Associates in Otolaryngology of New Jersey, PA

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

Home Address: _____ **City**: _____ **State**: _____ **Zip**: _____
(STREET ADDRESS ONLY, NO PO Boxes)

Home Phone # : _____ **Cell #**_____ Sex: M____ F____ Student? FT ____ PT ____
Marital Status: Married ____ Single ____ Widowed ____ Divorced ____ **Email Address**:_____

Employer Name: _____Work Phone #: _____

Employer Address: _____ City: _____ State: _____ Zip_____

EMERGENCY CONTACT: _____ Emergency Phone #: _____

Primary Care Physician (First and Last Name):_____

Address:_____ Phone #: _____

Guardian / Spouse Information

Name: _____ Date of Birth: _____ Sex: M_____ F_____

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

Home Phone #: _____ SS#: ____-____-____ Relationship to Patient:_____

Employer Name: _____ Work Phone#:_____ _____

Primary Insurance

Name of Insurance: _____ ID #: _____ Group #:_____

Policy Holder: _____Policy Holder Address: _____

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

Employer Name: _____Effective Date of Insurance_____

Secondary Insurance

Name of Insurance: _____ ID #: _____ Group #:_____

Policy Holder: _____ Relationship to Patient: _____

Policy Holder's Date of Birth: _____ Policy Holder's SS#: ____-____-____

Employer Name: _____Effective Date of Insurance_____

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.

_____ _____

(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.

_____ _____

Patient Signature Date

Associates in Otolaryngology of New Jersey, PA

Patient Name: _____

Reason for seeing the doctor today: _____

_____

Consultation requested by: _____

Personal and Family Medical History: Have you, or a family member, been diagnosed with any of the following medical problems: Please indicate: Yes or No, Who and the year and age diagnosed.

Ailment	**Yes/No**	**Patient/Family**	**Onset/Age**
Heart Disease			
High Blood Pressure			
Thyroid Disease			
Kidney Disease			
Diabetes			
Blood Disease			
Asthma			
Arthritis			
Cancer			
Glaucoma			
Migraines			
Jaundice			
Other:			

Prescription Medications: _____

Over the Counter Medications: _____

Do you currently smoke: Yes ____No____ If yes, how much: _____ If No, did you ever smoke?_____
Do you drink coffee/tea/soft drinks: Yes____ No____ If yes, how much? _____
Do you drink alcohol/wine/beer? Yes ____ No ____ If yes, how much? _____

Have you been hospitalized recently? (If yes, please explain)

_____

_____

Any allergic reactions to Medications or Anesthesia? Yes____ No____
If yes, please explain:

_____

Do you suffer from hay fever or allergies? Yes ____ No ____
Do you bleed/bruise easily? Yes ____ No ____
Have you had blood clots in your legs or lungs? Yes ____ No ____

M. D. Initials _____

If NO change since last visit, please check here _____ Signature_____ Date_____

Associates in Otolaryngology of New Jersey, PA

FINANCIAL POLICY

We are committed to providing you with the best possible care. 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. You must realize, however, that;

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 must emphasize that as medical care providers we are dedicated to providing you the best treatment for our patients. We will do our best in the filing of insurance claims; however, all charges are your responsibility from the date services are rendered.

Thank you for your understanding of our Office Financial Policy. If you have any questions, Please do not hesitate to ask.

I have read the Office Financial Policy of Associates in Otolaryngology of New Jersey, PA, and I understand and agree to this policy.

_____ _____

Signature of Patient/Parent/Guardian Date

Associates in Otolaryngology of New Jersey, PA
741 Northfield Avenue
Suite 104
West Orange, NJ 07052
973-243-0600

PATIENT NAME: _____ Patient #: _____

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, 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/PARENT/GUARDIAN SIGNATURE DATE

Associates in Otolaryngology of New Jersey, PA
741 Northfield Avenue
Suite 104
West Orange, NJ 07052
973-243-0600

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of this date set forth below a copy of the Practice's "Notice of Privacy Practices"

_____	_____
Printed Name of Patient	Patient's Date of Birth
_____	_____
Signature of Patient (Or patient's personal representative)	Date
_____	_____
Printed name of patient's personal representative	Relationship of personal representative to Patient or personal representative's authority to act for the patient, if applicable
	_____
	Date

Associates in Otolaryngology of New Jersey, PA

CANCELLATION POLICY

Appointments missed or cancelled without a 24 hour notification will be assessed a $25.00 fee.
Out of respect and consideration for other patients, anyone arriving late for their appointment may be asked to reschedule.
In select cases, you may be asked to provide a name of another ENT provider to whom we may forward your records.

I have read and understand the Appointment Cancellation Policy.
I understand that this is a NON-REFUNDABLE fee and NON-BILLABLE to my insurance company.

_____ _____

Signature of Patient or Parent/Guardian Date

NO ELECTRONIC RECORDING DEVICE POLICY

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.

Your signature indicates your understanding and agreement to comply with this policy.

_____ _____

Signature of Patient or Parent/Guardian Date