C/V ENT
SURGICAL GROUP

PATIENT INFORMATION

Name: Age: Date of Birth: Sex: M F

Social Security Number: Martial Status: Single Married Divorced Widowed

Home Address: City: State: Zip:

Home Phone: Cell Phone:

Email: May we email you special offers/newsletters: Y N

Employer: Work Phone:

Employer's Address: City: State: Zip:

How did you find us, please be specific?

Referring physician

Emergency contact: Emergency Contact Phone:

RESPONSIBLE PARTY INFORMATION

Same as above

Name: Age: Date of Birth: Sex: M F

Social Security Number: Relationship to patient: Spouse Parent Other:

Address: City: State: Zip:

Home Phone: Cell Phone:

Employer: Work Phone:

PRIMARY INSURANCE INFORMATION

Insurance Company: Group #: ID #:

Insured's Name: Date of Birth: Sex: M F

Insured's Social Security Number: Relationship to patient: Spouse / Parent / Other:

SECONDARY INSURANCE INFORMATION

Insurance Company: Group #: ID #:

Insured's Name: Date of Birth: Sex: M F

Insured's Social Security Number: Relationship to patient: Spouse / Parent / Other:

MEDICAL HISTORY

Do you have any medical problems, if so what are they specifically?

Have you had any surgeries, if so what are they (please include any cosmetic surgeries)?

Are you allergic to any medications, if so please list the specific medications?

What medications are you currently taking; please include any herbal medications or vitamins as well?

OVER

Please list any serious medical conditions that run in your immediate family (i.e. mother, father, siblings):

NO YES

Cancer: WHO:

Tuberculosis:		WHO:				
Diabetes:		WHO:				
Heart Problems:		WHO:				
High Blood Pressure:		WHO:				
Stroke:		WHO:				
Bleeding Tendency:		WHO:				
Review of Systems:						
Height:	**Weight:**					
General:	NO	YES	**Genitourinary:**		NO	YES
Recent weight change:			Frequent urination:			
Change in energy level:			Pain or burning with urination:			
Skin:	NO	YES	Blood in urine:			
Skin disease:			Kidney stones:			
Hives, eczema, rash:			**Gynecological:**		NO	YES
Frequent skin infections:			Age periods started:			
Head, Ears, Eyes, Nose, Throat:	NO	YES	How long do periods last:			
Eye disease or injury:			Frequency of periods:			
Double vision:			Date of 1st day of last period:			
Glaucoma:			Number of pregnancies:			
Difficulty hearing:			**Musculoskeletal:**		NO	YES
Dizziness:			Weakness in muscles or joints:			
Neck:	NO	YES	Muscle pain:			
Neck stiffness:			Joint pain:			
Thyroid trouble:			Difficulty walking:			
Enlarged glands:			**Neuro-psychiatric:**		NO	YES
Difficulty swallowing:			History of seizures:			
Voice changes:			Frequent Headaches:			
Respiratory:	NO	YES	Depression:			
Spitting up blood:			Anxiety:			
Shortness of breath:			Paralysis:			
Wheezing/Asthma:			**Hematologic:**		NO	YES
Cough:			Blood diseases:			
Cardiovascular:	NO	YES	Anemia:			
Chest pain or angina			Abnormal bruising:			
Difficulty walking 2 blocks:			Excessive bleeding with dental work:			
Heart trouble or heart attacks:			**Allergic:**		NO	YES
High blood pressure:			Autoimmune disorders:			
Gastrointestinal:	NO	YES	Food allergies:			
Frequent nausea or vomiting:			**Endocrine:**		NO	YES
Liver trouble:			Hypothyroid/Hyperthyroid:			
Hepatitis:			Parathyroid disorders:			
Heartburn:			Change in growth:			

Responsible Party Signature:_____ **Date:**_____

C/V ENT
SURGICAL GROUP

OFFICE AGREEMENT

Thank you for selecting us as your personal ENT physicians and Head & Neck Surgeons. To promote a long-term, mutually satisfying relationship, we would like to explain our office policy regarding treatment, insurance, appointments and fees. PLEASE read this agreement carefully and ask any questions or bring up any concerns you may have BEFORE treatment is rendered with our Practice Administrator. Submission to treatment implies your consent to the terms of this agreement.

