Ear, Nose & Throat Consultants of East TN.

Patient Intake Form

Date: _____

Last Name: _____ First Name: _____ MI: _____ Date Of Birth: ____/____/_____

Preferred Name: _____ Previous Name (If Applicable):_____

Address: _____ City: _____ State: _____

Zip: _____ Sex: Male /Female _____ Home Phone: (_____) _____

Cell: (_____) _____ Work: (_____) _____ ext: _____

Email Address: _____ **(If patient is a minor, please list a parent or guardian email address)**

SSN: _____ Marital Status: _____ Employer: _____

Languages: ☐ English ☐ Sign Language ☐ Spanish; Castillian ☐ Other (Please Specify): _____

Primary Care Physician: _____ Phone Number: (_____) _____

Referring Physician: _____ Phone Number: (_____) _____

*Emergency Contact: _____ Relationship to Patient: _____ Phone:(_____)_____

Primary Insurance Information:
Plan Name: _____
Subscriber Name (if not self): _____
Relationship: _____
Employer: _____
Subscriber DOB: _____

Secondary Insurance Information:
Plan Name: _____
Subscriber Name (if not self):_____
Relationship: _____
Employer: _____
Subscriber DOB: _____

Pharmacy: _____ City: _____

****If the patient is a MINOR** Please list the parent(s)/guardian(s) information:**

Last Name: _____ First Name: _____ DOB: ____/____/_____

Employer: _____ Relationship to Patient: _____ Responsible Party: Y / N

Best Contact #: (_____) _____ Work #: (_____) _____

Last Name: _____ First Name: _____ DOB: ____/____/_____

Employer: _____ Relationship to Patient: _____ Responsible Party: Y / N

Best Contact #: (_____) _____ Work #: (_____) _____

Please list any other individuals that have your permission to seek medical treatment/services for your child:

Name: _____ Relationship: _____ Phone #: (_____) _____

Name: _____ Relationship: _____ Phone #: (_____) _____

Name: _____ Relationship: _____ Phone #: (_____) _____

Signature: _____ Date: _____

Thank you for choosing us as your health care provider. The following is a statement of our Financial and Office policies, which we require you to read and sign prior to any treatment. Please read each statement and sign below.

OUR OFFICE POLICY

◆◆ **Release of Medical Information:** Your signature below allows us to release to insurance company(s), hospitals, referring physicians, other healthcare providers, and attorneys your health information for treatment, billing and healthcare operations. It also allows us to obtain necessary information from your other healthcare providers if needed for care provided by our office.

◆◆ **Appointments:** We require at least 48 hours' notice to reschedule or cancel an appointment. **Our office may elect to reschedule an appointment if the patient is late.** We reserve the right to charge for missed appointments or for insufficient notice when cancelling or rescheduling appointments. Excessive missed appointments may result in discharge from this practice. It is imperative to your health and well-being that follow-up appointments are kept.

◆◆ **Physician:** Dr. Almand is an Otolaryngologist/Head and Neck Surgeon (Ear, Nose and Throat Physician). He is primarily trained as a surgeon, but can also help with difficult ear, nose and throat problems. ***As a specialist, he is unable to provide routine medical treatment that could and should be provided by your primary care physician.***

◆◆ **HIPAA:** You have been given a copy of our privacy practices that describes how your health information is used and shared. The Foothills ENT Allergy & Hearing Center has the right to change this notice at any time and a current copy can be obtained by contacting our office.

◆◆ **List person(s) to whom our office is allowed to release information regarding your medical care: (Name & relationship):**

_____

_____

_____

◆◆ **Emergencies:** If you have a true emergency after hours, Dr. Almand can be reached by calling the office and following the recorded telephone instructions. Please do not call after office hours for problems that are not considered emergencies. Non-emergencies must be handled during regular office hours.

◆◆ **Contact:** I hereby give my permission for doctors or staff to leave a message at the home and cell telephone numbers listed on the patient information sheet.

I have read and understand the policies listed above and agree to the terms. I agree to take full responsibility for this account. I also authorize the doctors to provide me with reasonable and proper medical care by today's standards. I have received a copy of the full Financial Policy.

