Cumberland Valley ENT

Comprehensive, compassionate care since 1978

Ear • Nose • Throat • Allergy

WELCOME TO OUR PRACTICE

Date: _____

Dear _____:

We welcome you to our practice and appreciate the opportunity to be of service to you. Our staff is a group of well-qualified professionals who work as a team to provide you with the highest level of treatment in a professional and caring environment.
Your appointment is scheduled with Doctor _____on _____.
We ask you to arrive at _____ to allow us time to update your information and copy your insurance card(s). One of our nursing staff will be taking a medical history at this time. ***Please bring a complete list of the medications you currently take, your allergies to medications, and your surgical history with year of surgery.***

Referrals: If your insurance is an HMO, a referral from your primary care physician (PCP) **is required** for you to be treated by our physicians. You are responsible for providing us with the referral before you are seen by our doctors. If you fail to provide us with a referral, you will be responsible for your charges.

Minors: All children under the age of 18 **must be accompanied by a parent or legal guardian**. If the parent or legal guardian is unable to accompany the minor child, we must have a note stating who will be accompanying the minor and permission from the parent/legal guardian authorizing this practice to treat the minor child.
Cancellations: We require at least a 24-hour notice should you need to change or cancel your appointment.

Telephone Calls: Should you have a problem, please do not hesitate to call. Our office staff has been trained to handle all situations. A message will be taken and then given to one of our physicians, who will review the chart and respond appropriately. Please remember to leave a phone number where you can be reached.
Should you need to contact us after hours, call 301-714-4375 and our answering service will forward your message to the physician on call. Please note that we share on-call coverage with Dr. Kirby Scott which means he may be returning your call.

In the event of an extreme emergency, go directly to the Emergency Room.

Green Entrance, Robinwood Professional Center
11110 Medical Campus Road, #126 Hagerstown, MD 21742 301-714-4375 (p) 301-714-4399 (f)

Medicare: We do participate with Medicare. We will file your claim for you and accept what Medicare **allows**. If you have a secondary carrier, we will submit any unpaid balance to it. All payments from Medicare and secondary carriers should be sent to our office. Please keep in mind that you may be responsible for any charges not covered by Medicare or the secondary insurance such as deductibles, co-payments, and co-insurances.

Commercial Insurance: We do participate with a number of insurance carriers. Please ask our staff if we participate with your particular insurance. If so, we will be glad to submit the charges for your visit and accept the insurance allowed amount for covered services. **Please keep in mind that you will be responsible for co-payments, deductibles and co-insurances.**

If you do not have insurance or have insurance with which we do not participate, we will expect your payment for services rendered at the time of your visit. You will receive two copies of the fee ticket to use when submitting your claim to your insurance company for reimbursement. If you are unable to pay at the time of service, you may make payment arrangements with our Billing Department prior to treatment. Please note that the charge for your visit depends on the level of service rendered to you. Prices may be higher if hearing tests or diagnostic/surgical procedures are required. Feel free to discuss charges with our physicians or staff prior to having these services. You may pay by cash, check, Visa, Mastercard or Discover.

Surgeries: If we participate with your insurance company, we will submit your surgery charges directly to your insurance company. Balances remaining after your insurance has paid are the responsibility of the patient.
Please be aware that we bill only for our physicians. You will receive bills from the anesthesiologist and the facility, which may include pathology fees.

Otolaryngologist-Head and Neck Surgeon- is a Specialist in diagnosing and treating diseases and disorders of the ear, nose and throat. The practice of Otolaryngology specializes in:

- Sinus infections
- Allergies
- Ear infections/ear surgery
- Snoring disorders
- Sleep Apnea
- Nasal problems
- Head and neck surgery for cancer of the mouth, throat and voice box
- Tonsils and adenoids
- Loss of hearing
- Thyroid disorders
- Plastic surgery for facial reconstruction

Additional Information:
Our office is designated as non-smoking and **we ask you not to bring food or drink into the office.**

In Conclusion: We thank you for choosing our practice and we hope that this letter will give you a better understanding of the services we provide to our community.