TREATMENT: You will find our entire staff is dedicated to helping you improve your ENT health as quickly as possible. Every effort will be made to make your appointment as comfortable and pleasant as possible. Please feel free to discuss your treatment with the doctor at any time.

INSURANCE: If this office is able to accept your insurance company's assignment, the patient is still fully responsible for treatment rendered. Your insurance may not cover the services or may only partially cover them; any estimate given by this office is considered a guideline until the final insurance payment is received, and then the patient's account is reconciled. The office can make no guarantee of actual payment by your insurance company. You will be personally responsible for all copays or deductibles.

MISSED APPOINTMENT: When we schedule your appointment, the time is reserved exclusively for you. When you fail to notify us of your inability to keep an appointment, another patient in need of care is unable to receive treatment. We request that you give us at least 24 hours notice when you realize that you cannot keep an office appointment. When the requested notice is not given within 24 hours of the appointment, a fee of $50.00 will be charged. If you cancel an authorized surgical or in-office procedure within 48 hours of the procedure, there is a fee of $500.00 assessed. These charges are because our physicians schedule time aside for your particular visit or surgical procedure and when you don't give adequate notice another patient in need of care cannot receive the services needed.
_____ Initials required

PROCESSING / RECORD REQUEST FEE: There will be an administrative processing fee of $25 for any disability paperwork requested. There is also a fee of $25 when a copy of your records is requested, depending on the amount of paperwork in your file. Payment is due at the time of service. There is also a $25 fee for any copies of CD images needed.

We accept cash, personal checks, American Express, MasterCard and Visa. When insurance applies, we will collect any deductible and estimated co-payments at the time of the visit, as required by law. Furthermore we may require a deposit before surgery to guarantee payment postoperatively and to reserve your surgical appointment. We have Care Credit available for patients needing financial assistance. If utilizing Care Credit, this must be approved before services are rendered. Please ask our treatment coordinator for more information if interested.

SERVICE CHARGES:

1. **MONTHLY BILLING / CREDIT CARD POLICY: Even though an insurance claim has been filed, you will still receive a statement each month from our billing service which will provide you with the outstanding balance due on your account, since you, not the insurance company are ultimately responsible for payment of your account. A 1.625% will be applied every month to accounts with balances outstanding 90 days or longer, regardless of outstanding insurance.**

2. RETURNED CHECKS: There is a $50.00 fee for returned checks. The check must be picked up personally, and credit card or cash must be used to cover the check and the fee. No checks accepted from then on.

3. COLLECTION FEES: Fees incurred to enforce payment required by this agreement will be charged to the patient whose failure to pay, required these fees to be incurred. Interest will continue to accrue on any and all balances until paid in full.

Signature _____ Date_____
Patient/ Parent or Guardian if patient is a minor

C/V ENT
SURGICAL GROUP

ENT / Head and Neck Surgery
Nose and Sinus Surgery
Thyroid and Parathyroid Surgery
Facial Plastic and Reconstructive Surgery

IN-OFFICE PROCEDURE POLICY

This letter is simply to inform you that during your initial or during any follow-up visits, your ENT specialist may recommend various in-office procedures. These are separate procedures to help in the diagnosis and treatment of your specific condition and are NOT part of the routine ENT exam or consultation. They are, however, a necessary part of the exam or treatment according to your specialist. We want to make you fully aware that your insurance company also considers these procedures as separate from the consultation and will recognize them as a "SURGICAL PROCEDURE." These procedures include NOSE/SINUS ENDOSCOPY, FLEXIBLE/RIGID LARYNGOSCOPY WITH OR WITHOUT STROBOSCOPY, FLEXIBLE NASOPHARYNGOSCOPY, NOSE CAUTERIZATION FOR TREATMENT OF NOSEBLEEDS, FOREIGN BODY REMOVAL, EAR WAX REMOVAL, HEARING TESTS/AUDIOGRAMS, CT SCANS, HEARING TESTS/AUDIOGRAMS, CT SCANS, BIOPSIES OF LESIONS OF THE SKIN OR MUCOSA, ETC.

