VALLEY ENT superior medical care, right in your neighborhood

20201 N Scottsdale Healthcare Dr Ste 230 Scottsdale AZ 85255

480-684-1360

www.entscottsdale.com

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

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Patient Name:_____DOB_____

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_____

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		

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Patient Name:_____DOB_____

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