

Primary Care Physician: Name: _____

Phone: _____ Fax: _____

What would you like to see us about?

☐ Ear issues
☐ Nose issues
☐ Throat issues
☐ Head or neck issues
☐ Trouble hearing
☐ Other- please describe:_____
_____
_____

What is your employment status?

☐ Employed
☐ Retired
☐ Unemployed
☐ Student

If employed, by who?
_____

Primary Insurance: _____

Policy ID#: _____

Group#: _____

Policy Holder: _____

Date of Birth: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent

Secondary Insurance: _____

Policy ID#: _____

Group#: _____

Policy Holder: _____

Date of Birth: _____

Relationship to Patient: ☐ self ☐ Spouse ☐ Parent

Identifying Information:

Preferred Language: ☐ English ☐ Spanish ☐ Other:_____

Ethnicity: ☐ Non-Hispanic ☐ Hispanic

Race: ☐ Caucasian ☐ Asian ☐ Native American ☐ Black/African American ☐ Other:_____

Pharmacy Information:

Pharmacy Name: _____

Address Street: _____ Suite: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

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Review of Symptoms

Date: _____

Patient Name: _____ **Date of Birth:** _____

Please check yes if you currently have any of the following symptoms.

ENT:	Yes	No	Comments		Yes	No	Comments
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				Sore Throat			
Coughing up blood							

Neurologic	Yes	No	Comments	Cardiovascular	Yes	No	Comments
Headaches				Chest pain			
Numbness				Palpitations			
Weakness							
Blurred vision							
Double vision							

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

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

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

General	Yes	No	Comments
Fever			
Weight loss			
Night sweats			
Fatigue			

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Allergy Questionnaire - Intake Questions

Date:_____

Patient Name:_____ Date of Birth:_____

Reviewed by: _____

1. Do you experience symptoms of allergies? ☐ Yes ☐ No

2. Do you experience any of these symptoms more than twice per year: ☐ Yes ☐ No

   Cough, Nasal Congestion, Difficulty Breathing, Headaches, Wheezing, Runny Nose, Sore Throat, Itchy/Irritated Eyes, Ear Pain, Unexplained Fatigue, Skin Irritation or Snoring?

3. Have you ever been diagnosed with asthma or bronchitis? ☐ Yes ☐ No

4. Regarding possible food allergies, do you experience any of the following (please check all that apply):

   - ☐ Bloating after eating
   - ☐ Diarrhea
   - ☐ Constipation
   - ☐ Stomach Pain
   - ☐ Upset Stomach
   - ☐ Indigestion
   - ☐ Nausea
   - ☐ Vomiting
   - ☐ Tingling of the mouth or other unusual sensation

5. Are you interested in learning more about our allergy testing? ☐ Yes ☐ No

6. If you answered yes to question 5, then do you have any of the following (please check all that apply):

   - ☐ History of Anaphylaxis
   - ☐ On a Beta Blocker
   - ☐ Uncontrolled Asthma
   - ☐ Currently Ill
   - ☐ Pregnant
   - ☐ Immune Compromised

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History and Physical

Patient Name: _____ **Date of Birth:** _____

Please check *all* that apply.

Social History:			
Tobacco:	☐ Never ☐ <1 pack per day ☐ Year Started:	☐ Former smoker ☐ 1 - 2 packs per day ☐ Year Quit:	☐ Currently smoke ☐ 3 or more packs per day
Alcohol:	☐ Never	☐ 0 - 2 drinks per day	☐ 3 or more drinks per day
Employment:	☐ Employed Occupation:	☐ Not employed	☐ Student

Family History:	Relationship	FAMILY ONLY	Relationship
☐ Asthma		☐ Sinusitis	
☐ Hearing loss		☐ Anesthesia problems	
☐ Bleeding disorder		☐ Meniere's disease	
☐ Thyroid goiter		☐ Stroke before 60	
☐ Thyroid		☐ Heart attack before 60	

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

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

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Current Medications

Date:_____

Patient Name:_____

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

Name of Drug	Dosage (Strength)	Frequency (times per day)	What is the medication for?

Drug Allergies:

Name of Drug	Reaction

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Patient's Name: _____

Date of Birth: _____

PCP: _____

ATTENDING PHYSICIAN LIST

(Who are your doctors that you see)

Cardiologist:

Name : _____

Address : _____

_____

Phone: _____

Fax : _____

Pulmonologist:

Name :

_____

Address :

_____

_____

Phone:

_____

Fax : _____

Dermatologist:

Name :

_____

Address :

_____

_____

Phone:

_____

Fax : _____

Oncologist / Radiation Oncologist:

Name :

_____

Address :

_____

Phone:

_____

Fax : _____

Gastroenterologist:

Name :

_____

Address :

_____

Phone:

_____

Fax : _____

Neurologist:

Name :

_____

Address :

_____

Phone:

_____

Fax : _____

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AUTHORIZATION TO DISSEMINATE INFORMATION ON DEVICES OR SERVICES

Valley ENT, PC, an Arizona professional corporation, would like to communicate with you from time to time on new clinical services and/or medical devices that can assist you with your healthcare needs. In order to mail you information on new medical devices or new clinic services that we offer, we must request your authorization to use your name and address to send you the information.

