Pinon Hills ENT Financial Policy

Contracted Medical Insurance

If you have medical insurance and we are contracted with them, we will gladly submit fees for your covered medical services to your insurance company. All co-pays, coinsurance and deductibles are due at the time of service. If your insurance requires a referral from your primary care physician it is your responsibility to acquire this. If a referral is needed but not received, we will have to reschedule your appointment to a later date.

Non-Contracted Medical Insurance

If you have medical insurance and we are not contracted with your insurance company, we will gladly submit fees for your covered medical services to your insurance company. However, we expect full payment at the time of service due to the fact that your insurance company will pay you because we are not a contracted provider. If payment in full is not received we will have to reschedule your appointment for a later date.

Payment for Services

Payment for services, including co-pays, deductibles and coinsurance are due at the time services are rendered. Failure to pay co-pays, deductibles or coinsurance may result in the rescheduling or cancellation of your appointment. Returned checks and unpaid balances after 60 days will be sent to an external collection agency that will result in added collection fees.

For your convenience we accept cash, checks, MasterCard, Visa, and Discover.

If you have any questions about the above information please do not hesitate to ask us.

There will be a $35.00 check fee for all returned checks. If this is not paid within 60 days, this will be sent to our collection agency.

Cancellation and No-Show Policy

We require 24 hours notice in the event of a cancellation or rescheduling of an appointment. There is a $30.00 charge for missed appointments without proper notice. The patient should understand that this charge will not be covered by insurance and will be the patient's responsibility. In the event that the patient has some unforeseen problem, our office may choose to overlook it the FIRST time.

My signature below constitutes acknowledgement and acceptance of the above policies.

X______________________________ ______________________________

Patient or Guarantor Date

Notice of Privacy Practices

X I, ________________________ am a patient of Pinon Hills ENT. I have received a copy of the Pinon Hills ENT NOTICE OF PRIVACY PRACTICES published and effective April 14, 2003.

X______________________________ ______________________________

Patient's Signature Witness Signature

Date: X______________________________

PLEASE PRINT

SS# ________ - ________ - ____________ **Circle One**

First Name ______________________ Marital Status: Married Single Divorced Widow Child Other

Middle ______________________ Male ______ Female ______ DOB ____ / ____ / ______

Last ______________________ Race ______________ Religion ______________

Mailing Address ____

City ______________ State ______________ Zip Code ______________

Home Phone # ______________ Cell# ______________ Email Address ______________

Employer ______________________ Bus. Phone # ______________

Employer Address ____

City ______________ State ______________ Zip Code ______________

Primary Physician ______________ Referring Physician ______________

Preferrred Pharmacy ____

Spouse or Father (Guardian)

SS# ______________________ DOB ______ / ______ / ______

Name ____

Mailing Address ____

City ______________________ State ______ Zip Code ______________

Home Phone # ______________________ Cell ______________

Employer ______________________ Phone ______________

Employer Address ____

City ______________________ State ______ Zip Code ______________

Mother (Guardian)

SS# ______________________ DOB ______ / ______ / ______

Name ____

Mailing address ____

City ______________________ State ______ Zip Code ______________

Home Phone # ______________________ Cell ______________

Employer ______________________ Phone ______________

Employer Address ____

City ______________________ State ______ Zip Code ______________

PLEASE LIST AN EMERGENCY CONTACT

Name ______________________ DOB ______ Relationship To Patient ______ Phone ______________

I AUTHORIZE PAYMENT DIRECTLY TO THE PHYSICIAN OF THE SURGICAL AND/OR MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR HIS/HER SERVICES AS DESCRIBED. I HEREBY AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY TREATMENT NECESSARY TO PROCESS INSURANCE CLAIMS. I FURTHER ACKNOWLEDGE THAT I AM RESPONSIBLE FOR ALL DEDUCTIBLES, CO-PAYS NON-COVERED SERVICE AMOUNTS AND REFERRALS..

Signature of Responsible Party ______________________ Date ______________

Pinon Hills Ear, Nose and Throat Associates, PA

In order to best serve your medical needs, we ask that you complete the following medical history form as completely as possible. The Health Care Consumer (HCC) - Health Care Provider (HCP) relationship is a privileged relationship built on trust and honesty. By completing and signing this form, you acknowledge that you understand that any intentionally false information may seriously and adversely affect your health.

Patient Name: ______________________________ DOB: ______________________________

Reason for Today's Visit: ______________________________ Today's Date: ______________________________

Referring Doctor: ______________________________ Primary Care Physician: ______________________________

Height: ______FT _____IN Weight: ______LBS Are your immunizations up to date: ______________________________

(*STAFF USE ONLY*) Temp: __________ HR: __________ Pulse: __________ BP:__________ O2:__________

Have you been diagnosed with or are you currently having problems with any of the following:

(Please check all that apply)

- ☐ Emphysema
- ☐ Bleeding Problems
- ☐ Liver Problems
- ☐ Asthma
- ☐ Seizures
- ☐ Kidney Problems
- ☐ Heart Disease
- ☐ Arthritis
- ☐ Trouble Swallowing
- ☐ Stroke
- ☐ Diabetes
- ☐ Heartburn
- ☐ Thyroid Problem
- ☐ Headaches
- ☐ Pneumonia
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ High Cholesterol
- ☐ Tuberculosis
- ☐ Seasonal Allergies
- ☐ Dizzy Spells

If you have any other health problems that are not listed above, please list and explain here:

____

____

SURGICAL HISTORY: Have you ever had any prior surgical procedures? If yes, please list them below.

