GREENWICH
EAR, NOSE & THROAT

ALIGN ENT+ Allergy
Partner

# Patient Intake

Name: _____ DOB: _____ Appointment Date: _____

What is the purpose of today's visit? _____

Have you had any previous workup related to this issue? _____

Have you seen any other medical providers related to this issue? _____

Who is your primary care physician (not group/practice, please)? _____

Did they refer you to us? o Yes o No If no, who did? _____

Who are your other physicians? _____

General Medical Information
Patient's Weight (lbs): _____ Height: _____

**Medical History—Please check if you have or have had any of the following conditions**

| | | |
|---|---|---|
| ☐ Anemia | ☐ Hearing Problems | ☐ Multiple Sclerosis |
| ☐ Arthritis | ☐ Heart Disease | ☐ Pacemaker |
| ☐ Asthma | ☐ Heart Murmur | ☐ Pneumonia |
| ☐ Bleeding Disorder | ☐ Hepatitis | ☐ Prostate Disorder |
| ☐ Blood Clotting | ☐ High Blood Pressure | ☐ Psychiatric Disorder |
| ☐ Bronchitis | ☐ High Cholesterol | ☐ Seizures |
| ☐ Cancer | ☐ HIV Positive | ☐ Stomach Ulcers |
| ☐ Cataracts | ☐ Kidney Disease | ☐ Thyroid Disorder |
| ☐ Diabetes | ☐ Migraine Headaches | ☐ Tuberculosis |
| ☐ Emphysema | ☐ Mitral Valve | |
| ☐ Glaucoma | ☐ Mononucleosis | |

Other Illnesses: _____

**Current Medical Issues—Please check all that apply**

| | | | | | |
|---|---|---|---|---|---|
| Eyes | ☐ Yes | ☐ No | Bleeding Problems | ☐ Yes | ☐ No |
| Lungs/Breathing | ☐ Yes | ☐ No | Numbness/Tingling | ☐ Yes | ☐ No |
| Digestion/Stomach Problems | ☐ Yes | ☐ No | Joint Aches/Pains | ☐ Yes | ☐ No |
| Bowel Movements | ☐ Yes | ☐ No | Depression/Anxiety | ☐ Yes | ☐ No |
| Bladder Problems | ☐ Yes | ☐ No | Epilepsy/Seizures | ☐ Yes | ☐ No |
| Heart Problems | ☐ Yes | ☐ No | Hepatitis | ☐ Yes | ☐ No |
| Appetite/Weight Change | ☐ Yes | ☐ No | | | |

Other Current Issues _____

**Females:** Are you currently pregnant? ☐ Yes ☐ No

**For Children:** Is your child up to date with immunizations? ☐ Yes ☐ No

**Do you have a latex allergy?** ☐ Yes ☐ No

**List ALL ENT-Related Surgeries (include year)**

**List ALL Other Surgeries (include year)**

**List ALL Hospitalizations (include year)**

**List ALL Medications & Doses (include over-the-counter)**

**List ALL Allergies (drugs, food, environmental):**

### Family History—Please check all that apply

☐ Stroke
☐ Heart Disease
☐ Diabetes
☐ Hearing Loss
☐ High Blood Pressure
☐ Cancer
☐ TB
☐ Arthritis
☐ Respiratory Disease
☐ Kidney Disease
☐ Blood Clotting Problems
☐ Other: _____

### Social History—Please check all that apply

Tobacco Use: ☐ Yes ☐ No Usage ☐ < 1 pack/day ☐ 1 pack/day ☐ > 1 pack/day

Alcohol Consumption: ☐ Yes ☐ No ☐ Daily ☐ 1-2 drinks/week ☐ 1-2 drinks/month ☐ 1-2 drinks/year

History of Substance Abuse: ☐ Yes ☐ No If yes, specify: _____

Recreational Drugs: ☐ Yes ☐ No If yes, specify: _____

### ENT-Related Symptoms—Please check all that apply

| **Ears** | Right | Left |
|---|---|---|
| ☐ Hearing Loss | ☐ | ☐ |
| ☐ Noise in Ears | ☐ | ☐ |
| ☐ Ear Discharge | ☐ | ☐ |
| ☐ Earache | ☐ | ☐ |
| ☐ Dizziness | | |
| ☐ Off-Balance | | |
| ☐ Loud Noise Exposure<br>☐ Guns ☐ Job | | |

