COMMONWEALTH
Ear, Nose & Throat Specialists

Patient Information

Referring Physician _____ Primary Care Physician _____
Patient's Full Name_____ Date of Birth_____/_____/_____
Age _____ Marital Status _____ Sex: ☐ Male ☐ Female Social Security # _____
Address_____ Apt. # _____
City_____ State_____ Zip code_____
Home Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____
Email Address _____
Preferred Method of Contact ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Email
Pharmacy Name _____ Pharmacy Loc. & Phone#_____
Race_____ Ethnicity_____ Language_____

Emergency Contacts

Name	Relationship	Contact #

Responsible Party

If you are providing the information above for a patient under the age of 18 years old, please complete this section below:
Name_____ Relationship to Patient _____
DOB_____/_____/_____ Phone (____) _____
Address (If different from above) _____

Insurance Information

Primary Insurance Company_____ Policy ID#_____ Group# _____
Policy Holder's Name_____ DOB_____/_____/_____
Employer (If GHP) _____ Phone_____ Relationship to Patient_____
Secondary Insurance Company _____ Policy ID#_____ Group# _____
Policy Holder's Name_____ DOB_____/_____/_____
Employer (If GHP) _____ Phone_____ Relationship to Patient_____
Is today's visit pertaining to a motor vehicle accident or a worker's compensation injury? ☐ **Yes** ☐ **No**
If you answer yes, please complete the following information:
Insurance Company Name_____
Agent Name/Contact Name_____ Phone (____) _____
Claims/Billing Address_____
Claim#_____ Date of Accident or Injury_____

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Name_____ Date of Birth_____ Age_____

Referring Physician_____ Primary Care Physician & Tel#_____

Occupation_____ Employer_____

Please specifically give the reason for your visit: _____

If your reason involves an injury or injuries, please describe the nature and give dates: _____

Do you currently have, or have you ever been treated for any of the following conditions:

- ☐ Allergies
- ☐ Anemia
- ☐ Asthma
- ☐ Cancer
  Type: _____
- ☐ COPD or emphysema
- ☐ Depression
- ☐ Diabetes
- ☐ GERD/Acid Reflux
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Heart Problems: _____
  _____
- ☐ Hepatitis
- ☐ Hiatal Hernia
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Irregular Heartbeat
- ☐ Kidney Disease
- ☐ Latex Allergy
- ☐ Liver disease
- ☐ Low Blood Sugar
- ☐ Lupus
- ☐ Migraines
- ☐ Mitral Valve Prolapse
- ☐ MRSA
- ☐ Nasal Obstruction
- ☐ Pneumonia
- ☐ Psychiatric Problems
- ☐ Rheumatoid Arthritis
- ☐ Sickle Cell Disease
- ☐ Sleep Apnea
  ☐CPAP
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Tuberculosis
- ☐ Other: _____
  _____
  _____

In the past 6 months, have you experienced:

☐Weight loss	☐Chest Pain	☐Joint Pain
☐Nausea/Vomiting	☐Shortness of breath	☐Headaches
☐Fever/Chills	☐Nasal Obstruction	☐Depression
☐Night Sweats	☐Muscle weakness	☐Sore throat
☐Fatigue	☐Difficulty Swallowing	☐Heartburn

Social History

Do you currently use tobacco? ☐Yes ☐No

Packs per day _____ How long? _____ years

If you smoked previously, when did you quit? _____

Does anyone in the house smoke? ☐Yes ☐No

Do you drink alcohol? ☐Yes ☐No

Indicate if drugs or alcohol ever posed a dependency problem for you: ____ Drugs _____ Alcohol

SURGERIES ☐ **Check if none**

List all surgeries you have had, including childhood surgeries such as tonsillectomy or ear tubes:

Surgery	Date	Surgeon/Hospital

MEDICATIONS (List on a separate sheet if you have more to list) ☐ **Check if none**

List all medications you are currently taking (including over the counter medicines, aspirin or aspirin containing medicines, birth control pills, diet pills, Vitamin E, or herbal preparations), along with the dosage and frequency:

Medication	Dosage	Duration (How long?)

ALLERGIES TO MEDICATIONS (List on a separate sheet if you have more to list)

List any medications to which you are allergic: ☐ **Check if none**

Medication	Type of reaction

Do you or anyone in your immediate family have a history of bleeding problems? ☐No ☐Yes: explain_____

Do you or anyone in your immediate family have a history of anesthesia reactions? ☐No ☐Yes: explain_____

Do you have a history of bad scarring? ☐No ☐Yes: explain_____

(Female Patients) Are you currently Pregnant and/or breastfeeding? ☐No ☐Yes: explain_____

For office use

☐ Dr. Bridges
☐ Dr. Gibbons
☐ Dr. Kerr
☐ Dr. Fishero

☐ Entered in EMR

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Please read, initial, and sign acknowledging that you have read and understand each policy below.