DATE _____ PATIENT / PARENT SIGNATURE _____

PATIENT MEDICAL HISTORY

Today's Date:_____

Patient's Name _____ **Date of Birth** _____ **Age**_____

CHIEF COMPLAINT

What is the main reason for today's visit? _____

When did the symptoms begin? _____

What Medications have you taken or are you taking for this problem? _____

If medical problem is related to sinus issues, are you using Saline Rinses? _____Yes _____No. Have you taken antibiotics for sinusitis, is so please list:_____.

PAST MEDICAL HISTORY

Please list any medical problems, illnesses, hospitalizations or surgeries that you have had in the past or that you currently have:

_____

_____

_____

Do you take any medications/supplements on a routine basis? _____Yes _____No ; **If yes, please complete reverse side of this form.**

Are you allergic to any medications? _____Yes _____No **If** Yes, please list _____

Are you allergic to Latex? _____Yes _____No

FAMILY HISTORY * Is there any family history of problems with general anesthesia? _____Yes _____No

SOCIAL HISTORY

Have you ever smoked or chewed tobacco? _____Yes _____No If Yes, how many packs per day_____ For how many years? _____

Are you still smoking? _____ If not, how many years since you quit? _____

Do you consume alcohol? _____Yes _____No; Have you consumed alcohol this past year? _____Yes _____No. If yes, how many daily_____ monthly____?

REVIEW OF SYSTEMS **HEIGHT:**_____ **WEIGHT:**_____

Please check the following symptoms that you currently have or had:

NOSE AND SINUS
- ☐ Sinus Pain
- ☐ Snoring
- ☐ Nose Bleeds

THROAT/MOUTH
- ☐ Sore Throats
- ☐ Swollen Neck Glands
- ☐ Difficulty Swallowing
- ☐ Hoarseness
- ☐ Cough

EARS
- ☐ Decreased Hearing
- ☐ Ringing in Ears
- ☐ Earache

WOMEN ONLY
- ☐ Are you pregnant
- ☐ Currently Breastfeeding
- ☐ If not currently, are you thinking of becoming pregnant?

MEDICAL
- ☐ Thyroid Disease
- ☐ Chest Pain
- ☐ Heart Murmur
- ☐ Tuberculosis
- ☐ Liver Disease
- ☐ Gastrointestinal Problems
- ☐ Diabetes
- ☐ Genitourinary Problems
- ☐ Neurologic Problems
- ☐ Seizures
- ☐ High Blood Pressure
- ☐ Lung Disease
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Depression
- ☐ Heart Disease

Have you taken aspirin, aspirin - containing, blood thinning or anti-inflammatory medications in the last two weeks? _____Yes _____No

If you are scheduled to have ANY surgery, you MUST be off all aspirin - containing products for two weeks prior to having surgery

PRESCIPTION MEDICATION & OVER-THE-COUNTER SUPPLEMENT LIST

Pt. Name: ______________________________

		DOSAGE Strength, How often, Route			Date Reviewed & Initialed (for office use)											
(ie. Amoxicillin)	*(ie. Aleve, Fish Oil)*	*(ie. 10 mg)*	*(ie. 2x)*	*(ie.oral)*												
Prescription	Supplement	**S**	**O**	**R**												

Ear, Nose and Throat Consultants of East Tennessee, PC

Foothills Ear Nose and Throat, Allergy and Hearing Center

Patient Financial Policy

Patient Name: _____ DOB: _____

Thank you for choosing **Foothills Ear Nose and Throat** for your ENT, allergy and audiology care!

We are committed to the success of your medical treatment and care. Please understand that a mutual financial understanding is part of our relationship. We sincerely hope that by sharing our financial expectations we will strengthen the physician-patient relationship and keep the lines of communication open. This financial policy helps us provide quality care to our valued patients. If you have any questions or need clarification of any of the below policies, please feel free to ask a receptionist or contact us at **865-983-4090**.

Payment is Due At the Time of Service

- We accept cash, checks, debit, credit cards and Care Credit.
- All insurance co-payments, deductibles, co-insurance and fees for non-covered services are due at the time of service.
- Patient-responsible balances are due when you check in for your appointment.
- There is a $29.00 charge for checks returned to us for NSF.
- Outstanding balances not paid within 60 days of receiving your statement may be forwarded to an external collection agency and additional fees of 25% will be added to your account. We also reserve the right to discontinue care.
- If you make an overpayment on your account, we will issue a refund only if there are no other outstanding debts on your account to the same guarantor or financial responsible party that paid.