**Nose**
- ☐ Congestion or Stuffiness
- ☐ Runny Nose
- ☐ Postnasal Drip
- ☐ Nosebleeds
- ☐ Broken Nose
- ☐ Sinus Infections
- ☐ Breathing Obstruction
- ☐ Abnormality of Smell

**Throat**
- ☐ Sore Throat
- ☐ Difficulty Swallowing
- ☐ Hoarseness
- ☐ Cough
- ☐ Mouth Ulcers
- ☐ Heartburn

**Face & Neck**
- ☐ Lump in Neck
- ☐ Non-Healing Sore
- ☐ Change in Mole
- ☐ Scar
- ☐ Pain

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# Patient Financial Policy • Assignment of Benefits • Consent to Treat

Thank you for choosing Align ENT + Allergy (Align) Partner Practices as your health care provider. Our main concern is that you receive the proper and optimal treatments needed to restore your health. Therefore, if you have questions or concerns about our policies, please ask us during your visit or contact us at 203-869-2030.

**Insurance Information**
We participate with most insurance companies. If we do not participate with your insurance company, payment is due in full at the time of service, or we may recommend that you contact your insurance company for a participating provider. All insured patients are required to sign the assignment of benefits for payment from the insurance company. We will submit your claim to participating insurance companies on your behalf. It is the patient's responsibility to notify the organization of any changes in health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim.

After your insurance company has settled the claim, you will be billed for any noncovered services, copays, deductibles and/or coinsurance. You will receive a statement for any outstanding balance if you are no longer covered by your insurance plan. Accounts not paid within 90 days will be considered delinquent and will be turned over to a collection agency or attorney. In the event your account is turned over for collection, you will be responsible for all reasonable collection and court costs at the time the account is considered delinquent.

Some insurance plans require the patient to obtain a referral, precertification or prior authorization for services. Please review your insurance policy to see if any of those are required prior to your visit. If a required referral, precertification or authorization is not on file at the time of the visit, the appointment could be rescheduled, or the patient will be responsible for all charges incurred on this date.

It is your responsibility to understand your individual coverage. If you have questions about what your insurance company or benefit plan will cover, please contact them directly.

Workers' compensation and automobile insurance companies may require additional referrals and/or documentation. We will make a commercially reasonable effort to bill those carriers, but if you do not provide the necessary information, if the benefit is exhausted or in dispute with your workers' compensation or automobile insurance, you will be billed for the services and payment will be due at time of service.

**Time of Service Payments**
Copays and out-of-pocket charges are due at time of service. For your convenience, we accept most major credit cards, cash and check or money orders. There will be a charge of $25 for returned checks and payment will be required by cash or credit card.

**Cancellation and No-Show**
We understand that situations arise in which you must cancel your appointment. It is, therefore, requested if you must cancel your appointment, you provide the notice stated in the table below based on the service or procedure. If cancellations are not completed within the requested timeframe, patients will be subject to the fees in the table below. The Cancellation and No-Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment. Patients who have missed more than one scheduled appointment without prior notice will be restricted from scheduling future visits unless an exception is granted. Our practice firmly believes that good physician/patient relationships are based upon understanding and good communication.

| **Service/Procedure** | **Required Notice** | **Fee for Lack of Notice** |
|---|---|---|
| Office Appointment | 48 Hours | $25.00 |
| Procedure or Special Test in Office<br>• Allergy Testing (Prick testing, Intradermal testing)<br>• Speech Therapy Appointments (Fiberoptic endoscopic evaluation of swallowing [FEES], Videostroboscopy)<br>• Audiology appointments (Videonystagmography [VNG], Tinnitus evaluation) | 72 Hours | $75.00 |
| Ongoing Tinnitus Appointments | 72 Hours | $250.00 |
| Outpatient Ambulatory Center or Hospital | 120 Hours (5 Days) | $350.00 |

Please initial that you have read, understand and agree to this Cancellation and No-Show policy. **Patient's Initials** _____

**Specialty Services**
Our doctors are board-certified in otolaryngology. They specialize in ear, nose and throat issues, and in some cases, sleep medicine, sleep surgery and allergy. As specialists, our doctors offer in-depth testing to better evaluate, diagnose and treat the issues you are experiencing. One or more of the following procedures may be done at your appointment. Insurance companies consider these tests a surgical procedure and, as such, are billed in addition to your office visit. Your insurance may apply additional copay, coinsurance and/or deductible. The below list is not an all-inclusive list, but includes the most common ear, nose and throat office procedures.

