Alpine ENT Face Sheet

Today's Date: _______________ Chart #: ____________________

Personal Information

First Name: ____ MI: ______________ Last Name: ____

Address: ____

City: ________________________________ State:____ Zip Code: _________________________________

Date of Birth: ________________________ Sex: _________________________________ Marital Status: Married / Single / Divorced / Widowed

Home Phone: __________________ Cell Phone: __________________ Work Phone: ___________________ Email:_____________________________________

Please circle the option you would like us to use to send appointment reminders: Home phone / Call to cell phone / Text to cell phone / Email

Referring Provider's Name & Contact info: ____

Primary Care Physician's Name & Contact info: ____

Insurance Information:

Please present your insurance card(s) to the receptionist. Please give complete information.

Primary Insurance: ____

Patient's Relationship to Subscriber: Self / Spouse / Child / Other

Subscriber Name: ____ Subscriber DOB: ____

Member ID #: ____ Group #: ____

Secondary Insurance: ____

Subscriber Name: ____ Subscriber DOB: ____

Patient's Relationship to Subscriber: Self / Spouse / Child / Other

Member ID #: ____ Group #: ____

If we are seeing you for a Work Related Injury or Auto Accident related injury please list the insurance we should bill, the date of injury, claim number, adjuster name and contact number below:

Name of Work Comp or Auto Carrier: ____

Injury is: Work Related / Auto Related Date of Injury:______________________________ Claim Number: ____________________

Adjuster Name:____ Contact Phone Number: _________________________

If we are filing insurance for your visit, we must have complete information and any required referral at the time of the visit. If you cannot provide the information, we will be unable to file your insurance, and payment in full will be required.

Payment of your charges cannot be determined until the claim is submitted to your insurance company. Payment will be based on your individual health plan, and the amount applied to your plan deductible and/or coinsurance will be your responsibility. Procedures which are excluded from coverage, based on your plan's determination of medical necessity, will also by your responsibility. Your office visit co-pay is due at the time of the visit and, in many cases, covers only the office visit charge. Any procedures performed may be considered surgery by your insurance company, and deductibles and coinsurance may apply.

For all other patients, payment is required at the time of service.

We will provide you with the necessary documentation to file for reimbursement upon your request.

I have read the above information and understand that I am responsible for payment for services I receive.

Patient/Responsible Party Signature:____ Date: _____________________________________

Responsible Party Name: ____ Responsible Party Date of Birth: ______________________________

ALPINE ENT/ALLERGY PATIENT HEALTH HISTORY

Patient Name: ______________________________ DOB: ______________ Visit Date: ____________

Gender: ☐Male ☐ Female ☐Other/Prefer not to state Reason for your visit today: _________________________

Primary Provider: __________________________ Referring Provider:_______________________________

Pharmacy Preference: ______________________ Pharmacy Address: _______________________________

Current Height: ______________________ Current Weight: _____________

Current Medications: Please list ALL medications you are currently taking	Dose	How Often Taken?

CONSENT TO ELECTRONIC PHARMARY BENEFITS DATA EXCHANGE: May we use Surescripts RxHub to review medications that have been prescribed to you by any provider? **Please initial:** YES: ____ No: _____

Medication Allergies ☐ No known drug allergies ☐ Yes, please list:	Type of reaction (rash, swelling, etc)

Non Medication Allergies: ____

Tobacco Use: ☐None ☐ Smoker, # Packs/day___ ☐ Former Smoker, year quit _____ ☐Smokeless/chew

Caffeine Use: ☐None ☐ # of drinks/day ___

Alcohol use: ☐None ☐ #of drinks/week ___ ☐ History of alcoholism

Other drug use: ☐Marijuana ☐ Vaping ☐Illicit drugs (specify): ______________________________

Females age 65+: Have you ever had a bone scan (DXA Scan) to screen for osteoporosis? ☐No ☐Yes, I have

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Home Living Situation: ☐ Alone ☐ with spouse ☐ with children ☐ Assisted Living ☐Other:__________

☐ Will accept blood transfusion, if needed

ALPINE ENT/ALLERGY PATIENT HEALTH HISTORY, PAGE 2

Patient Name: ________________________________ DOB: _______________

Past Health History: Please check any that have been diagnosed now or in the past.

