

Diablo Valley ENT PATIENT INFORMATION

Name:	Date of Birth:	
Address One:	Social Security #:	
Address Two:	Sex:	
City/St/Zip:		
Home Phone#:	Work #:	Cell #:
Emergency Contact Name:		
Emergency Contact Phone #:		Relationship to Patient:
Referring Physician:	Primary Care Physician:	

INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
Subscriber Name:	Subscriber Name:
Subscriber Date of Birth:	Date of Birth:
Relation to Patient:	Relation to Patient:
Policy #:	Policy #:
Group #:	Group #:
Copay:	Copay:
Ins. Street Address:	Ins. Street Address:
City/St/Zip:	City/St/Zip:

The information Below will be used to improve the quality of healthcare by granting us the ability to measure and minimize care disparities based on race, ethnicity, and preferred language. It gives our practice an accurate estimate of our patient population and accordingly assesses the need for different services, such as interpreter services, translated patient forms and cultural competency training for staff. You have the option of refusing to report.

Race	<input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> More than one Race <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Refuse to Report
Ethnicity:	Hispanic or Latino: <input type="checkbox"/> Yes <input type="checkbox"/> No
Preferred Language:	

Consent for Treatment/Insurance Authorization: I hereby authorize the release of medical information to my insurance company concerning charges/treatment provided by Diablo Valley ENT. I hereby assign benefits and I understand that payment is due as services are provided, including my deductible, co-payment, coinsurance, or any other balance not paid by my insurance. If, after 60 days, insurance payment has not been received, I understand that the charges are my responsibility and payable immediately. Additionally, I understand that I am responsible for providing the referral from my primary care physician. In the event that such a referral has not been obtained, I agree to pay for services at the time they are rendered.

I hereby authorize the physicians of Diablo Valley ENT and their staff to perform diagnostic tests and provide necessary treatment for medical evaluation and health care. I understand that primary medical care is not the responsibility of the physicians of Diablo Valley ENT and their staff.

Signed (patient or parent if minor)

Date

**Consent for Diagnostic Tests/Procedures that may be Necessary
To Fully Diagnose and Treat Your Condition**

Patient Name: _____ DOB: _____

Diablo Valley ENT physicians are pleased you have chosen them to assist in your care. Our physicians feel that a patient presenting to our office with sinus, allergy, throat, hearing or voice complaints requires a thorough examination of that specific area. In some cases, this can only be accomplished through the use of diagnostic tests/procedures. The tests and/or procedures are separate from the physician's office consultation and thus have a separate charge. Insurance companies may consider the nasal endoscopy and laryngoscopy a "diagnostic procedure" and apply them to your deductible and/or coinsurance. The following lists are the tests/procedures that may be performed:

- Audiogram (Hearing Test)
- Ear Wax Removal
- Control of Nosebleed
- Nasal Endoscopy
- Sinus cleaning ("debridement") after sinus surgery
- Laryngoscopy
- Video Laryngostroboscopy
- Fiberoptic Endoscopic Evaluation of Swallowing (FEES)
- Minor Surgical procedures and/or biopsies

Additional tests/treatments may be ordered at the time of the consultation. Again, there are separate charges for these tests/treatments and your specific financial responsibility is based on your insurance plan benefits. These tests/treatments are as follows:

- Videonystagmography (VNG)
- Auditory Brain Response (ABR)
- Voice Evaluation
- Voice Therapy
- Visi-Pitch Test
- Balance Testing

Please note that we collect all co-insurance and unmet deductibles at the time of the visit. Please sign below to acknowledge that you have read the above and understand your financial liability.

Signature: _____ Date: _____

Health Questionnaire



Name: _____ Pharmacy/Location: _____

Referring Physician: _____ Primary Care Physician: _____

Reason for this Visit: _____ Age: _____ Height: _____ Weight: _____

Allergies?: (medications, foods, seasonal, etc.) _____

Do you have any pets? No Yes: Type: _____

Family Medical Problems:

Father _____ Sisters _____

Mother _____ Brothers _____

Medical Problems / Hospitalizations / Surgeries:

	Date		Date
1) _____		5) _____	
2) _____		6) _____	
3) _____		7) _____	
4) _____		8) _____	

Medications: (include BCP, calcium, vitamins, aspirin, herbs)

	Dosage		Dosage
_____		_____	
_____		_____	
_____		_____	

Last Menstrual Period: _____ Birth Control Method: _____

Social History: Occupation: _____ Live with: Spouse Alone Family Other _____

Alcohol use: No Yes, I have approximately _____ drink(s) per day.