- 31231 Diagnostic Nasal Endoscopy*
- 31575 Flexible Laryngoscopy*
- 31237 Nasal Endoscopy Surgical with Debridement (Unilateral or Bilateral)*
- 31238 Nasal Endoscopy with Cautery of Blood Vessels (Unilateral or Bilateral)*
- 31579 Videostroboscopy*
- 69210 or G0268 Removal of Impacted Cerumen (Ear Wax Removal) (Unilateral or Bilateral)

**Hearing Tests:**

- 92557 Audiogram
- 92550 Tympanometry and Reflex Threshold Measurements
- 92587 Otoacoustic Emissions
- 92567 Tympanogram

Highmark Federal Employee Program charges a $150 copay for the * procedures listed above and potentially others. This copay will be billed to you. You will be responsible for any additional copayment, coinsurance and/or deductible your insurance plan applies to your claim.

**Consent to Call, Email & Text**
I understand and agree that Align Partner Practices may contact me using automated calls, emails and/or text messaging. These communications may notify me of appointment reminders, preventative care, test results, treatment recommendations, outstanding balances or any other communications from Align Partner Practices. I understand that I may opt out of receiving such communications by informing my provider's front desk or scheduling staff.
This consent and authorization will remain fully effective until it is revoked in writing. You have the right to discontinue services at any time. I certify that I have read and understand the above statements.

**General Consent to Care**
I, the undersigned, for myself, a minor child or another person for whom I have authority to sign, hereby consent to medical treatment, as ordered by a provider, for which such medical treatment is provided through Align Partner Practices This consent includes my consent for all medical services rendered under the general or specific instructions of the provider. I agree and acknowledge that Align Partner Practices is not liable for the actions or omissions of, or the instructions given by, the physicians/providers who treat me while I am a patient. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations.
You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any tests ordered for you. If you have concerns regarding any test or treatment recommended by your provider, we encourage you to ask questions.

**Patient Acceptance**
I have read and understand the above policies and have had the opportunity to ask questions. This acknowledgment will be in force unless revoked in writing.

**Patient's Signature** _____ **Date** _____

**Assignment of Benefits**
I hereby guarantee payment of all charges incurred at Align Partner Practices. I hereby assign and direct to pay all benefits for medical services under this claim directly to Align Partner Practices. I hereby authorize the release of any medical information requested by the insurance companies. I give permission to Align Partner Practices to appeal on my behalf. I also understand and agree this Assignment of Benefits will continue for as long as I am being treated or cared for by the organization and will constitute a continuing authorization, maintained on file, which will authorize and allow for direct payment to the organization of all applicable and eligible coverage benefits for all subsequent and continuing treatment, services, supplies and/or care provided. I also realize that I am responsible for paying any noncovered services, copayments, deductibles or coinsurance amounts due.

**Patient Name** _____ **Patient DOB** _____

**Patient's Signature** _____ **Date** _____

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# Patient Consent Form

I understand that under the Health Insurance Portability and 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 health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certification.

I have been informed by you of your Notice of Privacy Practices, which contains a complete description of the uses and disclosures of my health information. I have the right to review such Notice of Privacy Practices before signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices occasionally and that I may contact this organization at any time to obtain a current copy of them.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

**Patient Name** _____ **Signature** _____

**Date** _____ **Relationship to Patient if Signed by Representative** _____

*Align ENT + Allergy Partner Practices may release my medical information to:*

**Name** _____ **Relationship to Patient** _____

**Name** _____ **Relationship to Patient** _____

**Name** _____ **Relationship to Patient** _____

**Name** _____ **Relationship to Patient** _____