Type of Surgical Procedure:	Date or age at time of Operation:
1.	
2.	
3.	
4.	
5.	

MEDICATIONS: Please list (or show us your own printed record) all prescriptions and non-prescription medications.

Medication	Dosage (mg/pill)	Frequency

Are you allergic to any medications? If yes, please list below and please include type of reaction:

Medication:	Type of reaction you experience:

FAMILY HISTORY: Please list any close relatives with a history of the following:

	Relative		Relative
☐ Cancer		☐ Stroke	
☐ Hearing Loss		☐ Diabetes	
☐ Heart Disease		☐ Kidney Problems	
☐ High Blood Pressure		☐ Bleeding Problems	
☐ Neurology/Brain		☐ Anesthesia Problems	

SOCIAL HISTORY:

Employed/Retired/Unemployed /Disabled (circle one) If employed, please state occupation: ____________________

Marital status (circle one): Single, Partner, Married, Divorced, Widowed, other: ____________

Alcohol Use ☐ Yes ☐ No ☐ Never If yes, circle one *occasionally* *Less than 10/week* *More than 10/week*

Tobacco Use ☐ Yes ☐ No If yes, ________ pack(s) per day for _______ years. If you quit, _____ years ago

Other tobacco use: ☐ Chew If yes, how much? ________

REVIEW OF SYSTEMS:

Do you currently have or have had any of the following symptoms in the past year? If yes, please check the appropriate box. If none of the symptoms apply to you, please check the No Problems box.

General:
- ☐ Fever
- ☐ Weight Loss/Gain
- ☐ Night Sweats
- ☐ Fatigue/ Weakness
- ☐ **No Problems**

Eyes:
- ☐ Vision Change
- ☐ Blurred Vision
- ☐ Itchy Eyes
- ☐ **No Problems**

Ears/Nose/Throat:
- ☐ Sore Throat
- ☐ Swallowing Problems
- ☐ Hoarseness
- ☐ Nasal Drainage
- ☐ Nasal Obstruction
- ☐ Snoring
- ☐ Nose Bleeding
- ☐ Hearing Loss
- ☐ Ear Pain
- ☐ Tinnitus (Ear Ringing)
- ☐ Vertigo/Dizziness
- ☐ Neck Mass
- ☐ **No Problems**

Cardiovascular:
- ☐ Chest Pain
- ☐ Irregular Heart Rhythm
- ☐ **No Problems**

Respiratory:
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ **No Problems**

Gastrointestinal:
- ☐ Nausea/Vomiting
- ☐ Heartburn
- ☐ **No Problems**

Women Only:
- ☐ Possible Pregnancy

Integument:
- ☐ Rash
- ☐ Hives
- ☐ New Skin Lesions
- ☐ **No Problems**

Neurological:
- ☐ Seizures
- ☐ Tingling or Numbness
- ☐ Headaches
- ☐ Lightheadedness
- ☐ **No Problems**

Musculoskeletal:
- ☐ Bone/Joint Pain
- ☐ **No Problems**

Endocrine:
- ☐ Kidney Stones
- ☐ Excessive Urination
- ☐ Excessive Thirst
- ☐ Hot/Cold Intolerance
- ☐ **No Problems**

Psychiatric:
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ **No Problems**

Blood/Lymphatic:
- ☐ Easy Bleeding
- ☐ Easy Bruising
- ☐ Swollen Glands
- ☐ **No Problems**

Allergic-Immunologic:
- ☐ Seasonal Allergies
- ☐ Sneezing
- ☐ Congestion
- ☐ **No Problems**

Signature of Patient/Parent or Guardian ________________________________ Date: ____________

No Changes Date: ________ ________ ________ ________ ________ ________ ________ ________

PINON HILLS EAR, NOSE, AND THROAT ASSOICATES, PA

DL WILKEY, MD BRETT M CLARKE, MD

Minor Procedure Notification

Minor surgical procedure examples are: laryngoscopy, nasal endoscopy (physician inserts "tube" into the nose to see the nose and/or throat), removal of lesion-head and neck, surgery for fluid in ear(s), debridement of sinuses (may be done following sinus surgery and there are no global follow up days for sinus surgery therefore, there is a charge for this procedure if done). There are other surgeries that may be performed in the office and this list is not all inclusive. If you have any questions, please ask prior to seeing the physicians.

DATE: ______________

PATIENT NAME: ____

Your insurance company requires that we bill our services to you using a coding system known as CPT (Current Procedural Terminology). The codes used to describe the services we did for you are found in the "surgery" section of the CPT codebook. This does not mean we are implying that you had an operation. This is merely the way the CPT book is organized for ease of use by both the insurance companies and physicians.

If you require a procedure be performed in this office during the course of your care today or in the future, it will be shown on your Explanation of Benefit form from your Insurance company as a surgical procedure. As such, your insurance company may apply a surgical co-insurance responsibility or deductible to this procedure which you are responsible for.

Please know that we have correctly performed and documented the services as required by the CPT coding guidelines.

By signing below, you acknowledge responsibility for all co-insurance and co-pays which are separate and In addition to your office visit co-pay depending on your insurance policy.

PATIENT OR PATIENT REPRESENTATIVE SIGNATURE:

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