

GREENWICH

EAR, NOSE & THROAT

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? Yes 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:

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

Other Illnesses: _____

Current Medical Issues—Please check all that apply

- | | | | | | |
|----------------------------|------------------------------|-----------------------------|--------------------|------------------------------|-----------------------------|
| Eyes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Bleeding Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Lungs/Breathing | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Numbness/Tingling | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Digestion/Stomach Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Joint Aches/Pains | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bowel Movements | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Depression/Anxiety | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bladder Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Epilepsy/Seizures | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hepatitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Appetite/Weight Change | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |

Other Current Issues: _____

For 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

- | | | |
|---|--|--|
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> TB | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Blood Clotting Problems | <input type="checkbox"/> 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 | Nose | Throat | Face & Neck |
|--|--------------------------|--------------------------|---|--|---|
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Congestion or Stuffiness | <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Lump in Neck |
| <input type="checkbox"/> Noise in Ears | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Runny Nose | <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Non-Healing Sore |
| <input type="checkbox"/> Ear Discharge | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Postnasal Drip | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Change in Mole |
| <input type="checkbox"/> Earache | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Cough | <input type="checkbox"/> Scar |
| <input type="checkbox"/> Dizziness | | | <input type="checkbox"/> Broken Nose | <input type="checkbox"/> Mouth Ulcers | <input type="checkbox"/> Pain |
| <input type="checkbox"/> Off-Balance | | | <input type="checkbox"/> Sinus Infections | <input type="checkbox"/> Heartburn | |
| <input type="checkbox"/> Loud Noise Exposure
(<input type="checkbox"/> Guns) (<input type="checkbox"/> Job) | | | <input type="checkbox"/> Breathing Obstruction | | |
| | | | <input type="checkbox"/> Abnormality of Smell | | |

GREENWICH EAR, NOSE & THROAT

Patient Financial Policy • Assignment of Benefits • Consent to Treat

Thank you for choosing us 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 • Allergy Testing (Prick testing, Intradermal testing) • Speech Therapy Appointments (Fiberoptic endoscopic evaluation of swallowing [FEES], Videostroboscopy) • Audiology appointments (Videonystagmography [VNG], Tinnitus evaluation)	72 Hours	\$75.00
Ongoing Tinnitus Appointments	72 Hours	\$250.00
Outpatient Ambulatory Center or Hospital	120 Hours (Five 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.

- | | |
|---|---|
| <ul style="list-style-type: none">• 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)*• 69210 or G0268 Removal of Impacted Cerumen (Ear Wax Removal) (Unilateral or Bilateral) | <ul style="list-style-type: none">• 31579 Videostroboscopy* <p>Hearing Tests:</p> <ul style="list-style-type: none">• 92557 Audiogram• 92550 Tympanometry and Reflex Threshold Measurements• 92587 Otoacoustic Emissions• 92567 Tympanogram |
|---|---|

Consent to Call, Email & Text

I understand and agree that Greenwich Ear, Nose & Throat 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 Greenwich Ear, Nose & Throat. 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 Greenwich Ear, Nose & Throat. This consent includes my consent for all medical services rendered under the general or specific instructions of the provider. I agree and acknowledge that Greenwich Ear, Nose & Throat 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 the office of Greenwich Ear, Nose & Throat. I hereby assign and direct to pay all benefits for medical services under this claim directly to Greenwich Ear, Nose & Throat. I hereby authorize the release of any medical information requested by the insurance companies. I give permission to Greenwich Ear, Nose & Throat 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: _____

GREENWICH EAR, NOSE & THROAT

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: _____

Greenwich ENT may release my medical information to:

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____