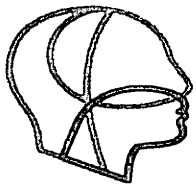

entacc
Ear, Nose and Throat
Associates of Chester County

Patient Name:_____ **DOB:**_____

Height: ___ft ___in **Age:** _____ **Weight:**_____

1. **Past Medical History – Have you ever had the following? (If other, please specify.)**

☐ COPD	☐ Heart Disease	☐ Thyroid Disease	☐ Kidney Problems
☐ Diabetes	☐ Hypertension	☐ Headaches/Migraines	☐ GI Problems
☐ Blood Disorder	☐ Seizures	☐ Pneumonia	☐ Sleep Apnea
☐ Stroke	☐ Asthma	☐ Liver Failure/Hepatitis	☐ Other:_____
☐ High Cholesterol	☐ GERD	☐ Seasonal Allergies	_____
☐ TB (tuberculosis)	☐ Arthritis	☐ Cancer: _____	

2. **Past Surgical History – Have you ever had the following? (If other, please specify.)**

☐ Sinus Surgery	☐ Vocal / Larynx Surgery	☐ Hernia	☐ Other: _____
☐ Ear Surgery	☐ Chest Surgery	☐ Appendectomy	_____
☐ Eye Surgery	☐ Abdominal Surgery	☐ Gall Bladder	_____
☐ Tonsillectomy	☐ Heart Valve Replacement	☐ Gyn. Surgery	_____
☐ Thyroid/Neck	☐ Pacemaker	☐ Ortho Surgery	_____

3. **Current Medications: (Including over the counter medications, supplements and vitamins.)**

___ Medication list attached. (Please fill out attached sheet for list of medications)

Name	Dosage	How often taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. **Allergies: (Please include Medications, foods and environmental allergies.)**

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

5. **Family History: (Please specify maternal/paternal. Ex: PGM = paternal grandmother)**

Condition	Relationship	Condition	Relationship
☐ Cancer	_____	☐ Stroke	_____
☐ Neurology disorder	_____	☐ Kidney Problems	_____
☐ Hearing Loss	_____	☐ Bleeding Problems	_____
☐ Heart Disease	_____	☐ Diabetes	_____
☐ Hypertension	_____	☐ Anesthesia Problems	_____

Please list any other family history here:

Condition	Relationship	Condition	Relationship
_____			
_____			

6. Social History:

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Occupation: _____

Tobacco ☐ Never ☐ Yes _____packs per day ☐ Former _____ years ago

Alcohol ☐ Never ☐ Yes _____drinks per week (social)

Please select anything you have a history of:

Constitutional:

☐ fatigue	☐ loss of appetite	☐ generalized weakness	☐ night sweats
☐ chills	☐ unintentional weight loss	☐ fever	☐ body aches
☐ malaise	☐ additional symptoms _____		

HENT:

☐ headaches	☐ bleeding gums	☐ breath odor	☐ pressure in ear
☐ **vertigo (1)**	☐ dental problems	☐ ear pain	☐ deviated septum
☐ dentures	☐ **lightheadedness (1)**	☐ decreased sense of smell	☐ hearing loss
☐ recent head injury	☐ neck stiffness	☐ **ringing in ears (4)**	☐ **snoring (2)**
☐ sinus pain	☐ neck pain	☐ **roaring sound in ears (4)**	☐ oral ulcers
☐ neck swelling	☐ **nasal obstruction (3)**	☐ ear discharge	☐ oral white spots
☐ nose bleeding	☐ neck tenderness	☐ ear fullness	☐ mouth pain
☐ nasal pain	☐ thyroid mass	☐ itchiness in ear	☐ mouth swelling
☐ **post nasal drip (3)**	☐ sore throat	☐ ear swelling	☐ dry mouth
☐ enlarged tonsils	☐ change in voice	☐ difficulty swallowing	☐ neck mass
☐ hoarseness	☐ frequent throat clearing	☐ lump in throat sensation	☐ swollen glands

☐ additional symptoms: _____

Eyes:

