OC EAR, NOSE, THROAT
HEAD & NECK SURGERY

3500 Barranca Parkway Suite 325 Irvine CA 92606
Tel: (949) 715-0500 Fax: (855)558-2730 www.ENTdoctorOC.com

PATIENT NAME: _____ DOB: _____

Parent/Guardian Name : _____ SS#: _____

Address City State Zip

Home phone Cell phone I give my permission to be contacted at/by: ☐ Home ☐ Cell ☐ Email ☐ Text Ok to leave message? __yes __ no

E-MAIL _____ What is your primary language? _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated Gender ☐ male ☐ female ☐ non-binary

INSURANCE INFORMATION (Must be filled out completely for verification purposes) ☐ **Check HERE if you have NO insurance**

Primary insurance company Policyholder name Policyholder DOB Patient relationship to insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy # Group #

Secondary insurance company Policyholder name Policyholder DOB Patient relationship to insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy # Group #

We are required to ask this question about your race: ☐ White or Caucasian ☐ Hispanic or Latino ☐ Black Hispanic or Latino ☐ Black or African American ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Asian ☐ Other ☐ I prefer to not answer

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I authorize the release and/or discussion of my health information with the following persons.This authorizes access to your medical chart.

Name_____ Relationship _____ Phone number _____

Name_____ Relationship _____ Phone number _____

Do you have an Advance Directive? ☐ Living Will ? ☐ Medical Power of Attorney? ☐

☐ Do not discuss my information with anyone. (**Information may be released per HIPAA guidelines for treatment, payment, and operations**)

PHARMACY

Name of Pharmacy Address/Cross Streets: Phone number

EMERGENCY CONTACT (This is who will be called if you have an emergency while in the office)

Name_____ Relationship _____ Phone number _____

I declare that the above answers and statements are true and correct to the best of my knowledge. I hereby acknowledge that I have read this entire section front and reverse, and agree to of all the terms herein.

x_____ _____

Signature of patient, responsible party Date

NEW PATIENTS: Please indicate how you heard about us. Thank you!

☐ Physician ☐ Friend ☐ Word of mouth ☐ Insurance company ☐ Internet ☐ Other:

Referring Physician: **Primary Care Physician**:

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Financial Policy

I. Financial Policy

This is a statement of OCHNS' financial policy. You understand that you are obligated to ensure that our fees are paid in full. We will verify your coverage and bill your insurance carrier on your behalf. You agree that you will pay any deductible, co-payment, and/or co-insurance as determined by your insurance plan. Those payments will be due at the time of service. Many insurance companies have additional requirements or stipulations that may affect your coverage. You are responsible for any amounts not covered or payable by your insurance. If your insurance denies any part of your claim, you agree to be responsible to pay the full balance. Claims not paid within 90 days will be made patient due; the patient will then need to contact the insurance company for further claims payment actions. Late fees/penalties may apply.

II. No Show/Cancellation Policy

OCHNS requires a minimum of 24-hour notice from our patients when canceling or rescheduling an appointment. Failure to cancel/reschedule before the 24 hour window will result in a $50 FEE per infraction (payable upon receipt of billing). Telephonic reminders are made by our staff when time permits. However, it is ultimately the patient's responsibility to remember scheduled appointments. You may leave notice of cancellations/re-schedules via phone 949-715-0500 but it must be at least 24 hours in advance of the appointment time. Please assist us in maintaining good service through efficiency.

III. Office Visits and In office Procedures

Office visits are considered as the evaluation of you by the physician. Any diagnostic materials/tools that are used during the office visit may be termed as a "Surgery" as outlined by the CPT guidelines by the American Medical Association. These can include, but are not limited to,: scopes used to visualize the throat , ear canals, or nasal passages, CT scans, ear cleanings, hearing tests, injections, allergy serums and the preparation, etc. The copay usually covers ONLY the office visit (consultation) and your deductible/co-insurance will apply to all other services that happen during the consultation.

IV. HIPAA (Health Insurance Portability and Accountability Act of 1996)

We disclose your protected health information to carry out treatment, payment, and health care operations. If you would like a more detailed description of such uses and disclosures, please refer to the Notice of Privacy Practices. You have the right to review the Notice of Privacy Practices before signing this consent form. The terms of the Notice of Privacy Practices may change from time to time. You can get a copy of the latest Notice of Privacy Practices by contacting our office. We also will post a copy of our current Notice of Privacy Practices in our office.
You have the right to request that we restrict how we use or disclose protected health information to carry out treatment, payment, or health care operations. We do not have to agree to such requests, but must honor the requests to which we agree. You have the right to revoke this consent in writing, and the revocation will become effective except to the extent that we acted in reliance on your consent.

My Acknowledgement

I have read and understand the financial and no show/cancellation policy described above. I agree to pay, promptly and in full, any amounts due to the provider, including co-payments, deductibles, surgery deposits, and amounts due for non-covered or services that are not payable by my insurance.

Patient Signature _____ **Date**_____

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NOTICE OF PRIVACY PRACTICES
(MEDICAL)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

The Health insurance Portability & Accountability Act of 1996 ("HIPPA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entitles that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.**
- **Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.**
- **Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.**

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- **The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to restriction, we much abide by it unless you agree in writing to remove it.**
- **The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.**
- **The right to inspect and copy your protected health information.**
- **The right to amend your protected health information.**
- **The right to receive an accounting of disclosures of protected health information.**

The right to obtain a paper copy of this notice from us upon request.
We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with our office or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filling a complaint.