Sincerely,

Drs. Saylor, Wathne, Manilla and Stonebraker

Green Entrance, Robinwood Professional Center
11110 Medical Campus Road, #126 Hagerstown, MD 21742 301-714-4375 (p) 301-714-4399 (f)

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TO: Our Medicare and Blue Shield Patients

SUBJECT: Dual claims and co-pays for office visits with hearing tests

As part of your evaluation today, your doctor may order a hearing test, which is performed by one of our Doctors of Audiology.

Medicare and Blue Shield require that audiologists credential with them just like our physicians. What this means is our audiologists must bill under their own provider number for all services provided to Medicare and Blue Shield patients. Because we have a contractual relationship with both Medicare and Blue Shield, we are required to abide by our contracts and submit two **separate** claims to your insurance company, one for the doctor's visit and one for the hearing tests performed by our Doctors of Audiology.

How does this affect you? If your insurance company requires a co-pay, Medicare and/or Blue Shield may process a co-pay on ***each*** claim because the providers are different. As dictated by your insurance company, you would then be responsible for two co-pays, one for the office visit and the other for the hearing test.

If you have any questions about this policy, please contact Medicare and Blue Shield. These policy guidelines originate from The Center for Medicare and Medicaid Services (Medicare) and/or your insurance company.

CUMBERLAND VALLEY ENT CONSULTANTS

Michael J. Saylor, M.D.
Diplomate, American Board of Otolaryngology

Jarl T. Wathne, M.D.
Diplomate, American Board of Otolaryngology

A. Christopher Manilla, D.O.
Diplomate, American Board of Otolaryngology

Angela C. Stonebraker, M.D.
Diplomate, American Board of Otolaryngology

Edward J. Drawbaugh, M.D., Emeritus
Diplomate, American Board of Otolaryngology

Margaret T. Eackles, M.S., CCC-A
Certified Audiologist

Jennifer L. Campbell, AuD, CCC-A
Certified Audiologist

DIZZY QUESTIONNAIRE

Name: _____ Date: _____

I) When you are "dizzy" do you experience any of the following sensations?
(Please read the entire list first, then check yes or no **to describe your feelings most accurately.**)

Yes	No	
☐	☐	1. Light-headedness or swimming sensation in the head?
☐	☐	2. Blacking out or loss of consciousness?
☐	☐	3. Tendency to fall: To the right ?
☐	☐	To the left?
☐	☐	Forward?
☐	☐	Backward?
☐	☐	4. Objects spinning or swimming around you?
☐	☐	5. Sensation that you are turning or spinning inside with outside objects remaining stationary?
☐	☐	6. Sensation of the environment moving up and down while you walk?
☐	☐	7. Loss of balance when walking: Veering to the right?
☐	☐	Veering to the left?
☐	☐	8. Headache?
☐	☐	9. Nausea/vomiting?
☐	☐	10. Pressure in the head?
☐	☐	11. Palpitations, perspiration, shortness of breath, or a feeling of panic?

II) Please check yes or no and fill in the blanks. Please answer all questions.

Yes	No	
☐	☐	1. My dizziness is: Constant.
☐	☐	In attacks.
		2. When did dizziness first occur?_____
		3. If in attacks: How often? _____
		How long do they last? _____
		When was last attack? _____
☐	☐	Do you have any warning that the attack is about to start?
☐	☐	Do they occur at any particular time of day or night?
☐	☐	Are you completely free of dizziness between attacks?

Yes	No	
☐	☐	4. Does change of position make you dizzy?
☐	☐	5. Do you have trouble walking in the dark?
☐	☐	6. When you are dizzy, must you support yourself when standing?
☐	☐	7. List the possible causes of dizziness?_____
		8. Do you know of anything that will:
☐	☐	Stop your dizziness or make it better?_____
☐	☐	Make your dizziness worse?_____
☐	☐	Precipitate an attack? (eg: Fatigue, exertion, hunger, stress, emotional upset or menstrual period) _____
☐	☐	9. Were you exposed to any irritating fumes, paints, etc. at the onset of dizziness?
☐	☐	10. Please list any medications you are allergic to _____ _____
☐	☐	11. If you ever injured your head, were you unconscious?
		12. Please list any medications you take regularly _____ _____
☐	☐	13. Do you use tobacco in any form (please list) _____
		How much?_____

III) Do you have any of the following symptoms? please check yes or no and which ear is involved.

