Maryland ENT Center, L.L.C.

Otolaryngology-Head & Neck Surgery, Facial Plastic & Reconstructive Surgery, Nose & Sinus Surgery, Audiology & Hearing Aid Services

PATIENT DEMOGRAPHIC AND INSURANCE INFORMATION

Today's date:	PCP:		
PATIENT INFORMATION			
Patient's Last Name: First: Middle:			Marital status (circle one) Single / Mar / Div / Sep / Wid
Social Security Number:	Birth date: / /	Sex: ❑ M ❑F	Referring Physician Name / Phone #:
Street address:		Home Phone Number: ( )	Cell Phone Number: ( )
P.O. Box:	City:	State:	ZIP Code:
Occupation:	Employer:		Employer Phone: ( )
E-Mail (Utilized for appointment reminders)			

INSURANCE INFORMATION		
Primary Insurance:	Insurance Holder's Name:	Insurance Holder's Birth Day: / /
Patient's relationship to insurance holder:	❑ Self ❑ Spouse ❑Child ❑ Other	
Secondary Insurance	Insurance Holder's Name:	Insurance Holders Birth Day: / /
Patient's relationship to insurance holder:	❑ Self ❑ Spouse ❑ Child ❑ Other	

NOTE: If the patient is not the primary insurance holder, the office will need to know the policy holder's date of birth for claims processing. Without this information, claims may deny and a bill could be erroneously sent to you (see *Financial Policy*).

IN CASE OF EMERGENCY			
Name of Individual:	Relationship:	Home Phone ( )	Work Phone: ( )

I hereby authorize Maryland Ear, Nose & Throat, L.L.C. and The 33rd Street Surgery center as their billing agent to apply for benefits on my behalf for covered services rendered. I request payment from Medicare B or other insurance carrier to be made directly to the provider. I certify that the information I have reported with regard to my insurance is correct and further authorize the release of any necessary information, including medical information to other insurance carrier, or above named group, or to my referring physician (in case of Medicare benefits, HCFA). This information may be revoked by my insurance or me at any time in writing. I understand and agree to be responsible for any portion of this claim that, for any reason, is not covered by my insurance.

_____ _____

Patient/Guardian signature *Date*

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PAST MEDICAL, SOCIAL, & FAMILY HISTORY

To the best of your knowledge, do you, or have you experienced any of the following conditions (please circle)?

Anemia	Difficulty Urinating	Nausea and/or Vomiting
Anesthesia Problems	Emphysema	Numbness
Angia	Facial Pain and/or Pressure	Post Nasal Drip (Excessive mucous in back of nose/throat)
Anxiety	Fever	
Arthritis	Frequent Urination	Production of Sputum
Asthma	General Allergies	Recurrent Sinusitis
Back Pain	Hearing Loss	Recurrent Urinary Infection
Bleeding Disorder(s)	Heart Attack	Runny Nose
Blood In Urine/Stool	Heart Palpitations	Seizure Disorder or Epilepsy
Cancer	Heartburn	Skin Rash
Change in Bowel Habits	Hepatitis	Sleep Apnea
Chest Pain	High Blood Pressure	Spitting Blood
Chronic Headaches	HIV and/or AIDS	Stroke
Constipation	Jaundice	Thyroid Disorder
Coronary Disease	Kidney Disease	Tinnitus/Ear Ringing
Cough	Loss of Appetite	Vertigo/Dizziness
Depression	Mental Illness	Weakness of the Extremities
Diabetes	Migraine Headaches	Weight Loss
Diarrhea	Muscle Weakness	Wheals
Difficulty Swallowing	Nasal Congestion	Wheezing

Do you have any **allergies** (please list all medications and/or foods): _____

_____

Please list all **current medication** (all prescription and non-prescription): _____

_____

Previous major **surgery** (please specify type of surgery and date performed): _____

_____

Do you have an **advance directive**? ❑ Yes ❑ No Have you **provided the office** with a copy? ❑ Yes ❑ No

SOCIAL HISTORY				
Type	***Y/N***	***Frequency per wk.***		
Smoking/Tobacco Use *Quit Date:* _____	Y / N	0-2	3-5	Daily
Alcohol Use *Quit Date:* _____	Y / N	0-2	3-5	Daily
Recreational Drug Use *Quit Date:* _____	Y / N	0-2	3-5	Daily
Caffeine Intake *Quit Date:* _____	Y / N	0-2	3-5	Daily
Exercise	Y / N	0-2	3-5	Daily

FAMILY HISTORY		
Condition	*Y / N*	*Family Member*
Anesthesia Problems	Y / N	
Asthma	Y / N	
Bleeding Disorder	Y / N	
Coronary Heart disease	Y / N	
Diabetes	Y / N	
Epilepsy	Y / N	
Hearing Loss	Y / N	

Alan H. Shikani, MD, FACS ***Mohammad Abraham Kazemizadeh Gol, MD*** ***Pat Tana, MD, FACS***

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FINANCIAL POLICY

In order to continue to offer exceptional patient care, Maryland ENT Center, LLC & 33RD Street Surgery Center, LLC adhere to the following strict financial policy.