☐ dryness	☐ discharge from the eye	☐ **redness or itching (3)**	☐ eye pain
☐ excessive tearing	☐ burning	☐ impaired vision	☐ eye discomfort
☐ periorbital swelling	☐ blurred vision	☐ double vision	
☐ scotoma	☐ peripheral vision changes	☐ changes in vision	

☐ additional symptoms: _____

Breasts:

☐ lumps ☐ tenderness ☐ swelling ☐ nipple discharge

☐ additional symptoms: _____

Cardiovascular:

☐ chest pain	☐ irregular heartbeats	☐ rapid heart rate	☐ **lightheadedness (1)**
☐ syncope	☐ lower extremity swelling		

☐ additional symptoms: _____

Respiratory:

☐ shortness of breath ☐ cough ☐ wheezing ☐ hoarseness ☐ abnormal sputum product

☐ additional symptoms: _____

1 – Vertigo 2 – Sleep 3 – Allergy 4 – Tinnitus 5 – GERD

GI:

☐ nausea	☐ bloating	☐ loss of appetite	☐ hemorrhoids
☐ diarrhea	☐ retching	☐ **heartburn (5)**	☐ narrow stools
☐ abdominal pain	☐ vomiting	☐ **excessive belching (5)**	☐ excessive flatulence
☐ blood in stool	☐ constipation	☐ jaundice	

☐ additional symptoms: _____

Genitourinary:

☐ urgency	☐ urinary hesitancy	☐ amenorrhea	☐ difficulty voiding
☐ frequency	☐ post-void dribbling	☐ scrotal pain	☐ decreased libido
☐ hot flashes	☐ irregular menses	☐ change in urine color	☐ genital sores
☐ urinary retention	☐ vaginal discharge	☐ incontinence	☐ possible pregnancy
☐ impotence	☐ scrotal mass		

☐ additional symptoms: _____

Skin:

☐ **rash (3)**	☐ pigmentation changes	☐ hair growth changes	☐ color changes
☐ lumps	☐ new skin lesions	☐ acne	☐ **itching (3)**
☐ nail changes	☐ sores	☐ dry skin	☐ mole changes

☐ additional symptoms: _____

Neurologic:

☐ muscular weakness	☐ **loss of balance (1)**	☐ speech difficulty	☐ tremors
☐ tingling/numbness	☐ **incoordination (1)**	☐ memory difficulty	☐ difficulty concentrating

☐ additional symptoms: _____

Musculoskeletal:

☐ joint pain	☐ muscle pain	☐ muscle weakness	☐ back pain
☐ joint swelling	☐ limited motion	☐ muscle cramps	

☐ additional symptoms: _____

Endocrine:

☐ heat intolerance	☐ weight gain	☐ acne	☐ hot flashes
☐ excessive sweating	☐ loss of hair	☐ cold intolerance	☐ weight loss

☐ additional symptoms: _____

Psychiatric:

☐ anxiety	☐ compulsive behavior	☐ impulsive behavior	☐ homicidal ideation
☐ hallucination	☐ delusions	☐ suicidal ideation	☐ irritability
☐ feeling confused	☐ **difficulty sleeping (2)**	☐ excessive anger	

☐ additional symptoms: _____

Heme-Lymph:

☐ easy bruising	☐ lymph node enlargement	☐ **lightheadedness (1)**	☐ easy bleeding

☐ additional symptoms: _____

Allergic-Immunologic:

☐ **allergic dermatitis (3)** ☐ sinus allergy symptoms ☐ frequent illnesses

☐ additional symptoms: _____

_____ _____

Signature of Patient or Guardian or Minor Patient Date

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Ear, Nose and Throat
Associates of Chester County

Insurance & Billing

I hereby authorize payment of medical benefits directly to Ear, Nose and Throat Associates of Chester County for professional services rendered. I authorize the release of medical information necessary to process the claims and secure payment of health benefits. I understand I am ultimately responsible for all charges whether paid or not by my insurance.

Patient initials _____

ENTACC participates with most insurance plans. Certain insurance plans require a co-payment and this must be paid at the time of the visit. **Failure to pay your co-payment at the time of service will result in a $10 service fee added to your original co-pay amount.**

Payment will be requested at the time of service for all services that are non-covered or determined to be the patient's responsibility, including co-payments. Payment may be made by cash, check, Debit Card, MasterCard, Visa, American Express and Discover.

