New Patient Information

PATIENT INFORMATION

Name (First, M.I. Last): ________________________________ Nickname: _______________

Date of Birth: _____________________ Marital Status: _______________ Sex: Male/ Female

Address: ____

City, State, Zip ____

Phone #: _________________________ Social Security #: _______________

____

Work #: __________________________ Cell #: ___________________________________

Employer & Employer Address:

____

Referring Physician: ____

SUBSCRIBER INFORMATION

(This Section Only Needs to Be Completed If The Insurance Is In Another Name)

Name: ______________________________ Relationship to patient: ____________________

Date of Birth: ____________________ **Social Security #:** ___________________________

Address: (if different from above) ____

Home Phone #: _____________________ Work Phone #: ____________________________

EMERGENCY CONTACT: ______________________ Phone #: ______________________

MEDICAL RELEASE AUTHORIZATION, FINANCIAL RESPONSIBILTIY AND INSURANCE ASSIGNMENT

I, ___________________________________ hereby authorize WENT to apply for benefits on my behalf for covered services rendered. I request payment from my insurance company be made to the above named provider.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered, and that my insurance coverage is a contract between me and the insurance carrier, and not between the insurance carrier and WENT, and that I am still fully responsible for all fees. Should timely payment of this account not be made, I authorize WENT to retain the services of an attorney and/or collection agency to assist with the collection of any outstanding balance. Any expenses incurred by such action shall become an additional liability for which I assume responsibility.

If applicable, I request that payment of authorized Medicare benefits be made to WENT for any services rendered. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information, to my insurance company, or its agent, in order to determine insurance benefits to which I may be entitled. This authorizes WENT to release and/or send medical information regarding my case to other consulting and/or referring physicians.

Due to our contractual agreement with your insurance company we require payment be made for all Co- pays, Coinsurances and Deductibles at the time of your visit unless other arrangements have been made prior to services being rendered. I will be fully liable for charges on my account, I understand when I receive a statement from the WENT I will have 30 days to pay before my balance starts to accrue interest at a rate of 21% per annum. After 45 days, an unpaid balance will be charged a late fee of $20.00 that will be applied to my patient account. Should I default on the payment of my account, I agree to be responsible for charges accrued related to the collection of my account balance.

We are now requiring 24 hours notice of cancellation of appointments, otherwise you account will be charged according to the type of appointment you had scheduled. Please note we are also adding a “no show” fee to your account, if you do not show up for you appointment. A schedule of cancellation and no show fees is available at your request.

____

Signature **Date**

2013 Notification of New WENT Group Cancellation /No Show Policy

Washington ENT Group is now requesting 24-hour notice for appointment cancellation. If notification is not provided within 24 hours, you will be responsible for a charge of $35. A No-Show fee is now in effect as well. If you fail to show up for an appointment, Washington ENT Group will be charging your patient account for $75.00 to cover the missed appointment slot. We are sorry for any inconvenience this may cause; however, we need to make every effort to maintain adequate schedules for our physicians and clinical providers. Thanks for your understanding in this matter.

Notification of Patient Responsibility

I authorize WENT Group/ DC Audiology to apply for benefits on my behalf for my medical services rendered by them or their associates. I request and authorize payment from my insurance company be made directly to WENT Group / DC Audiology. I certify that all information I have provided is completely accurate. I understand my insurance coverage is an agreement between the insurance carrier and myself, that I will be fully liable for charges on my account. I understand that I will be responsible for payment for any services rendered which are not covered by my insurance plan(s). I agree to pay any deductibles and co-pays at the time services are rendered. I understand that once the WENT Group/ DC Audiology sends me a statement of my account ("patient bill"), I have 30 days to pay before my balance starts to accrue interest at a rate of 21% per annum. After 45 days, an unpaid balance will be charged a late fee of $20.00 that will be applied to my patient account. Should I default on the payment of my account, I agree to be responsible for charges accrued related to the collection of my account balance.