For any services rendered by our physicians (at our office locations, hospital locations, or surgical center locations), our office will bill according to the insurance information provided to us. Once the insurance payment processes (in accordance with any copayment, deductible, or co-insurance), our office will forward any remaining patient balance as directed by your insurance. If your insurance denies coverage, or cannot identify you as insured using the data you have provided to our office, you will receive a statement in the mail for the balance.

For patients without insurance coverage and patients with known copayment amounts, payment will be requested at the time you check in for your appointment. For your convenience we accept cash, checks, Visa and MasterCard.

Our office will mail out statements detailing any remaining patient balance on your account. Payments may be made in person, by phone, or by mail. If payment is not received despite 3 billing statements, sent over the course of 100 calendar days, your account could be at risk of being turned over to our external collection agency.

APPOINTMENT REMINDER POLICY

We utilize appointment reminders in an effort to maximize kept appointments. Your home phone number, mobile phone number, and email address will be utilized to employ a third-party automated outreach and messaging system, for the purpose of notifying you of: pending appointments, missed appointments and or other healthcare related functions. The reminder messages will not contain detailed personal information regarding your appointment; they will only contain the location, provider, and any special instructions for your visit.

CANCELLATION & NO SHOW POLICY

We understand that life can be busy, but we ask that your respect the time and energy of our staff, and your fellow patients. Most importantly we ask that you place your health first; chronic cancellations and no shows negatively impact your care. Should you need to cancel we ask that you do so as soon as you are aware, so we can avoid any unnecessary fees.

* No show appointments	Fee: $20.00
*Canceling within 24 hour period of follow up appointment	Fee: $20.00
*Canceling within 24 hour period of in-office procedure appointment.	Fee: $100.00
*Canceling within one week of scheduled surgical appointment.	Fee: $100.00

ALL FEES MUST BE PAID IN FULL AT THE TIME OF RESCHEDULING

I have read and understand the policies of the practice and I agree to be bound by the terms. I also understand and agree that such terms may be amended from time to time by the practice.

SIGNATURE OF PATIENT/PARENT DATE

PRINT NAME OF PATIENT (MINOR) DATE

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NOTICE OF PRIVACY PRACTICES

Uses and Disclosure

We may use or disclosure identifiable health information about you without your authorization in situations related to your treatment, to obtain a payment for treatment, and continuity of care with other providers who are also responsible for your care. Information may be shared by paper mail, electronic mail, fax or other methods.

Patient Rights

In most cases, you have the right to look at or get a copy of health information about you. If you request copies, we may charge you only normal photo copy fees. You also have the right to receive a list of certain types of disclosures of your information that were made. If you believe that information in your record is incorrect, you may have the right to request that we correct the existing information.

We are required by law to protect the privacy of your information, provide this notice about our information practices, follow the information practices that are described in this notice, and see your acknowledgement of receipt of this notice. Before we make significant change in our policies, we will change our notice and post the new notice in the reception area. You can also request a copy of our notice at any time.

HIPAA Release

This section is used to confirm the individual(s) you authorize to request, to use, or to disclose your health information. Maryland ENT Center, LLC & 33RD Street Surgery Center, LLC, will only disclose information to the individuals listed below. It is not required that you release this information, if you do not wish to add any individuals, please leave blank.

NAME RELATIONSHIP PONE NUMBER

_____

_____

_____

_____

I authorize the use and/or disclosure of my health information as described in the HIPAA Release section. I understand this authorization is voluntary. I understand if the persons I authorize to receive and/or use my health information are not subject to the federal or state health information privacy laws, they many further disclose my health information, and it may no longer be protected by the health information privacy laws.

_____

SIGNATURE OF PATIENT/PARENT DATE

_____

PRINT NAME OF PATIENT (MINOR) DATE

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Patient's Consent for Nasal Endoscopy and/or Laryngoscopy

Maryland ENT Center, LLC is comprised of physicians (known as otolaryngologists) who specialize in treating ailments related to the ears, nose, throat and neck region. An *endoscope* is a long and slender, minimally invasive medical device commonly used by ENT doctors to examine the nose and/or larynx (also called the "voice box"). An *endoscopy* can be performed during initial and follow-up appointments

Nasal Endoscopy

Indications for the use of a nasal endoscopy include, but are not limited nasal stuffiness and obstruction, sinusitis, allergic rhinitis, nasal polyps, nasal tumors, and epistaxis (nose bleeds). Just before a nasal endoscopy, the nose will be sprayed with lidocaine (a topical anesthetic), which temporarily numbs the nose and helps to decrease the chance of sneezing.