☐ ADHD
☐ Allergies (hayfever)
☐ Anxiety
☐ Asthma
☐ Atrial Fib/Flutter
☐ Autoimmune disorder
☐ Breast cancer
☐ Cataracts
☐ COPD/emphysema
☐ Dementia
☐ Depression
☐ Diabetes
☐ Eczema
☐ Glaucoma
☐ Hearing loss
☐ Heart failure
☐ Hepatitis
☐ Hiatal hernia
☐ High blood pressure
☐ High cholesterol
☐ HIV
☐ Hyperthyroid (high)
☐ Hypothyroid (low)
☐ Kidney disease
☐ Liver disease
☐ Migraines
☐ Nasal Polyps
☐ Osteoporosis
☐ Otitis media (ear infections)
☐ Perforated ear drum
☐ Prostate Enlargement
☐ Pulmonary Embolism
☐ Reflux
☐ Recurrent tonsillitis
☐ Skin cancer
☐ Sinus infections
☐ Sleep apnea
☐ Stroke
☐ Throat cancer
☐ TMJ (Jaw joint)
☐ Thyroid nodule

☐ History of bleeding or clotting problem. Please specify: ____

☐ Other, not listed above: ____

Past Surgical history (please list month and year of procedure):

History of problem with anesthesia. Please specify: ____

Ear surgery (eg. Ear tubes, Ear drum repair, Mastoid surgery): ____

Nasal surgery (eg. Septoplasty, Turbinate reduction, rhinoplasty): ____

Sinus surgery (eg. Balloon sinuplasty, sinus surgery, polyp removal): ____

Throat surgery (eg tonsils, adenoids, UPPP): ____

Neck surgery (eg. Thyroid, carotid surgery, tracheostomy): ____

Other (eg. Appendix, cataracts, gallbladder, heart surgery, heart stents, hemorrhoids, hernias):

____

____

____

Family History: Have any family members been diagnosed with any of the following? Please check all appropriate.

	Father	Mother	Brother	Sister
Allergy				
Asthma				
Bleeding/clotting				
Diabetes				
Hearing loss before 50				

	Father	Mother	Brother	Sister
Heart Disease				
Heart attack				
Anesthesia prob				
Stroke				

Cancers (specify type): ____

Other: ____

Acknowledgment Receipt: HIPAA Notice of Privacy Practice

In signing this form, you agree that you have received our Notice of Privacy Practices. This Notice, among other points, explains how we plan to use and disclose your protected health information for the purposes of treatment, payment and health care operations. This applies to the privacy practices of Alpine Ear Nose & Throat PC and all affiliated covered entities of Alpine Ear Nose & Throat PC issuing this Notice. You have the right to review our Notice of Privacy Practices prior to signing this form. It provides more detail on how we may use and disclose your information. The Notice of Privacy Practices may change. A current copay may be requested by anyone in our check in areas, by mail and by clicking the link "Patient Privacy" on the bottom of our internet home page.

By signing this form, you acknowledge, you have received our Notice of Privacy Practices and the Alpine Ear Nose & Throat PC and all affiliated covered entities can use and disclose your protected health information in accordance with HIPAA.

______________________________ ______________________________
Name of Patient (please print) Date

______________________________ ______________________________
Signature of Patient or Patient Representative Relationship of Representative

The following family members or representatives have my authorization to obtain or relay medical information with Alpine Ear Nose & Throat PC.

Name (please print)	Relationship	Phone Number
Name (please print)	Relationship	Phone Number
Name (please print)	Relationship	Phone Number

FINANCIAL POLICY

Please take a few minutes to review the following information prior to your appointment. We hope you understand that our financial policies are established to assure the financial resources needed to maintain this medical office for all our patients. We will work with you to ensure that your medical care does not become a financial burden.

- Charges for medical services are due and payable at the time of service. We accept cash, personal checks, and major card credit cards for payment of your account.

