Adult Patient Questionnaire

Today's date ____________

Patient information:							
Last name				First name			MI
Date of birth		Age	Sex M F	Country of birth		Occupation	
Marital status		Race		Height		Weight	
Primary care provider				How did you hear about us?			
Referring provider							

Contact info: CIRCLE the preferred contact phone number.					
Cell	Work	Home		Email	
Mailing address			City, State		Zip

Preferred pharmacy: Name, address, and phone number.

Reason for visit: What is the nature of the problem that brought you into the office today?

Social history:		
Do you smoke? Yes / No Other tobacco products? If yes: How many packs daily?____________ How long (years)? __________		Did you smoke in the past? Yes / No When did you quit?____________ How many packs per day?_________
Do you drink alcohol? Yes / No How many drinks per week? __________	Do you use other recreational drugs? Yes / No Please specify ____________	Do you exercise regularly? Yes / No How many times per week?________
Are you pregnant or nursing? Yes ☐ No ☐		

Medication allergies: List your medicine allergies and the reaction.
None ☐

Medical history: CIRCLE any past or present issues. Add others not in the list.		NONE
Cardiac (heart) disease	Thyroid disease	Bleeding/Clotting disorder
High blood pressure (hypertension)	Psychiatric disorder	Headache
Diabetes	Asthma	Seizure disorder
High cholesterol	Emphysema	Chronic bronchitis
Cancer	Irritable Bowel Syndrome	Sleep apnea CPAP? Yes / No
Chronic ear disease	Gastroesophageal reflux (acid reflux)	Hearing loss
Chronic sinusitis	Psoriasis/Eczema	Seasonal allergies
Other	HIV	Hepatitis

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Past surgical history: Please list **ALL** your surgeries and dates.			NONE
	Date		Date

Medications: Please list your current medications with dosages and frequency.		NONE

Do you take any blood thinners? No ☐ Yes ☐ (Please list above)	Do you take vitamins/supplements? No ☐ Yes ☐ (Please list above)

Family history: CIRCLE conditions which run in the family.		NONE
Cardiac (heart) disease	Asthma or seasonal allergies	Bleeding or clotting disorder
Diabetes	Cystic fibrosis	Neurologic disorder
Cancer	Hearing loss	Anesthesia complications
Other:		

Review of Systems: CIRCLE all symptoms that you have experienced in the last 3 months.	NONE
Constitutional	unexpected weight loss weight gain fever chills fatigue
Eyes	corrective lenses blurry vision double vision eye pain redness watering
ENT	headache difficulty swallowing nose bleeds ringing in ears earaches hearing loss
Cardiovascular	chest pain palpitations fainting murmurs
Respiratory	shortness of breath wheezing cough chest tightness pain with breathing snoring
Gastrointestinal	heartburn nausea vomiting constipation diarrhea bloody/tarry stools
Genitourinary	urinary frequency urinary urgency difficult or painful urination flank pain bleeding with urination
Musculoskeletal	joint pain swelling stiffness
Skin	skin changes sore that won't heal rash itching redness hives
Hematologic	easy bleeding bruising
Neurological	numbness tingling dizziness unsteady gait
Psychiatric	anxiety depression
Endocrine	excessive thirst heat intolerance cold intolerance
Allergic	reaction to foods or environment
Other (please list):	

OFFICE USE ONLY:							
	Date		Date		Date		Date
	Date		Date		Date		Date

Financial Policy

Thank you for choosing Chesapeake Ear, Nose & Throat, a division of Chesapeake Specialty Care, as your healthcare provider. We understand and realize the cost of healthcare is a concern for our patients and we are willing and available to discuss our fees with you at any time. Your clear understanding of our Financial Policy is important to our relationship. You must read, agree to, and sign this policy prior to any services performed by our healthcare providers and support team. Carefully review the following information.

PROVIDE ACCURATE INFORMATION: You have the responsibility to provide accurate and complete information regarding your health history, mailing address, health insurance coverage, and any other information needed for billing purposes. We require your insurance card and photo ID be scanned into our system to verify in the event of claim errors. If any information changes (name, address, phone, insurance coverage etc.), you must inform this change to us immediately. Insurance denials and/or billing errors due to incorrect patient supplied information will result in the balance being the patient's financial responsibility.

KNOW YOUR INSURANCE COVERAGE AND BENEFITS: Your health insurance coverage is a contract between you and your health insurance carrier. You are responsible for understanding your health insurance coverage and benefits, not our staff. There may be limitations and exclusions to your coverage. You are responsible for any charges not covered by your plan.

INSURANCE USE: We require you to present your insurance card at every visit. The front office representative may not always ask for it; however, in the event the staff member does, you must provide it. If you fail to provide us with the correct insurance information at any visit and/or do not provide the insurance card for scanning, you are required to sign a waiver stating you will be responsible for payment of all services rendered and you will be responsible for submitting for reimbursement from your insurance carrier.

- Co-pays are due at the time of services as required by your insurance carrier.
- If your insurance carrier requires a referral, please bring a copy with you to your visit, ***and*** have one faxed to us at (410) 356-7806. You are responsible for obtaining a referral from your primary care provider, not our staff.
- We will file claims to the insurance carriers with which we contract, provided that you authorize the assignment of benefits for payment directly to our practice. The practice will accept payments based on contractual agreements. You agree to pay any portion of charges not covered by insurance.
- For insurance carriers with which we do not contract, you will be responsible for all services rendered. We will give you the receipt for you to submit to your insurance for reimbursement.
- For Medicare and Medicaid insurance holders: We are not able to see any patients that have this insurance coverage as self-pay patients. No exceptions.