This request is strictly voluntary. It is not a condition of any treatment, payment, benefit, etc. The requested information will ONLY be used by VENT and its employees. No information will be provided to any outside vendor or agent.

The purpose of this request is strictly to provide information from the physician's office and its professional staff to you.

This Authorization will remain in effect for 3 years following my last office visit with VENT, at which time this Authorization will expire. A photocopy of this Authorization will be considered as effective and valid as the original.

I understand that I have the right to revoke this Authorization in writing at any time by sending such written notification to the attention of VENT's Privacy Officer at 9097 East Desert Cove, Scottsdale, AZ 85260.

Signature of Patient or Patient's Representative

Date

Printed Name of Patient or Patient's Representative

[PATIENT OR PATIENT'S REPRESENTATIVE MUST RECEIVE A COPY OF THIS EXECUTED AUTHORIZATION FORM]

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Privacy Policy

NOTICE OF PRIVACY POLICY FOR PROTECTED HEALTH INFORMATION (PHI)
The office of Valley Ear, Nose and Throat is dedicated to protect your "nonpublic personal health information". This notice is to tell you how and why we collect that information, and who has access to that information.

HOW WE COLLECT YOUR INFORMATION:
Your personal demographic information such as name, address, birth date, social security number and medical insurance information is obtained from you. This is why we ask you to fill out the patient information sheet and why we ask for a copy of your insurance card. This ensures that the information we collect is correct.

If you came to our practice through a hospital encounter, we may obtain that information from the hospital. However, on your first visit to this office, we will ask you to fill out our information sheet to ensure that the information we received from the hospital was correct. We may also ask a doctor or other health care provide who referred you to this practice to give us health information that will enable us to better treat your medical condition. This benefits you in that we will have test results that have already been obtained by the referring entity.

WHY WE COLLECT THIS INFORMATION:
We collect this information so that we can treat your medical condition and obtain payment from you or your health insurance.

MAINTAINING ACCURATE AND TIMELY INFORMATION:
To ensure that the information we maintain is accurate, each time you visit this office you will be asked if any of your information needs to be updated.

WHO HAS ACCESS TO THIS INFORMATION:
Any person or persons you designate in writing, people directly involved in your medical care, people creating and maintaining your medical record, and those entities that need your information to process health care claims and obtain payment for our services have access to your Protected Health Information. Entities such as Governmental Oversight agencies, Judicial and Administrative Proceeding, Law Enforcement Agencies, Coroners and Medical Examiners, and Organ Procurement Organizations may obtain copies of your Protected Health Information. Law mandates these entities and this practice has no jurisdiction over such entities.

HOW WE PROTECT YOUR INFORMATION:
We release your information only to those people who need your information. We maintain physical, electronic, and procedural safeguards so that no one but persons involved in your healthcare or entities that need this information for claims processing have access to your Protected Healthcare Information.

YOUR RIGHTS:
You have the right to inspect your Protected Healthcare Information. You also have the right to amend any errors you may find in your record (the physician or other healthcare provider is not required to make such amendments). You may file a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your Protected Healthcare Information. If you leave this practice, your Protected Healthcare Information will continue to receive the protection outlined in this notice.

COMPLAINTS/COMMENTS:
If you feel your privacy rights have been violated you may file a written complaint at our office or you may contact the Chief Executive Officer of this practice at (480) 614-5406. You may also file a complaint by mailing it to the Secretary of the Department of Health and Human Services at 200 Independence Avenue, S.W Room 509F, HHH Building, Washington D.C. 20201.

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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 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.**

Insurance companies require submission of all claims within specified time limits. If you have a change in your insurance, and you fail to inform us of the change, we may not be aware until your insurance company denies a claim. Denials often arrive after the filing limits have expired, preventing us from re-filing the claim with another insurance company. 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.

If you 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 payments 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 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

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 carriers are classifying these procedures as "surgery" and applying the charges to a higher deductible amount. The result may be 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 and that all procedures are performed in the best interest of patient care.

Examples of in-office procedures include:

- Flexible Laryngoscopy / Nasopharyngoscopy

This procedure involves passing a long thin flexible fiber-optic scope through the nasal cavity and into the throat and or pharynx . The fiber-optic scope enables the physician to visualize areas of the sinus openings, throat and larynx , not readily seen using mirrors.

- Nasal Endoscopy

This procedure uses the flexible or rigid scope attached to a light source to view areas of the nasal cavities and sinus pas- sages that cannot be viewed by the physician using the standard nasal speculum and head mirror.

- Nasal Endoscopy with Debridement or Biopsy

This procedure uses the flexible or rigid scope attached to a light source to view areas of the sinus cavities, nasal recesses that cannot be viewed by the physician using the standard nasal speculum and head mirror and casting, crusting, debris or tissue will be removed.

Please speak with our clinical assistant if you have any questions.

_____ _____

Patient / Guardian Signature Date

_____

Print Name

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HIPAA 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