PLEASE REMEMBER- Your insurance is a contract between you and your insurance carrier. We, as healthcare providers, just execute that agreement for you. We are bound by the terms in your contract. As a result, it is your responsibility to understand your coverage and benefits. If your insurance requires a referral for "specialist" office visits, you need to contact your primary care physician to get that referral. We cannot see you without it, if it is required.

In Office Procedures

Initial here

- In order to properly evaluate/diagnose your problem, we may need to do a **diagnostic procedure** or use an instrument to perform a **"scope"**. This allows the physician to see into your sinus and/or throat. Most insurance companies classify this as a **"surgical procedure"** and in most cases, gets applied to your deductible or co-insurance and is **NOT** covered under your office co-pay. This amount is determined by your insurance carrier.

Surgical Procedures

- If you/your child requires a surgical procedure at the hospital, please note you will receive separate billing statements from the hospital, pathologists (if applicable) and anesthesiologist. Your responsibility to us is for our physician only.
- **We will call you with the amount you will be responsible for on your surgery.** This amount will need to be paid 2 business days prior to your surgery day.

Initial here

- **Post-Surgery**- Office visits after surgery that are related to the surgery and are within the "global period" as determined by the Center for Medicare & Medicaid Services, are included in the surgical charge and will not require an additional co-pay. However, endoscopic procedures (*scopes*) and a few other procedures do not have a global period and surgical aftercare is not included in the surgical fee. Many sinus surgeries require 1 or 2 **"debridements"** post-surgery which co-insurance and deductibles are applied, resulting in possible additional payments being due.

Filing Claims

■ We will gladly submit claims for your services to your insurance company on your behalf. If your insurance company has not paid the claims within 60 days, the balance becomes patient responsibility. We try to resolve most claim issues, but it may become necessary for you to contact your insurance company to get the claim paid. **Be sure to keep your insurance information up-to-date with us with any changes.**

Referrals

■ If you have a plan we are contracted with that requires a referral authorization for office visits (ie. AARP Medicare Complete, UHC Compass plan), you will need to obtain one from your primary care physician. If we have not received an authorization prior to your arrival at the office you will be asked to reschedule your appointment. Without an insurance required referral, the insurance company will deny payment for services.

No Show Policy

■ We request that at least a **two-business day** advance notice be given to the office if you will be unable to keep your scheduled appointment. This allows us to release your appointment time to another patient. We charge an administration fee of **$50 for no-shows or late cancellations.** Patients who repeatedly "no show", cancel or reschedule appointments may be discharged from the practice.

Arriving late for Appointment

■ We understand that sometimes you may be running late. Unfortunately, we have patients scheduled throughout the day and may not be able to see you if you arrive late. We will try to accommodate you if possible. Otherwise, you will need to reschedule your appointment.

Proof of Insurance

- Please bring your insurance card(s) and a valid photo ID with you to each appointment.

****It is <u>your</u> responsibility to notify the practice of changes in your health insurance.**

Self-Pay Accounts

- We designate accounts, **Self-Pay,** under the following circumstances: (1) patient does not have health insurance coverage (2) patient is covered by an insurance plan that our providers do not participate in, (3) patient does not have a current, valid insurance card on file, (4) patient does not have a valid insurance referral on file.

Self-Pay patients, please be prepared to pay in full at time of service. This includes the cost for the patient office visit and possible diagnostic endoscopy (scope). There may additional fees for in office procedures, including cerumen (earwax) removal, postoperative sinus debridement, allergy testing, hearing tests or hearing aids. If you are unable to pay, you will be asked to reschedule your appointment.

Audiology Services

- Hearing tests are an integral part of diagnosing hearing, tinnitus (ringing or noise in ear), pressure or pain in your ear. Without these tests your physician cannot make a proper diagnosis to help you. Hearing tests are <u>NOT</u> included in your office visit co-pay therefore, co-insurance and deductibles apply for these charges.

<u>As a courtesy, you will receive automated texts to remind you of your appointment.</u>

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility.

I authorize my insurance benefits be paid directly to Ear, Nose and Throat Consultants of East Tennessee.

Patient/Guarantor Signature _____ Date_____