Associates in Otolaryngology of New Jersey, PA

Patient Name _____ **Date of Birth**: _____ **Age**: _____

Home Address: _____ City:_____ State: _____ Zip:_____

Home #: _____ **Cell** #: _____ **Sex**: M ___ F___

Email address: _____ **Student**?: FT___ PT___

Marital Status: Married ___ Single ___ Divorced ___ Widowed ___

Primary Care Physician Name (First and Last): _____

Phone #: _____

Address: _____

Pharmacy: _____ Phone #: _____

Emergency Contact: _____ Phone #: _____

Employer Name: _____

Employer Address: _____ City:_____ State: _____ Zip:_____

If Applicable, Name of Guardian: _____

The information below must be filled out even though your insurance card was scanned

Primary Insurance

Name of Insurance: _____ ID #: _____

Group #:_____ **Policy Holder**: _____

Policy Holder Address: _____

Relationship to Patient:_____ Policy Holder's Date of Birth: _____

Employer Name: _____

Effective Date of Insurance: _____

Secondary Insurance

Name of Insurance: _____ ID #: _____

Group #:_____ **Policy Holder**: _____

Relationship to Patient: _____ Policy Holder's Date of Birth: _____

Employer Name: _____

Private Insurance Authorization of Benefits Release: I, the undersigned, authorize payment of medical benefits to Associates in Otolaryngology of New Jersey, PA for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

X_____ _____
(Patient, Parent/Guardian Signature (If child is under 18 years of age) Date

Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits be made on my behalf to Associates in Otolaryngology of New Jersey, PA for any services furnished me by the physician. I authorize my holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits payable for related services.

X_____ _____
Patient Signature Date

Name: _____ Date of Birth: _____

Reason for visit: _____

Referring provider: _____

Medical History:

Please check if **you** have ever suffered from the following:

Condition	Yes (✓)	No (✓)	Further Details if Indicated
Heart Disease			
High Blood Pressure			
Diabetes			
Sleep Apnea			
Cancer			
Deep vein thrombosis (blood clot)			
Pulmonary Embolism			
Clotting disorder (i.e. factor v leiden)			
Bleeding disorder (i.e. hemophilia)			
Anemia			
Asthma			
COPD			
Kidney Disease			
Glaucoma			
Acid reflux			
Autoimmune Disease			
Thyroid Disorder			
Other			

Family History:

Please check if a family member has suffered from the following:

Condition	Mother	Father	Sister	Brother	Grandparent
Diabetes					
Cancer					
High Blood Pressure					
Thyroid disorder					
Clotting disorder					
Bleeding disorder					
Malignant Hyperthermia					

Medications:

_____

_____

_____

_____

_____

_____

_____

_____

Medication Allergies:

_____

_____

_____

Have you ever had complications from Anesthesia (check one)?

___Yes ___No

If yes, describe:

_____

_____

Do you use tobacco (check one)?

___Yes ___No ___Used in Past

If yes:

Cigarettes	Yes	No
E-Cigarettes	Yes	No
Chewing tobacco	Yes	No

Do you drink alcohol (check one)?

___Sometimes ___Often ___Never

Do you use marijuana (check one)?

___Sometimes ___Often ___Never

Associates in Otolaryngology of New Jersey, PA

FINANCIAL, CANCELLATION, ELECTRONIC RECORDING, AND PRIVACY POLICIES

If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

If we do not have a contractual agreement with your insurance company, payment for the office services is due at the time services are rendered. We will be happy to help you process your insurance claim for reimbursement. Any such request must be accompanied by an insurance claim form when indicated by your insurance company. In special instances, we accept assignment of insurance benefits.

Returned checks and balances older than 90 days may be subject to additional collection fees. We will gladly discuss proposed treatment and answer any questions relating to your insurance. Please note:

1: If you have an indemnity plan, your insurance is a contract between you, your employer and the insurance company.

2: Our fees are generally considered to fall within the acceptable range by most companies and, therefore, are covered up to the maximum allowances determined by each carrier. Thus, our fees are considered to be usual and customary by most Companies. This statement does not apply to companies who reimburse on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.

3: Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

4: All co-payments are to be made at the time of service.

5: If your insurance is an HMO, you are responsible to supply this office with the referral and/or authorization forms PRIOR to being examined.

6: You are responsible for informing us of any changes in your insurance plan or policy. Failure to do so may result in denial of coverage, the fees for which you will be held responsible.

If you do not have the proper forms described in your insurance handbook, then you MUST reschedule or, if your plan offers "Out of Network" benefits, then you may be seen as an "Out of Network" patient at a somewhat higher cost to you. We will do our best in the filing of insurance claims; however, all charges are your responsibility from the date services are rendered.

Appointments missed or canceled without a 24 hour notification will be assessed a $50.00 fee. This is NON-REFUNDABLE and NON-BILLABLE to your insurance company. Out of respect and consideration for other patients, anyone arriving late for their appointment may be asked to reschedule.

To ensure confidentiality and privacy, any type of **electronic recording is strictly prohibited** at any location within these offices including, but not limited to, our waiting rooms, front desk areas, hallways, exam rooms, bathrooms, lounge area, etc.

I acknowledge that I have been made aware of the **"Notice of Privacy Practices"** posted in the waiting area. Copy available upon request.

I have read and agree to the **Financial, Cancellation, Electronic Recording, and Privacy Policies**:

_____ _____

Signature of Patient or Guardian Date

***Please list the individuals that we may speak with about your medical care and billing:**

PROCEDURE CONSENT FORM

As Board Certified specialist, we routinely perform procedures to treat and/or diagnose conditions of the ears, nose and throat. These procedures, including ENDOSCOPIES and MICROSCOPIES, are considered surgical procedures by your insurance company.

Diagnostic procedures allow the physician to examine the areas in the ears, nose and throat that cannot be visualized during a routine examination. Other procedures can treat a specific condition you are experiencing. Prior to the procedure being performed, the physician may spray a decongestant and topical anesthetic into each nostril, or in your throat. This will help with any slight discomfort you may experience. Once the anesthetic takes effect, the procedure will be performed. You may experience numbness for up to one hour after the procedure.

Your insurance company may not reimburse these “surgical” procedures at the same rate as your office visits. Please check with your insurance company if you are unsure of your benefits. When you receive your explanation of benefits, it will have listed these codes as surgeries, even though they were performed in the office.

By signing this form, you consent to these procedures being performed as medically necessary by your provider. This consent will remain in effect for future procedures unless otherwise noted.

Patient Name: _____ Date of Birth: _____

_____ _____

Signature of Patient or Guardian Date

Guardian name (if applicable): _____