



# Pediatric Patient Questionnaire

Today's date \_\_\_\_\_

Patient information:				
Last name		First name		MI
Date of birth	Age	Sex M F	Height	Weight
Name of parent(s)/guardian(s)		Is the patient a foster child? Yes <input type="checkbox"/> No <input type="checkbox"/>		
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: Include name, address, and phone number.				
Reason for visit: What is the nature of the problem that brought you into the office today?				
Medication allergies: List medicine allergies and the reaction.				
None <input type="checkbox"/>				
Birth/medical history:				
Was patient born full term? Yes <input type="checkbox"/> No <input type="checkbox"/> _____ weeks      Vaginal    C-section (circle one)				
Were there any complications with pregnancy or delivery? No <input type="checkbox"/> Yes <input type="checkbox"/> Please describe: _____				
Did they pass newborn hearing test? Yes <input type="checkbox"/> No <input type="checkbox"/> If applicable, how long was the child breastfed? _____ months/years				
Are immunizations up to date? Yes <input type="checkbox"/> No <input type="checkbox"/>		Any developmental delays? No <input type="checkbox"/> Yes <input type="checkbox"/> Describe: _____		
Social history:				
Is the patient in daycare? Yes <input type="checkbox"/> No <input type="checkbox"/> Current grade in school: _____		Are there any siblings? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Is the patient exposed to second-hand smoke? Yes <input type="checkbox"/> No <input type="checkbox"/>		Ages? _____		
Are there pets in the household? No <input type="checkbox"/> Yes <input type="checkbox"/> Type: _____				
Medical history: CIRCLE any past or present issues. Add others not in the list.			NONE	
Autism	Asthma	Seizure disorder		
Chronic ear disease	Gastroesophageal reflux (Acid reflux)	Hearing loss		
Chronic sinusitis	Psoriasis/Eczema	Seasonal allergies		
ADHD/ADD	Failure to thrive	Sleep apnea		
Other				
Medications: Please list current medications with dosages and frequency.				NONE



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<b>Past surgical history:</b> List <u>all</u> surgeries and dates.							<b>NONE</b>
<b>Family history:</b> CIRCLE conditions which run in the family (list others not listed below).							<b>NONE</b>
Cardiac (heart) disease	Asthma or seasonal allergies			Bleeding or clotting disorder			
Diabetes	Cystic Fibrosis			Neurologic disorder			
Cancer _____	Hearing loss			Anesthesia complications			
Other:							
<b>Review of Systems:</b> CIRCLE all symptoms experienced in the last 3 months.						<b>NONE</b>	
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	bedwetting urinary frequency urinary urgency difficult or painful urination 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	hyperactivity anxiety depression						
Endocrine	excessive thirst heat intolerance cold intolerance						
Allergic	reaction to foods or environment						
Other (please list):							
<b>OFFICE USE ONLY:</b>							
	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.

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Printed patient name

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DOB

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Patient or guardian signature

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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 be 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

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DOB

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Patient or guardian signature

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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

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DOB

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Patient or guardian signature

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Date