SELF-PAY PATIENTS: Self pay accounts are patients without insurance coverage or who are unable to provide us with valid insurance. You are responsible for paying 100% of charges and/or the down payment of $250.00 at the time the services are rendered.

WORKERS COMPENSATION AND MOTOR VEHICLE ACCIDENT: In the case of a worker's compensation injury, motor vehicle accident, and/or other third-party liability, you must obtain the claim number, phone number, contact person, and name and address of the insurance carrier PRIOR to your visit. Failure to provide the above information may result in balances transferring to patient responsibility. Payment for any services that we provide will ultimately be patient responsibility if not paid by another party.

BILLING STATEMENTS: A statement will be sent to your address on file once a balance becomes patient responsibility and will continue every 30 days. Unless you notify our office that you dispute the validity of the balance or any portion thereof within 30 days, we will assume the balance is valid and correct.

OUTSTANDING BALANCES AND COLLECTIONS: All overdue balances shall be due within 14 days. The only exception is if payment arrangements have been made with our billing department. After 90 days, you may be referred to our collection agency and will not be able to schedule an appointment or be seen for a previously scheduled appointment. If the account is referred to an outside collection agency, the patient is responsible for paying any incurred fees.

PAYMENTS: Our practice accepts Visa, Mastercard, American Express, Discover, cash, check, or money orders. If your check is returned for non-sufficient funds, you will be responsible for the return fee of $25.00.

TREATMENT OF MINORS: The parent(s) or legal guardian(s) is responsible for full payment and will receive the billing statements. A release will be required to treat unaccompanied minors.

Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of service. Our office will not bill any other personal party.

AUTHORIZATION: I have read, understand, and agree to the Financial Policy stated above and accept responsibility for payment of all fees/charges incurred with Chesapeake Ear, Nose & Throat, a division of Chesapeake Specialty Care.

______________________________ ______________

Printed patient name DOB

______________________________ ______________

Patient or guardian signature Date

Permission to Communicate/HIPAA Authorization

If you want your medical information to be shared with anyone other than your health care provider, please indicate below. By signing this document, you authorize the following person(s) to receive information in writing or over the phone regarding your care and treatment. Updates to this form must be made in person on an annual basis.

Chesapeake Ear, Nose & Throat, a division of Chesapeake Specialty Care, will not release protected health information to anyone except for (i) parent/legal guardian (if under 18 years of age), (ii) persons authorized by the patient, (iii) anyone we may reasonably infer from the circumstances such as having anyone in the exam room with you, we will assume, unless you verbally object, that the person is entitled to receive information regarding your treatment, (iv) in emergency situations, or (v) as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

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Printed name Relationship Phone Number

____________________ ____________________ ____________________

Printed name Relationship Phone Number

____________________ ____________________ ____________________

Printed name Relationship Phone Number

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Printed patient name DOB

____ ________________

Patient or guardian signature Date

Notice of Privacy and HIPAA Practices

Chesapeake Ear, Nose & Throat, a division of Chesapeake Specialty Care, “Notice of Privacy Practices” provides information about how we may use and disclose protected health information about you. Please acknowledge notice of this office’s Privacy Practices by signing below. You may also request a copy of our Notice of Privacy Practices at any time.

Our Notice of Privacy and HIPAA Practices states that we reserve the right to change the terms described. Should this happen, the most updated copy will posted at your next office visit or you may request a copy at any time.

You have the right to request restriction on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions, but if we do, we are bound by our agreement with you.

By signing this form, you consent to our Notice of Privacy and HIPAA Practices Policy. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

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Printed patient name DOB

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Patient or guardian signature Date

In-Office Procedure Consent

Certain procedures performed in our office are **not** included in the standard office visit charge. These procedures are billed separately in addition to office visit charges. They are performed in order to allow the medical providers to comprehensively diagnose and potentially treat ear, nose, and throat related problems that cannot be fully evaluated with a basic physical exam. Some insurance carriers classify these procedures as "surgery" and apply these costs to a higher deductible amount. The result may be an insurance payment for an office visit, but not a procedure. In these cases, payment for the procedure will be the financial responsibility of 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 but are not limited to:

- **Flexible laryngoscopy** involves passing a long thin flexible fiber-optic scope through the nasal cavity and into the throat. The fiberoptic scope enables the physician to visualize areas of the throat not comprehensively or easily seen using other instruments.
- **Nasal endoscopy** involves using a flexible or rigid scope attached to a light source to view areas of the nasal cavities and sinus cavities that cannot be viewed by the provider using the standard nasal speculum.
- **Nasal endoscopy with debridement or biopsy** is the same procedure as described above with removal or crusting, packing, or tissue.
- **Videostroboscopy** involves using a flexible or rigid scope attached to a light source in order to create a video recording of the larynx and lower pharynx (which are unable to be seen on conventional examination). This procedure is the gold standard for examination of the lower throat and voice box.

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Printed patient name DOB

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Patient or guardian signature Date