I authorize the release of any necessary information, including medical information, for this or any related claim to my insurance. A copy of this authorization is to be considered as valid as the original.

______________________________ ________________________

Patient /Guardian Signature **Date**

HEALTH AND HISTORY FORM

NAME: ____DOB _______________________

REASON FOR VISIT: ____

REFERRING DOCTOR: ____

PREFERRED PHARMACY PHONE #: ____

DATE OF FIRST SYMPTOMS ____

PRIMARY CARE PHYSICIAN ____

MEDICATIONS: (List all current prescriptions/non-prescription medications)

____

____

____

ALLERGIES: (List all current medication, iodine, shellfish, environmental or other allergies)

____

____

____

HOSPITALIZATION AND SURGERIES

Reason and Dates:

____

____

Do you smoke?☐Yes ☐ No If yes how much? ____________ How long? _______________

Did you ever smoke? ☐ Yes ☐No Quit ___________________

Other Tobacco Products: ☐Yes ☐ No

What Type? _________________ How Much? _______________________

Alcoholic beverages? ☐Yes ☐No

Number per day _________ Number per week __________ Number per month ______________

DO YOU OR DID YOU EVER HAVE ANY OF THESE PROBLEMS?

RESPIRATORY:

☐ Asthma ☐ Emphysema ☐ Pneumonia ☐ Upper Respiratory Infection

☐ Bronchitis ☐ Pulmonary Embolus ☐ Other ____________________

CARDIOVASCULAR:

☐ Heart Attack ☐ Chest Pain (Angina)

☐ Heart Failure ☐ High Blood Pressure

☐ Heart Murmur ☐ Irregular Heart Beat

☐ Coronary Artery Disease ☐ Peripheral Vascular Disease

☐ Elevated Cholesterol, Lipids, Triglycerides

☐ Other _____________________________________

GASTROINTESTINAL:

☐ Hepatitis ☐ Cirrhosis

☐ Hepatitis A ☐ Liver Failure

☐ Hepatitis B ☐ Gallstones

☐ Hepatitis C ☐ Ulcers (Duodenal or Peptic)

☐ Reflux ☐ Other ___________________________

ENDOCRINE:

☐ Diabetes ☐ Hyperthyroidism ☐ Hypothyroidism

☐ Parathyroid ☐ Hashimoto ☐ Pituitary

UROLOGY:

☐ Kidney Stones ☐ Prostatitis ☐ Renal Failure

☐ BPH ☐ Nephritis ☐ Other _________________________

EYES:

☐ Cataracts ☐ Glaucoma ☐ Blindness ☐ Other

MUSCULOSKELETAL:

☐ Arthritis ☐ TMJ ☐ GOUT ☐ Spinal Stenosis

☐ Degenerative Disc Disease ☐ Fibromyalgia ☐ Spinal Fusion

HEMATOLOGIC

☐ Anemia ☐ Leukemia (CLL) ☐ Lymphoma

☐ Bleeding Disorders ☐ Deep Venous Thrombosis

PSYCHIATRIC:

☐ Depression ☐ Anxiety ☐ Bi-Polar Disorder

NEUROLOGIC:

☐ Headache ☐ Stroke ☐ Multiple Sclerosis

☐ Seizures ☐ Speech Problem ☐ Myasthenia Gravis

☐ Migraines ☐ Bell 's palsy ☐ Tremor

☐ Other ________________________________

OTOLOGY:

☐ Hearing Loss ☐ Impacted Cerumen ☐ Vertigo/Dizziness

☐ Middle Ear infection ☐ Deafness ☐ Tinnitus/Ringing in ears

☐ External Ear infection ☐ Perforation of eardrum

☐ Ear fullness/pressure ☐ Other __________________________

CANCER:

☐ Yes ☐ No

Type: ____

Any other medical problems the physician should know?

____

____

____

____

Signature ________________________________

Date ____________________

NOTICE OF PRIVACY PRACTICES FOR THE WASHINGTON ENT GROUP

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY AND SIGN BELOW.