Yes	No		Right	Left	Both
☐	☐	1. Difficulty hearing?	☐	☐	☐
☐	☐	2. Noise in your ears?	☐	☐	☐
		Describe the noise _____			
		Does the noise change with dizziness? If so, how? _____ _____			
☐	☐	3. Fullness or stuffiness?	☐	☐	☐
☐	☐	4. Pain in your ears?	☐	☐	☐
☐	☐	5. Discharge from your ears	☐	☐	☐

IV) Have you experienced any of the following symptoms? Please check yes or no and if constant or in episodes.

Yes	No		Constant	In Episodes
☐	☐	1. Double vision, blurred vision or blindness.	☐	☐
☐	☐	2. Numbness of face.	☐	☐
☐	☐	3. Numbness of arms or legs.	☐	☐
☐	☐	4. Weakness of arms or legs.	☐	☐
☐	☐	5. Clumsiness of arms or legs.	☐	☐
☐	☐	6. Confusion or loss of consciousness.	☐	☐
☐	☐	7. Difficulty with speech.	☐	☐
☐	☐	8. Difficulty with swallowing.	☐	☐
☐	☐	9. Pain in the neck or shoulder.	☐	☐
☐	☐	10. Seasickness or car sickness.	☐	☐

Thank You

CUMBERLAND VALLEY EAR, NOSE, & THROAT CONSULTANTS

Jarl T. Wathne, MD
Angela C. Stonebraker, MD
A.Christopher Manilla, DO
Rhonda R. Williams, PA-C

PATIENT SELF HISTORY SHEET

Name: _____ **SEX: MALE / FEMALE** Last 4 SS# _____

Who Referred you to CVENT? **(choose one)**
☐ Family Dr Name: _____ ☐ UC Dr Name _____
☐ ER Dr Name: _____ ☐ Self Referred

Main Reason for today's visit: (**Describe in ONE Sentence)**: _____

_____

Location (Where is the problem?): _____

Date symptom(s) began: _____

Frequency of Symptoms: ☐ Constant ☐Intermittent ☐ Occasional ☐ Rare

Intensity of Symptoms: ☐ Mild ☐ Moderate ☐ Severe

How did symptoms start? ☐ Gradual ☐ Suddenly

Associated Symptom(s): _____

_____

Have you taken any medications for this problem? ☐ No ☐ Yes, if so please list:

_____

Have you had any Labs, X-Ray, CT, MRI or Ultrasounds for this problem? ☐ No ☐ Yes, if so what test(s) & where

_____

HEARING HEALTH CARE

Hearing Loss? YES or NO (If yes…) **Which Ear?** ☐ Right ☐ Left ☐ Both

Family History of Hearing Loss? ☐ Mother ☐ Father ☐ Siblings ☐ Grandparents ☐ None

Tinnitus ("Ringing Noise in Ears") ☐ **Which Ear?** ☐ Right ☐ Left ☐ Both
How long? _____ yrs. _____ mos.

Exposure to Noise Trauma ☐ Concerts ☐ Jet Engines ☐ Firearms ☐ Musical Instruments
☐ Other: _____

PHARMACIES:

Please list your preferred pharmacy.

	Pharmacy Name	Street Name	City, State
Local Pharmacy	_____	_____	_____
Mail Order Pharmacy	_____	_____	_____

PAST/PRESENT MEDICAL HISTORY:

Please check any ongoing medical conditions that you have already been diagnosed by doctors, including serious illness of the past. DO NOT check any problems which have not yet been addressed by a doctor.

- ☐ No Past/Present Medical Hx
- ☐ Acid Reflux
- ☐ Alcoholism
- ☐ Alzheimer's Disease
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis/ Rheumatoid
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bipolar Disorder
- ☐ Cancer (Year:_____) Type: _____
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Degenerative Disc Disease
- ☐ Depression
- ☐ Diabetes Type I(Insulin Dep)
- ☐ Diabetes Type II(Non-Insulin)
- ☐ Drug Abuse
- ☐ Eczema
- ☐ Emphysema
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Hearing Loss
- ☐ Heart Failure (Congestive)
- ☐ Heart Attack(Year:_____)
- ☐ Hepatitis (Circle:) A B C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ High Triglycerides
- ☐ HIV
- ☐ Kidney Disease
- ☐ Macular Degeneration
- ☐ Migraine/Headaches
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Panic Disorder
- ☐ Prostate Enlargement
- ☐ Seasonal Allergies
- ☐ Seizure Disorder
- ☐ Sleep Apnea
- ☐ Stomach Ulcers
- ☐ Stroke (Year:_____)
- ☐ Thyroid Problems
- ☐ TIA (Year: _____)
- ☐ Other: _____ _____