Tobacco History:

- Current smoker
- Never smoked
- Former smoker
- Age quit: _____
- I smoke _____ packs per day
- I have been smoking for _____ years
- Tobacco use (please check all that apply):
 - Cigarettes
 - Pipe
 - Cigars
 - Chewing tobacco

Complete this section for children under the age of 10:

Pediatrician: _____ Immunization Status: Up to date Not up to date

Speech/Language Issues No Yes _____

Developmental Issues No Yes _____

Please complete reverse side of Health Questionnaire

Review of Systems: (Please circle all that apply)

General

Anorexia
Appetite Loss
Chills
Dietary Changes
Fatigue
Fever
Medication Changes
Night Sweats
Obesity
Weight Gain > 10 lbs.
Weight Loss > 10 lbs.
No Symptoms

Skin

Bruising
Change in Wart/Mole
Dryness
Clamminess
Excessive Sweating
Hair Growth
Hair Loss
Hives
Nail Changes
New Lesions
Pruritus (*Itching*)
Pallor (*Abnormal Paleness*)
Rash
Skin Color Changes
No Symptoms

HEENT

Blurred Vision
Headache
Head Injury
Color Blindness
Decreased Night Vision
Diplopia (*Double Vision*)
Excessive Tearing
Eye Pain
Eye Redness
Visual Disturbances
Visual Loss
Hearing Loss
Deafness
Decreased Hearing
Ear Discharge
Ear Infection
Earache
Tinnitus (*Ringing in the Ears*)
Vertigo (*Spinning Sensation*)
Frequent Colds
Nasal Congestion
Rhinitis (*Nasal Discharge*)
Seasonal Allergies
Sinus Pain
Bleeding Gums
Hoarseness
Oral Ulcers
Sore Throat
Voice Changes
No Symptoms

Neck

Neck Mass
Neck Pain
Neck Stiffness
Swollen Glands
No Symptoms

Respiratory

Chronic Cough
Cough
Decreased Exercise Tolerance
Snoring
Difficulty Breathing
Dyspnea (*Shortness of Breath*)
Hemoptysis (*Coughing Blood*)
Sputum Production
Wheezing
No Symptoms

Cardiovascular

Chest Pain
Claudications (*Calf Cramps*)
Difficulty Breathing w/ Exertion
Fainting/Blacking Out
Edema
Irregular Heart Beat
Abnormal Blood Pressure
Hypertension (*Elevated Blood Pressure*)
Orthopnea (*Difficulty Breathing Lying Down*)
Palpitations (*Rapid Heart Rate*)
Paroxysmal Nocturnal Dyspnea (*Difficulty Breathing at Night*)
Leg Pain and/or Swelling
Phlebitis (*Inflammation of the vein*)
Shortness of Breath
Swelling of Extremities
No Symptoms

Gastrointestinal

Abdominal Mass
Abdominal Pain
Black, Tarry Stool
Bloody Stool
Change in Bowel Habits
Constipation
Diarrhea
Dysphagia (*Difficulty Swallowing*)
Food Intolerance
Gas
Hematemesis (*Vomiting Blood*)
Heartburn
Indigestion
Jaundice
Melena (*Abnormal Dark/Tarry Stool Containing Blood*)
Nausea
Rectal Bleeding
Vomiting
No Symptoms

Female Genitourinary

Amenorrhea (*No Menstrual Period*)
Blood in Urine
Change in Bladder Habits
Change in Urinary System
Dysmenorrhea (*Painful Menstruation*)
Dyspareunia (*Painful Intercourse*)
Dysuria (*Difficulty in Urination*)
Metrorrhagia (*Excessive Non-Menstrual Bleeding*)

Female Genitourinary (cont)

Fetal Movements Present
Fetal Movements Decreased
Flank Pain
Hematuria (*Blood in Urine*)
Incontinence (*Inability to Control Urination*)
Menorrhagia (*Excessive Menstrual Bleeding*)
Menstrual Irregularities
Nocturia (*Urination at Night*)
Painful Urination
Pelvic Pain
Polyuria (*Frequent Urination*)
Urethral Discharge
Urgency
Urinary Retention
Vaginal Bleeding
Vaginal Discharge
No Symptoms

Male Genitourinary

Change in Bladder Habits
Change in Urinary System
Dysuria (*Difficulty in Urination*)
Flank Pain
Hematuria (*Blood in Urine*)
Hesitancy of Urination
Impotence
Incontinence (*Inability to Control Urination*)
Nocturia (*Urination at Night*)
Painful Urination
Penile Lesions
Polyuria (*Frequency of Urination*)
Testicular Pain or Mass
Urethral Discharge
Urgency
Urinary Retention
No Symptoms

Musculoskeletal

Backache
Back Pain
Decreased Range of Motion
Fasciculations (*Muscle Twitching*)
Joint Pain/Stiffness/Swelling
Muscle Atrophy (*Weakness*)
Muscle Cramps
Muscle Pain
Myalgia (*Diffuse Muscle Pain*)
Swelling of Extremities
No Symptoms

Neurological

Auras (*Signals Migraine/Seizure*)
Decreased Memory
Difficulty Speaking
Dizziness
Dysarthria (*Difficulty Pronouncing Words*)
Dysesthesia (*Alteration in Sensation*)
Fainting
Focal Neurological Symptoms (*Weakness or Paralysis*)

Neurological (continued)