Upper Airway Endoscopy (Laryngoscopy)

Indications for the use of a laryngoscope to examine the upper airway include, but are not limited to voice problems, such as a breathy voice, scratchy throat, hoarse voice, weak voice, or no voice; trouble swallowing, a feeling of a lump in the throat, phlegm and/or mucus in the throat, spitting blood, laryngitis, throat symptoms related to acid reflux or GERD; injuries to the throat, narrowing of the throat (strictures), or blockages in the airway; history of head and neck cancer or history of heavy smoking. Just before a laryngoscopy, the throat will be sprayed with lidocaine (a topical anesthetic) to temporarily numb the throat to decrease the chance of gagging during the procedure.

I, _____ understand an endoscopy may be performed during my examination if deemed necessary by the treating ENT physician. I consent to the procedure and I accept full financial responsibility for the cost of the endoscopy should my insurance company not pay for the cost of the procedure. I understand that, if the physician feels that is indicated, I may have to undergo a follow up endoscopy or laryngoscopy during future appointments. I also understand that I have the right to decline this procedure and that such a decision could limit the doctor's ability to accurately assess my condition.

SIGNATURE OF PATIENT/PARENT DATE

PRINT NAME OF PATIENT (MINOR) DATE

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Sino-Nasal Wellness Update

Below you will find a list of symptoms and social/emotional consequences of rhinosinusitis. We would like to know more about these problems and would appreciate your answering the following questions. There are no right/wrong answers, and only you can provide us this information.

	SEVERITY				FREQUENCY		
	N/A	Mild	Moderate	Severe	Occasionally/ Never	Seasonal	Most of the Year/Daily
Itchy Eyes	0	1	2	3	0	1	2
Watery Eyes	0	1	2	3	0	1	2
Red Eyes	0	1	2	3	0	1	2
Runny Nose	0	1	2	3	0	1	2
Itchy Nose	0	1	2	3	0	1	2
Stuffy Nose	0	1	2	3	0	1	2
Frequent Sneezing	0	1	2	3	0	1	2

	NO	YES
Have you ever been diagnosed with asthma?	☐	☐
Have you ever been diagnosed with atopic dermatitis?	☐	☐
Do you take prescription or over the counter medications to manage your allergy symptoms?	☐	☐

Name any of the above medications and last date taken: _____

_____

_____

_____

OFFICE USE ONLY:

Sum of Severity (0-21): _____ **Sum of Frequency (0-14):** _____

Order 95004: ☐ **Yes** ☐ **No** **Date of Last Physical Exam:** _____ /_____ /_____

Provider Signature: _____ **Date:** _____ /_____ /_____

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MARYLAND ENT CENTER, LLC AND AUDIOLOGY ASSOCIATES, INC.

As of November 1, 2018 Audiology Associates, Inc. acquired the audiology division at Maryland ENT Center, LLC. Many of our patients at Maryland ENT Center, LLC require additional testing, hearing aid checks and other appointments with an Audiologist. During your appointment with our Otolaryngologist, you may be referred to Audiology Associates, Inc. for further testing.

To streamline paperwork between our two companies, we have provided a HIPAA privacy form below, which will authorize Audiology Associates, Inc. to access your records through our electronic health record system.

Please be advised that you may incur separate specialist co-pays for your appointment with the physician at Maryland ENT Center, LLC., and your appointment with the audiologist at Audiology Associates, Inc., per the instructions of your insurance carrier.

Melissa J. Segev, Au.D.
Briana Bruno Holtan, Au.D.
Mikayla Abrams, Au.D.
Deirdre Courtney, Au.D.
Aimee Kaplan, Au.D.

Audiology Associates INCORPORATED

Jennifer Kincaid, Ph.D.
Corinne Richards, Au.D.
Candace G. Robinson, Au.D.
Sofia Roller, Au.D.
Jessica Verni, Au.D.

Authorization for Use or Disclosure of Protected Health Information (PHI), required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164).

1. **Authorization**: I authorize Maryland ENT Center, LLC (health care provider) to use and disclose the PHI described below to Audiology Associates, Inc. (health care provider).
2. **Effective Period**: This authorization covers all past, present and future periods of healthcare.
3. **Extent of Authorization**: I authorize the release of my complete health record.
4. **Use**: The medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I direct.
5. **Termination**: This authorization shall be in effect until the provider fulfills the request.
6. **Revocation Rights**: I understand I have the right to revoke this authorization in writing at any time. The revocation will be effective immediately upon my healthcare provider's receipt of my written notice, except that the revocation will not have effect on any action taken by my healthcare provider in reliance on this authorization before the receipt of my written notice of revocation.
7. **Benefits**: I understand my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

SIGNATURE OF PATIENT DATE

PRINT NAME OF PATIENT DATE