ALLERGIES:

Latex Allergy: _____ No _____ Yes (if yes, list reaction) _____

Drug Allergies: _____ No _____ Yes (if yes, list **drug** and type of **reaction** below)

_____ _____

_____ _____

_____ _____

IMMUNIZATIONS:

Have you received an Influenza Vaccine this year? □ No □ Yes (Date: _____)

Have you ever received a Pneumonia Vaccine? □ No □ Yes (Date: _____)

FAMILY HISTORY:

Please check any medical conditions/diseases in your IMMEDIATE family. These should be serious illnesses of mother, father, or siblings. Please indicate beside the illness, **F=Father**, **M= Mother**, **B= Brother, S= Sister**

- □ No Known Family History
- □ Alcoholism _____
- □ Alzheimer's Disease _____
- □ Arthritis _____
- □ Asthma _____
- □ Bleeding Disorder _____
- □ Cancer (Type): _____
- □ Congestive Heart Failure _____
- □ Depression _____
- □ Diabetes _____
- □ Emphysema _____
- □ Glaucoma _____
- □ Heart Disease _____
- □ High Cholesterol _____
- □ Hypertension _____
- □ Kidney Disease _____
- □ Migraine Headaches _____
- □ Osteoporosis _____
- □ Parkinson's Disease _____
- □ Thyroid Problems _____
- □ Unknown
- □ Other _____ _____

SOCIAL HISTORY:

Do you smoke or use tobacco products?				Amount	Duration
Cigarettes	□ Never	□ Currently	□ Previously	_____	_____
Chews	□ Never	□ Currently	□ Previously	_____	_____
Cigar	□ Never	□ Currently	□ Previously	_____	_____
Pipe	□ Never	□ Currently	□ Previously	_____	_____
Dips Snuff	□ Never	□ Currently	□ Previously	_____	_____
Vape	□ Never	□ Currently	□ Previously	_____	_____

Do family members smoke/vape outside? □ No □ Yes

Do family members smoke/vape inside? □ No □ Yes

Do you drink alcohol beverages? □ No □ Yes, if so, how many drinks per week: _____,

Have you ever used recreational/illicit drugs?

Marijuana	□ Never	□ Currently	□ Previously
Heroin	□ Never	□ Currently	□ Previously
Cocaine	□ Never	□ Currently	□ Previously

Marital Status:

□ Single □ Married □ Widowed □ Divorced □ Separated

Employment:

□ Full Time □ Part Time □ Disabled □ Retired □ Student □ Unemployed

Occupation: _____

Do you have animals in your home? □ No □ Yes If yes, what type? _____

Is Daycare used? □ No □ Yes

SURGICAL HISTORY:

Please check ANY surgeries you have had in your lifetime.

□ No Previous Surgery	□ Coronary Artery Bypass Year: _____	□ Lobectomy (removal of lung/ all or part)	□ Prostatectomy
			□ Septoplasty
□ Adenoidectomy	□ Defibrillator (Placement)	□ Lumpectomy	□ Sinus Surgery: Year & Where: _____
□ Appendectomy	□ Ear Drum Repair	□ Mastectomy	
□ Back Surgery (Disc)	□ Ear Tubes	□ Mastoidectomy	□ Skin Biopsy
□ Breast Biopsy	□ Gallbladder	□ Nephrectomy (kidney removal)	□ Splenectomy
□ Cardiac Pacemaker	□ Herniorrhaphy (Hernia)		□ Thyroidectomy
□ Cardiac Stenting	□ Hip Replacement	□ Oophorectomy	□Tonsillectomy
□ Carotid Endarterectomy	□ Hysterectomy	□ Oral Surgery	□ Other:
□ Cataract	□ Knee Arthroscopy	□ Ovarian Cyst	_____
□ Colectomy (Partial/Complete Removal of Colon	□ Knee Replacement	□ Prostate – Biopsy	_____