Acknowledgement of Financial Responsibility

_____ I hereby authorize Commonwealth ENT Specialists, P.C. to release medical information to any of my physicians or insurance companies that may be pertinent to my case. I hereby authorize the release of medical records to third party insurers or other authorized persons to whom disclosure is necessary to establish or collect a fee for the service. I understand that I am financially responsible for charges not covered by my insurance company. A photocopy of this authorization shall be valid as the original.

Referral Policy

_____ If your insurance carrier requires a referral for you to see a specialist, it is your responsibility as the patient and insured party to contact your primary care office and notify them of your upcoming appointment with the Commonwealth ENT Specialists, at least 72 hours in advance so that an insurance referral can be generated in a timely manner. If no referral is provided, then the patient will be held responsible for any payment of services rendered.

Acknowledgement of Receipt of Notice of Privacy Practices

_____ I acknowledge that I have received from the Practice a copy of a separate document, entitled, "Notice of Privacy Practices" which sets forth this Practice's privacy practices and my rights regarding the privacy of my protected health information.

Consent for Use or Disclosure of Patient Information for the Purposes of Treatment, Payment, and Healthcare Operation

_____ I hereby consent to Commonwealth ENT Specialists using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me or to carry out the Practice's healthcare operations. I also consent to Commonwealth ENT using or disclosing my protected health information for treatment activities provided by another health care provider, as well as the payment activities conducted by another healthcare provider or entity. I further consent to the disclosure of my protected health information for another provider or health care entity to conduct healthcare operations including but limited to quality assessment and reviewing the competence of healthcare professionals.

Patient's Consent for Provider to Disclose PHI to Authorized Persons

I hereby authorize you, my healthcare provider, to disclose any and all of my medical and protected health information (PHI) to the person(s) indicated below:

	Name	Relationship	Contact #
1.	_____	_____	_____
2.	_____	_____	_____

If you do not have anyone that you would like to have permission to, still sign and date below to acknowledge that you have read this.

_____ _____

Patient Name or Representative Date

_____

If a Representative signs, state the Representative Authority

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Informed Consent

Endoscopy and Cerumen Removal

Please be aware that certain procedures to include but not limited to endoscopy + binocular microscopy and cerumen removal in our office are not included in the standard visit. These procedures will be billed separately in addition to the office visit charges and may be subjected to your deductible and coinsurance as some insurance companies may list this diagnostic procedure as "surgery" on the explanation of benefits form that you receive.

Patients presenting to our office with sinus, allergy, throat/voice complaints, or cerumen impaction require a thorough exam of that specific area. In some cases, this can only be accomplished using an endoscope or microscope. These procedures have almost no risk and provide your physician with excellent view of the area involved. Complications may include bleeding, reaction to the topical anesthesia, pain and coughing or shortness of breath. These are all very rare.

Please sign below to acknowledge that you have read the above and agree to undergo the procedure as deemed necessary by your physician upon your visit.

AUTHORIZATION TO PERFORM PROCEDURE:

_____ _____

Patient Name Date

_____ _____

Patient/Guardian Signature Witness

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Cancellation and No-Show Fees for Doctor Appointments, Audiograms, VNG, and Surgery

Missed/Cancellation Appointment Policy: At Commonwealth Ear Nose and Throat Specialists, P.C., we are dedicated to serving our patients. It is our goal to service every patient in the same courteous manner, therefore, we require 24 BUSINESS hour notice prior to canceling or rescheduling any appointments. If advanced notification is not given, Commonwealth Ear Nose and Throat Specialists, P.C., reserves the right to charge a cancellation fee (listed below). These fees are not covered by your insurance company. Under certain circumstances, Commonwealth Ear Nose and Throat Specialists, P.C., also has the right to refuse care for future services and may result in being discharged from the practice.

Courtesy Reminder: Commonwealth Ear Nose and Throat Specialists, P.C., provides text, e-mail, and phone call reminders to its patients as a courtesy. In the event of issues or failure of technology, **patients are still held responsible for attending their scheduled appointments.**

Less than 24 business hour notice or No-Show:
Doctor Appointment: $60.00
Audiogram Appointment: $60.00
VNG Appointment: $120.00

CANCELLATION/NO SHOW POLICY FOR SURGERY:

To consider the hospital staff and anesthesia staff, it is necessary for us to implement a cancellation/no show policy. If you need to cancel your surgery, we ask that you do so in a timely manner.

Cancellations less than seventy-two hours before surgery will be charged a two-hundred-dollar ($200.00) fee; this will not be covered by your insurance company.

Cancellations less than twenty-four hours before surgery will be charged a four-hundred-dollar ($400.00) fee; this will not be covered by your insurance company.

I have read, understood and agree to the fees and payment obligations as listed above:

_____

PRINT

_____ _____

Signature Date

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COLLECTIONS POLICY

Collection Agency/Attorney Fees

In the event that your account is turned over to a collection agency or attorney, you agree that you will be responsible for a collection fee equal to 33.3% of the outstanding balance due on the date the account is turned over for collection.

Collection Costs

In the event that the account becomes delinquent and is necessary to expend costs for the collection of the account, you understand that you will be responsible for the costs. These costs could include court costs for filing suit against you.

_____ _____

Patient/Responsible Party Signature Date