- Your insurance policy is an agreement between you and your insurance company. Our relationship is with you, and not with your insurance company. Therefore, all charges are ultimately your responsibility, regardless of your insurance status. We expect any required co-payments, co-insurance, or deductibles due at time of service

IT IS THE PATIENT'S RESPONSIBILITY TO KNOW THEIR BENEFITS. YOUR POLICY MAY APPLY ALLERGY TESTING/INJECTIONS, AUDIO TESTS, CONSULTATIONS, SCOPES (including postoperative scopes) and other office procedures, TO YOUR DEDUCTIBLE; THEREFORE, IF YOU HAVE QUESTIONS REGARDING YOUR BENEFITS, IT IS IN YOUR BEST INTEREST TO CONTACT YOUR CARRIER DIRECTLY.

If you have an appointment with the Audiologist and an ENT or Allergy Provider, your insurance will be billed for each visit.

I authorize Alpine ENT to furnish diagnosis and records of any treatment or examination rendered to me or my child during the period of such care to any or all of the following: Physicians involved in my treatment, Medicare, my insurance carrier(s), or my employer (for work related injuries).

I authorize and request my insurance company to pay directly to the doctor(s) group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

If you do not have insurance, we offer a Self-Pay discount and will require payment at check-in that will be applied toward the charges for that visit. This payment should not be considered payment in full for that visit.

Please sign and date this form. Upon return to the Receptionist, we can provide you with a copy for your records.

I have read and understand the above statement. I understand that accounts 30 days past due are subject to collection proceedings. Should my account become delinquent and turned over to an attorney and/or collection agency, I will be responsible for all costs of collections, legal fees and/or attorney fees.

______________________________	______________________________
Name of Patient (Please Print)	Date
______________________________	______________________________
Signature of Patient or Representative	Relationship of Representative

Late Arrival, No-Show & Same Day Cancellation Policy

We are glad you have chosen Alpine Ear, Nose and Throat! We look forward to providing your care and building a collaborative relationship with you.

We know unexpected circumstances pop up in everyone's life. Sometimes they make us unavoidably late to appointments or unable to get to them at all. We understand. We will always do the best we can to be flexible and deliver the planned care you need in our physician and provider offices. However, there may be times when we must reschedule a visit for a patient who arrives late for their appointment, or a patient may need to wait to see our providers, so we don't interrupt the appointment scheduled for patients who arrived on time.

Again, we know life sometimes throws the unexpected at us. If you are going to be late or won't make your appointment at all, give us a call no less than 24 hours before your appointment to let us know. We'll do our best to be flexible. But please be aware of these policies we practice so we can ensure all our patients – yourself included – get quality time with their provider as scheduled.

Definitions

"No Show" shall mean any patient who fails to arrive for a scheduled appointment.

"Same Day Cancellation" shall mean any patient who cancels an appointment less than 24 hours before their scheduled appointment.

"Late Arrival" shall mean any patient who arrives at the clinic 15 minutes after the expected arrival time for the scheduled appointment.

Late Patient Policy

When a patient is 15 or more minutes late for their expected arrival time, we will check you in for your visit if we can do so without disrupting the needs of other patients. If your visit disrupts other patients' needs, we'll try to offer you another appointment on the same day. If that doesn't work for our providers, staff, and you, we will reschedule with the original provider at their next-available date.

No-show/Same-Day Cancellation Patient Policy

When a patient does not notify their provider's office of a need to cancel or reschedule and does not arrive for an appointment, or cancels the same day, we call this a no-show. Frequent no-shows can cause challenges for provider offices when important time for patients goes unused. We'll remind you of your upcoming appointment by text or phone several days in advance and give you the opportunity to let us know of any need to cancel or reschedule. If a patient is a no-show, we'll alert them to ensure awareness. A patient who does not show up (or same day cancels) two times within 12 months will not be scheduled without patients' primary care or referring providing contacting the Alpine provider to request another appointment. If you know you must miss an appointment, please contact us 48 hours prior to the day before if you can. If something happens closer to your appointment time, call to let us know.

______________________________________ ______________________________________

Name of Patient (Please Print) Date

______________________________________ ______________________________________

Signature Relationship of Representative