MEDICATIONS:

Please list all MEDICATIONS including supplements, herbals, CBD products and/or medical marijuana usage.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

REVIEW OF SYSTEMS:

GENERAL	SKIN	HEENT	NECK
□ Fever	□ Skin Rashes	□ Headaches	□ Swollen Glands
□ Chills	□ Itchy Skin	□ Voice Changes	□ Neck Mass
□ Night Sweats	□ Bruising	□ Blindness	
□ Weight Gain/ Loss			□ None
□ None	□ None	□ None	
RESPIRATORY	**CARDIOVASCULAR**	**GASTRO-INTESTINAL**	**NEUROLOGICAL**
□ Cough	□ Irregular Heartbeats	□ Abdominal Pain	□ Seizures
□ Shortness of Breath	□ Chest Pains	□ Nausea	□ Fainting
□ Wheezing	□ Blood Clots	□ Vomiting	□ Disorientation
		□ Reflux	
□ None	□ None	□ None	□ None
PSYCHIATRIC	**ENDOCRINE**		
□ Anxiety	□ Diabetes		
□ Excessive Stress	□ Thyroid Problems		
□ Panic Attacks	□ Excessive Urination		
□ Depression			
□ None	□ None		

Notice of Privacy Practices

Cumberland Valley ENT Consultants

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights
When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

You have the right to:
Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way about your medical information (for example, home or office phone) or to send your medical information to a different address.
- We will say, "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or healthcare item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared (disclosed) your health information, for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and healthcare operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
You can file a complaint with us if you feel we have violated your rights by contacting our Privacy Officer.

- To file a complaint with our organization, please submit your request in writing to the Privacy Officer **(Sundae Meyer), (11110 Medical Campus Rd, Suite 126, Hagerstown, MD 21742).**
- You can file a complaint with the U.S. Department of Health and Human Services' Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, by calling 877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**
- We will not retaliate against you for filing a complaint.

Your Choices
For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, contact us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference - for example, if you are unconscious, we may share your information if we believe it is in your best interest to do so. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these following cases, we **never** share your information unless you give us written permission:

- Marketing purposes
- Sale of your protected health information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again. We will honor your request to not contact you again.

Our Uses and Disclosures

We typically use or share your health information in the following ways:

Treatment

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

- **We will never share any substance abuse treatment records without your written permission.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our **website, or we can mail a copy to you.**

08/01/2023 Effective Date of Notice

CUMBERLAND VALLEY ENT CONSULTANTS AND/OR HEARING CARE CENTER

HIPAA Compliant Information Form

Date_____ *(Please complete front & back, and sign form)*

For Office Use Only
Chart # _____
Doctor _____
Updated _____
Initials _____

Please PRINT clearly

PATIENT INFORMATION

Name (Last): _____ (First): _____ (MI): _____

Sex:___ M __ F Date of Birth:_____ Age: _____ SS #: _____

Marital Status: S____ M____ Other _____ P.O. Box: _____

Street Address: _____ City:_____ State:_____ Zip: _____

Billing Address: _____ City:_____ State:_____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone:_____

Please share your email address. Patient/Guardian email address is: _____

Employer: _____ Employer Address: _____

Family Doctor (Full Name): _____ Referring Doctor (Full Name): _____

Pharmacy: _____ Address: _____ Phone: _____

Please list an alternate person to whom we may release medical information if you are unable to be reached. (Example: spouse, parent, etc.)