Headaches
Incontinence Stool
Incontinence Urine
Lack of Coordination
Parasthesias (*Tingling Sensation*)
Syncope (*Loss of Consciousness*)
Vertigo (*Spinning Sensation*)
Stroke
Seizures
Tremor
Unusual Sensation
Unsteadiness
Visual Changes
Weakness
Weakness in Extremities
No Symptoms

Psychiatric

Anxiety
Change in Sleep Pattern
Delusions
Depression
Early Awakening
Fearful
Hallucinations
Hypersomnia (*Excessive Sleeping*)
Inability to Concentrate
Mood Changes
Insomnia (*Inability to Sleep*)
Panic Attacks
Suicidal Ideation
Suicidal Planning
No Symptoms

Endocrine

Appetite Changes
Cold Intolerance
Hair Changes
Heat Intolerance
Hot Flashes
Libido Change
Sexual Dysfunction
Thyroid Problems
Polydipsia (*Excessive Thirst*)
Polyuria (*Excessive Urination*)
No Symptoms

Hematology

Abnormal Bleeding
Anemia
Blood Clots
Easy Bruising
Enlarged Lymph Nodes
Epistaxis (*Nose Bleed*)
Petechiae (*Pinpoint Hemorrhages*)
Prolonged Bleeding
Spontaneous Bleeding
HIV/AIDS
Cancer: _____
No Symptoms

Other Not Listed:

Cancer: _____

DATE: _____

PATIENT SIGNATURE: _____

Name: _____

Date of Birth: _____

Diablo Valley ENT appreciates your confidence in choosing us to provide for your health care needs. Our services imply a financial responsibility on your part - an obligation to ensure payment in full of our fees. We would like to share our financial policies with you since a clear understanding of our financial policies is an important component of our professional relationship.

Methods of Payment

We will bill your insurance as a courtesy to you with a copy of your current insurance card, which must be presented at each visit. If you do not have your insurance card, payment is due at the time of service. For your convenience, we accept cash, check, credit and debit cards, as well as CareCredit. Please note that there is a \$35 charge for checks returned by the bank for insufficient funds.

Participation with Insurance & Medicare

Diablo Valley ENT participates with Medicare, as well as many HMO & PPO plans, which means that we accept assignment of benefits. If payment is not received from your insurance carrier within our contract limits, any balance will be your responsibility.

If we do not have a contract with your insurance company, you are responsible for payment in full and considered to be Self-Pay. Payment is due at the time of service and we will mail you a courtesy claim within 7 days.

Medicare: As a Medicare patient, you are responsible for your deductible and for the difference between the approved charge and the amount Medicare pays. If you have supplemental insurance with a company with whom we are contracted, we will bill your secondary insurance for you. Any remaining balance will be billed to you.

PPO Plans: As a component of our contracts, we collect co-payments for every visit. In addition, we collect co-insurance (your portion for the services as established by your insurance company), deductibles, and past due balances at the time of your service. Please note that we estimate these payment portions, and that you may receive a statement indicating that additional co-insurance or deductible portions may be due, based upon how your insurance company processes your claim.

HMO Plans: If you are insured through an HMO (Hill or Muir), a referral is required from your primary care physician. If we do not receive a referral, we will require payment at the time of service.

Our Contracted Payors: Aetna, Affinity Medical Group, Blue Cross, Blue Shield, ChoiceCare (Humana), Cigna, Great West, Hill Physicians Medical Group, Medicare, John Muir Medical Group, Sutter East Bay Medical Foundation (Diablo Division), UnitedHealthcare

Self-Pay

Depending upon the type of visit, a minimum deposit is due when you check in for your appointment. Any additional charges must be paid at the end of the visit. A 25% Time of Service discount is applied when fees are paid the same day the service is provided.

Our Fees

We are committed to provide the best treatment possible for our patients and we charge what is usual and customary for our area. If we do not have a contract with your insurance company, you are responsible for payment in full regardless of any insurance company's arbitrary determination of rates. Co-payments, co-insurance, and deductibles, or unpaid balances are due at the time of service.

Fees for Completion of Forms

There is a \$35 charge to complete forms such as disability or FMLA forms.

I have read the Financial Policies of Diablo Valley ENT. I understand that it is my responsibility to provide current insurance information at each visit, as required by my insurance provider.

Signature of Patient or Guardian

Date



Consent to the Use and Disclosure of Health Information

Name _____ DOB _____

I understand that I have rights regarding my protected health information. These rights are governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I have been informed of, and given the opportunity to review and secure a copy of Diablo Valley ENT's Notice of Privacy Practices, which contains a complete description of the uses and disclosure of my protected health information.

I understand that The Notice of Privacy Practices information serves as:

- A basis for planning my care and treatment.
- A means of communication amongst the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations, such as assessing care quality and reviewing the competence of healthcare professionals.

I authorize my medical information to be discussed/disclosed to:

- Patient Physician
 Family member or friend _____ Other _____

Detailed messages regarding test results can be left on answering machine or voicemail:

Yes No Phone # _____

* **Do not disclose medical information**

I acknowledge that I have been provided an opportunity to review the Notice of Privacy Practices for Diablo Valley ENT.

Signature of Patient or Legal Representative

Date