<u>Health Information Exchange</u>
This practice is participating in the Hoag Health Information Exchange (HIE), an electronic system through which it and other participating healthcare providers can share patient information according to nationally recognized standards and in compliance with federal and state law that protects your privacy. Through the HIE, your participating providers will be able to access information about you that is necessary for your treatment, unless you choose to have your information withheld from the HIE by personally opting out from participation.

If you choose to opt out of the HIE (that is, if you feel that your medical information should not be shared through the HIE), We will continue to use your medical information in accordance with this Notice of Privacy Practices and the law, but will not make it available to others through the HIE.

To opt out of the HIE, please contact the Hoag Director of Health Information Exchange in writing at One Hoag Drive, Newport Beach, CA 92663, or by telephone at 949/764-8722.

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IN OFFICE PROCEDURES

Please be aware that certain procedures performed in our office are not included in the standard office visit fee. These procedures will be billed separately and in addition to the office visit charges. Your insurance company may classify these procedures as "Surgery" and apply the charges to your calendar year deductible. The result may be insurance payment for an office visit but not a procedure. In such cases, payments for the procedure will be due from the patient. Be assured that we are following accepted billing coding and guidelines as outline by the American Medical Association.

The physicians of Orange Coast Head and Neck Surgery only perform these procedures when deemed medically necessary to best diagnose and treat our patients. If you are presenting with a sinus, or throat/voice complaint or an ear complaint, in order for the physician to thoroughly examine the area, there is a good chance the surgeon will need to perform one of these procedures.

Examples of in-office procedures include but not limited to:

- **CPT 31231 Nasal Endoscopy**
  This procedure uses the flexible or rigid scope attached to a light source to view areas of the nasal cavities that can not be view by the surgeon using the standard nasal speculum and head mirror.
- **CPT 31237 Nasal Endoscopy with Debridement or Biopsy**
  This is the same procedure as above with removal of crusting or tissue.
- **CPT 69210**
  This procedure requires use of an instrument to remove ear wax from one or both ears.
- **CPT 92614**
  This procedure involves the passing a long thin flexible fiber optic scope through the nasal cavity to the throat. The fiber optic scope enables the surgeon to visualize the areas of the throat not readily seen. This may be performed as a video recording
- **CPT 92615**
  This is the interpretation and report of above procedure.

Please speak with our billing department if you have any questions.

Patient Name (Print): _____

Patient/Guardian Signature: _____

Date: _____

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Health History

Name: _____ Date of Birth: _____

☐ Primary Doctor ☐ Referring Doctor ☐ Previous Doctor: _____

Reason for Visit: _____

Current Pharmacy (Name and Cross Streets): _____

Other Medical Problems:

1 _____ 4 _____ 7 _____

2 _____ 5 _____ 8 _____

3 _____ 6 _____ 9 _____

Previous Surgeries:

1 _____ 4 _____ 7 _____

2 _____ 5 _____ 8 _____

3 _____ 6 _____ 9 _____

Current Medications (Attach List if Available)

	Medication	Strength	Frequency
1			
2			
3			
4			
5			
6			
7			

Allergies to Medications: _____

Environmental Allergies: _____

Health Habits/Personal Safety:
Tobacco Use: ☐ Yes ☐ No Type: ☐ Cigarettes ☐ Pipe ☐ Chewing tobacco
How long? _____ Year Quit: _____
Alcohol Use: ☐ Yes ☐ No Frequency: ☐ Occasional ☐ Several times per week ☐ Daily
History of Head and Neck Cancer in the Family? _____

The listed medications are most current and correct _____ _____

Patient Signature **Date**

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Health History - Current Symptoms

Patient Name: _____

General Symptoms	Yes	No	Describe
Persistent Infections			
Chills			
Fever			
Bruising			
New Lesions			
Rash			
Headache			
Head Injury			
Visual Disturbances			
Decreased Hearing			
Ear Discharge			
Ear Pressure			
Ear Itch			
Ringing in the Ears			
Vertigo			
Nasal Pain			
Runny Nose			
Post-Nasal Drip			
Mouth Discomfort			
Dry Mouth			
Nose Bleed			
Nasal Congestion			
Sinus Pain			
Mouth Lesion(s)			
Oral Ulcers			
Sore Throat			
Voice Changes			
Neck Mass			
Neck Pain			
Swollen Glands			
Cough			
Snoring			
Difficulty Breathing			
Pain On Swallowing			
Heartburn			
Vomiting			
Difficulty Speaking			
Dizziness			
Unsteadiness			

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Patient Partnership Plan

Dear Patient,

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your ***best possible health*** requires a "partnership" between you and your doctor. As our "partner in health," we ask you to help us in the following ways:

Schedule Visits with My Doctor for Routine Exams and Other Recommended Health Screenings

I understand that my doctor will explain to me which regular health screenings are appropriate for my age, gender, and personal and family history. I understand I will need to complete these recommended health screenings (ENT examination, audiometric testing, nasal endoscopy, CT scan, etc). **These health screenings are tests that can help detect life-threatening diseases and conditions.** If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and to discuss these health screenings.

Keep Follow-up Appointments and Reschedule Missed Appointments

I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him or her the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

Call the Office When I Do Not Hear the Results of Labs and Other Tests

I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results.

Inform My Doctor if I Decide *Not* to Follow His or Her Recommended Treatment Plan

I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that *not* following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide *not* to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, **at any time**, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

Patient Name (Print)	Date	Patient Signature