Name: _____ Relationship:_____

Home Phone: _____ Work Phone: _____ Cell Phone:_____

INFORMATION REQUIRED BY THE FEDERAL GOVERNMENT

Preferred Language: _____ Place of Birth: _____

Race:

_____ American Indian or Alaska Native _____ Asian _____ Black or African American

_____ More than one race _____ Native Hawaiian _____ Other Pacific Islander

_____ White _____ Refuse to report

Ethnicity:

_____ Hispanic or Latino _____ Not Hispanic or Latino _____ Refuse to Report

PARENT / LEGAL GUARDIAN *(For children under age 18)*

Name (Last): _____ (First): _____ (MI): _____

P.O. Box: _____ Street Address: _____ City:_____ State:_____ Zip:_____

Home Phone: _____ Work Phone: _____ Cell Phone:_____

Social Security #: _____ Date of Birth: _____

Legal Custodian: _____ Relationship to Patient: _____

Please provide us with a copy of legal documentation

The person(s) listed above are authorized to receive medical information for this patient: YES or NO (Please Circle)

*****Note: The parent who brings a child to the office for medical treatment is responsible AT THE TIME OF SERVICE for co-payment, deductibles, and account balances. If our provider is not a participating provider with your insurance company, payment in full is required at the time of service.**

See Reverse Side →

CUMBERLAND VALLEY ENT CONSULTANTS AND/OR HEARING CARE CENTER

HIPAA Compliant Information Form

For Office Use Only
Chart # _____
Doctor _____
Updated _____
Initials _____

Patient Name _____ **Date** _____

POWER OF ATTORNEY *(For Adults) (If Applicable)*

Name (Last): _____ (First): _____ (MI):_____

P.O. Box: _____ Street Address: _____ City:_____ State:_____ Zip:_____ __

Home Phone: _____ Work Phone: _____ Cell Phone:_____

Relation to patient: _____ ***Please provide us with a copy of legal documentation***

PRIMARY INSURANCE INFORMATION

Insurance Company: _____ Effective Date: _____

Policy Number: _____ Group Number: _____

Subscriber's Name: _____ Sex: ___M ___F Subscriber's Date of Birth:_____
(First) (MI) (Last)

Subscriber's SS #: _____ Patient's Relationship to Subscriber: _____

Subscriber's Employer: _____ Employer's Phone #: _____

Employer's Address: _____

SECONDARY INSURANCE INFORMATION

Insurance Company: _____ Effective Date: _____

Policy Number: _____ Group Number: _____

Subscriber's Name: _____ Sex: ___M ___F Subscriber's Date of Birth:_____
(First) (MI) (Last)

Subscriber's SS #: _____ Patient's Relationship to Subscriber: _____

Subscriber's Employer: _____ Employer's Phone #: _____

Employer's Address: _____

***Please inform us if you have a third insurance.**

If this is Workers' Comp. or accident related, please inform us and provide us with the proper paperwork.

Date of Injury: _____ Insurance Company: _____

Contact Person: _____ Phone Number:_____

Claim Number: _____

I certify that the information on this form is current and accurate to the best of my knowledge.

(SEAL)_____ _____ _____

Signature of Patient/Parent/Guardian | Relationship | Date

CUMBERLAND VALLEY ENT CONSULTANTS

Michael J. Saylor, MD
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Margaret T. Eackles, AuD, CCC-A
Certified Audiologist
Jennifer L. Campbell, AuD, CCC-A
Certified Audiologist
Kelsi J. Bubb, AuD
Certified Audiologist

HEARING HEALTH CARE

Name:_____

Patient ID:_____

Date:_____

Hearing History

☐ Hearing loss	**Which Ear?** ☐ Right ☐ Left ☐ Both	**How long?** yrs. mos.	☐ None
☐ Hearing test	**When?**	**Where?**	☐ None
☐ Family History of Hearing Loss	☐ Mother ☐ Father ☐ Siblings ☐ Grandparents ☐ <40 yrs old		☐ None
☐ Feeling of Ear Pressure/Fullness	**Which Ear?** ☐ Right ☐ Left ☐ Both	**How long?**	☐ None
☐ Tinnitus ("Ringing Noise in Ears")	**Which Ear?** ☐ Right ☐ Left ☐ Both	☐ Constant ☐ Intermittent	☐ None
☐ Sensitivity to Loud Noises	**Which Ear?** ☐ Right ☐ Left ☐ Both	**Types of Sounds:** _____	☐ None
☐ Repeat Ear Infections	**Which Ear?** ☐ Right ☐ Left ☐ Both		☐ None
☐ Hole in Ear Drum	**Which Ear?** ☐ Right ☐ Left ☐ Both		☐ None
☐ Treatment with:	☐ Intravenous Antibiotics ☐ Radiation ☐ Chemotherapy	**Why?**	☐ None
☐ Exposure to Noise Trauma	☐ Concerts ☐ Jet Engines ☐ Firearms ☐ Musical Instruments ☐ Other:_____		☐ None