Introduction:
At The Washington ENT Group, we're committed to treating and using protected health information (PHI) about you responsibly. This Notice of Privacy Practices describes how and when the personal information we collect from you is used and disclosed. It also describes your rights as defined by federal regulations.

Understanding Your Health Record/Information:
Each time you visit our facility we make a record of your visit. This record typically consists for your symptoms, examination and test results, diagnoses, and a plan for future care or treatment. This information, often referred to as your medical records, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third party payer can verify that services billed were actually provided
- A tool in educating health professionals
- A source of data for medical research
- A source of information for public health officials charges with improving the health of the nation
- A source of data for facility planning and marketing
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your records and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights:
Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- Obtain a paper copy of the notice of information practices upon request
- Inspect a copy of your health record. You must submit a written request to the privacy officer of this practice in order to inspect and/ or copy your health information. We may deny your request in certain limited circumstances. You may request that the denial be reviewed. The person reviewing your request at this point will NOT be the same person who denied your initial request. The outcome of this review will be complied with
- Amend your health record if you feel that information we have about you is incorrect or incomplete. You may ask us to amend the information. We may deny your request if it is not in writing or does not include a reason to support the request. Also, we may deny your request if you ask us to amend information that we did not create, is not part of the health information we keep, or is accurate and complete already
- Obtain an accounting of disclosures of your health information. To obtain a list of these disclosures, a written request must be submitted to the privacy officer. It must state specific time periods and may not include dates before April 14, 2003 when the HIPAA law was implemented
- Request communications of your health information by alternative means or at alternative locations
- Revoke your authorizations to use or disclose health information except to the extent that action has already been taken

Our Responsibilities:
This organization is required to:

- Maintain the privacy of your health information
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a request restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us.
We will not use or disclose your health information without your authorization, except as described in this notice.

For More Information or to Report a Problem:

If you have questions and would like additional information, you may contact the Privacy Officer at (202) 785-5000.

Print Patient Name:____

If you believe your privacy rights have been violated, you can file a complaint with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Examples of Disclosure for Treatment, Payment and Health Operations:

We will use your health information for treatment, for example: Information obtained by a nurse, physician or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In the way the physician will know you are responding to treatment.
We will also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him/her in treating you once you're discharged from this facility.

We will use your health information for payment, for example: A bill may be sent to you or a third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

We will use your health information for regular health operations, for example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in you health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Appointment reminders: We may contact you as a reminder that you have an appointment for treatment or medical care at the office. We may contact you if you miss an appointment to reschedule. This notification may be by phone call or mail. We may also call you by name in the waiting room when your provider is ready to see you.

Business Associates: There are some services provided in our organization through contracts with business associates. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Communications with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to you care.

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations.

As required by law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law.

Workers' Compensation: Your protected health information may be disclosed, by us, as authorized, to comply with workers' compensation laws and other similar legally-established programs.

Public Health: As required by law, we may disclosed your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law enforcement: We may disclose health information for law enforcement purposes as required by federal, state or local law or in response to a valid subpoena. Or if you were a member of the armed forces or part of the national security or intelligence community, we may be required to release health information about you.

Health Care Oversight: Your health information may be release to an appropriate health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

My signature below indicates that I have been provided with a copy of the notice of privacy practice.

____________________________________ ________________________

Signature of patient or legal representatives Date:

If signed by legal representative, please print name here____________________________________
If signed by legal representative, relationship to patient ____________________________________

Contact Information

Please complete and indicate if messages concerning medical information such as Labs or Radiology results may be left for you by checking the box or boxes adjacent to appropriate numbers or e-mail addresses.

Name ____________________________________

Date of Birth ____________________________________

Home # ____________________________________ ☐

Cell # ____________________________________ ☐

Work # ____________________________________ ☐

E-mail ____________________________________ ☐

Signature ______________________

Date: ________________________