If we DO NOT participate with your insurance company, this means that we will bill your insurance carrier as a courtesy but fees for services rendered will be due at the time services are rendered unless other financial arrangements have been made prior to date of service.

Payment for Services Performed

Our office accepts Visa, MasterCard, American Express, Discover and Debit cards for your convenience, as well as cash or a check. **All payments are expected at the time of service and any outstanding balances are due within 30 days, unless prior arrangements have been made with the Billing Department. All balances that reach 60 days past due with no activity will be sent to a collection agency. Should your account be sent to a collection agency, you will be financially responsible for all collection fees of 35% of your balance added to the amount due and legal fees that our office incurs through the process utilized to collect the outstanding delinquent balance.**

Payment in full of any past due balance is expected prior to being seen in our office in the future. In addition, payment in full will be expected at the time of service for any future services.

Patient Initials _____

Medicare Patients

All Medicare patients will be asked to sign an Advance Beneficiary Notice upon check-in for their office visit. An Advance Beneficiary Notice, or ABN, is a written notice from Medicare given to you before receiving certain items or services, notifying you:

- Medicare may deny payment for that specific procedure or treatment.
- You will be personally responsible for full payment if Medicare denies payment.

Medicare requires our office to have you sign this form prior to services being rendered. An ABN gives you the opportunity to accept or refuse the items or services and protects you from unexpected financial liability in cases where Medicare denies payment. It also offers you the right to appeal Medicare's decision. However, you should follow your physician's recommendations regarding the timeliness of your exams.

Fees

ENTACC fees are within the customary range for our specialty. We have standardized charges for various procedures. **Please be aware that certain procedures performed in our office are not included in the standard office visit.** These procedures will be billed separately and in addition to the office visit charges. Some insurance carriers are classifying these procedures as "surgery" and applying the charges to any out of pocket amount not met. The result may be insurance payment for an office visit but not a procedure. In such cases, payment for the procedure will be due from the patient. Be assured that we are following acceptable billing and coding guidelines and that all procedures are performed based on medical necessity and are in the best interest of patient care.

Pre-certification

Many procedures or treatment plans require pre-certification by your insurance company to verify benefits and obtain preauthorization and approval. ENTACC is able to request pre-certification or prior authorization on your behalf. **ENTACC is not able to generate referrals for patients**. These must come from your primary care provider. If you have questions regarding pre-certification please contact our office at (610) 363-2532.

For all patients undergoing surgical procedures and for those who have large out-of-pocket expense, a financial counselor will contact you to discuss payment options.

FORMULARY BENEFITS DATA CONSENT FORM

Formulary Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying

prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

By signing below I give permission for Ear, Nose and Throat Associates of Chester County to access my pharmacy benefits data electronically thru RxHub. This consent will enable Ear, Nose and Throat Associates of Chester County:

- **Determine the pharmacy benefits and drug copays for a patient's health plan.**
- **Check whether a prescribed medication is covered (in formulary) under a patient's plan.**
- **Display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications.**
- **Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so e-prescribe to these pharmacies.**
- **Download a historic list of all medications prescribed for a patient by any provider.**

In Summary, we ask your permission to obtain formulary information, and information about prescriptions prescribed by other providers using RxHub. Patient initials _____

ACKNOWLEDGMENT RECEIPT: HIPAA NOTICE OF PRIVACY PRACTICES

In signing this form, you agree that you have received our **Notice of Privacy Practices**. This Notice, among other points, explains how we plan to use and disclose your protected health information for the purposes of treatment, payment and health care operations. This applies to the privacy practices of ENTACC and all affiliated covered entities of ENTACC issuing this Notice.
You have the right to review our **Notice of Privacy Practices** prior to signing this form. It provides more detail on how we may use and disclose your information. The Notice of Privacy Practices may change. A current copy may be requested by contacting our Chief Privacy Officer at 610-363-2532 or visiting our website at www.entacc.com.

By signing this form, you acknowledge you have received our Notice of Privacy Practices and that ENTACC and all affiliated covered entities can use and disclose your protected health information in accordance with HIPAA.

Patient Name (Printed)	Patient Signature (or Responsible Party)	Date