Ear Surgery

☐ Tubes	**Which Ear?** ☐ Right ☐ Left ☐ Both	☐ None
☐ Ear Drum Repair	**Which Ear?** ☐ Right ☐ Left ☐ Both	☐ None
☐ Mastoid	**Which Ear?** ☐ Right ☐ Left ☐ Both	☐ None
☐ Stapedectomy	**Which Ear?** ☐ Right ☐ Left ☐ Both	☐ None

Hearing Aid History

☐ Hearing Aids	**Which Ear?** ☐ Right ☐ Left ☐ Both	**What Kind?**	☐ None
How old is (are) you Aid(s)? yrs. mos.		**How often do you wear it (them)?**	
☐ Using an Assistive Listening Device	☐ TV System ☐ FM System ☐ Amplified Phone ☐ Other:_____		☐ None
Are you interested in learning about hearing aids today?	☐ Yes ☐ No		

CUMBERLAND VALLEY ENT CONSULTANTS
HEARING CARE CENTER
11110 Medical Campus Road, Suite 126
Hagerstown, MD 21742
301-714-4375

For Office Use Only

Chart# _____
Updated _____
Initials _____

FINANCIAL AGREEMENT, AUTHORIZATION FOR TREATMENT AND NOTICE OF PRIVACY PRACTICES' RECEIPT

- Patient is responsible for payment at the time of service when: **1)** patient is a self-pay; **2)** patient has a nonparticipating insurance company; or **3)** patient has an HMO and comes without the referral specified by the insurance company.
- We file all claims to insurance companies in which we participate. You may use the fee ticket to file your insurance claims when we do not participate with your insurance company.
- There is a $5.00 charge for replacement of a lost receipt
- Patient is responsible for any service that is not covered by his/her insurance as well as any co-pays, deductibles, and co-insurance.
- As part of your routine ENT exam, we may perform some common procedures on you. These may include hearing tests and an examination of the nose, sinuses or throat with various telescopes. An important part of your entire ENT exam, these tests and procedures aid your doctor in determining the proper treatment for your condition. Based on the contract you have with your insurance company, the endoscopic procedures may be categorized as surgical procedures even though they are part of your exam. Patient is responsible to contact insurance company with questions regarding benefits and co-payment obligations for office surgical procedures.
- **Copays are due at the time of service.**
- It is the patient's responsibility to provide our office with a written referral when required by his/her insurance plan.
- Patient is responsible to make sure laboratory studies, x-rays, scans, pre and post-operative testing are performed at a facility participating with patient's insurance.
- I agree to pay all charges promptly.
- A $35 returned-check fee will be assessed to the patient's account for each check returned to our office for non-sufficient funds
- If my account is assigned to a collection agency, I agree to pay a 25% collection agency fee, court costs and attorney fees.

I hereby authorize Cumberland Valley ENT Consultants to furnish information, including records from other health care providers, to my insurance company, authorized agency, or health care provider specified concerning my medical care. I agree to pay all charges promptly upon presentation thereof. I hereby assign and transfer any medical benefits due me to Cumberland Valley ENT Consultants for the services provided to me by this medical practice. I permit a copy of this authorization to be used in place of the original. Regulations pertaining to Medicare Assignment of Benefits apply, as applicable. I acknowledge the information I have supplied is correct.

I hereby authorize Cumberland Valley ENT Consultants to treat me as needed. Also, I acknowledge receipt of the Notice of Privacy Practices.

_____ (SEAL) _____
Date Signature

I, parent or legal guardian, do hereby authorize Cumberland Valley ENT Consultants to treat_____, being _____years of age and a minor. I understand that I am fully responsible for this minor's medical charges and agree to pay all charges for services rendered by the above-named medical practice. Also, I acknowledge receipt of the Notice of Privacy Practices.

_____ (SEAL) _____
Date Signature
(Parent or Legal Guardian)

_____ _____
Printed name of parent or guardian Relationship to patient