As such certain insurance companies have different deductible and copay amounts for these procedures per your individual policy and you may have all or a certain portion of this billed procedure applied to your deductible or copay, which you will be responsible for.

Please sign below to to confirm you understand our in-office procedure policy and provide your informed consent.

_____
Patient / Guardian Signature

_____ _____
Printed Patient / Guardian Name *Date*

C/V ENT
SURGICAL GROUP

ASSIGNMENT OF BENEFITS

INSURANCE PAYMENT AUTHORIZATION:

I authorize payment of medical benefits to C/V ENT Surgical Group for any professional services rendered. If by chance I'm paid directly by the insurance company for services provided by C/V ENT Surgical Group, then I will forward that check on my behalf to C/V ENT Surgical Group for processing.

PATIENT'S NAME	SIGNATURE	DATE

MEDICARE PAYMENT AUTHORIZATION:

I request that payment of authorized Medicare benefits be made to C/V ENT Surgical Group for any professional services rendered by any providers in the group. I authorize any holder of my medical information to release to the health care financing administration and its agents any information needed to determine these benefits or these benefits payable to related services.

PATIENT'S NAME	SIGNATURE	DATE

C/V ENT SURGICAL GROUP

C/V ENT SURGICAL GROUP

Head and Neck Surgery
Pediatric and Adult ENT and Allergy
Facial Plastic and Reconstructive Surgery
Thyroid and Parathyroid Surgery

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

THE NOTICE OF PRIVACY PRACTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I acknowledge that I have access to the office Notice of Privacy Practices. I further acknowledge that the office Notice of Privacy Practices is available for review at the front desk upon request.

Date:_____

Who may we share medical information with?

Spouse:_____ **Phone:**_____

Parent:_____ **Phone:**_____

Other: (please specify)_____ **Phone:**_____

Where may we leave medical information?

Home Answering Machine.....Phone:_____

Office Voicemail.....Phone:_____

Cell Phone.....Phone:_____

Other (please specify).....Phone:_____

Patient Name:_____

Patient Signature:_____

If not signed by member, please indicate relationship_____

C/V ENT
SURGICAL GROUP

Effective 4/01/2023

Cancellation / No-show Policy

We understand that at times unplanned issues can come up and you may need to cancel your appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled at least 24 hours in advance during regular business hours.

Our doctors want to be available for your needs as well as the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen. Although we have always had a cancellation policy, circumstances have caused us to enforce a new policy and to increase our fees.

As such, if you are unable to make your appointment without giving at least 24 hours prior notice, the following is a schedule of missed appointment fees that you will be responsible for:

$50.00 Fee - first time

$100.00 Fee - second time

$150.00 Fee - third time

Thank you for being a valued patient and for your understanding and cooperation as we institute this policy. This policy will enable us to open otherwise unused appointments to better serve the needs of all our patients.

C/V ENT Surgical Group

Patient Signature_____

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Open Payments database

The federal Open Payments program is designed to promote transparency by requiring applicable manufacturers of drugs, devices, and biological or medical supplies to annually report to the Centers for Medicare & Medicaid Services certain payments and other transfers of value made to physicians, certain advanced practice providers (*e.g.*, nurse practitioners) and teaching hospitals. Currently, pharmaceutical companies in California must disclose their compliance program, including information related to the annual dollar limits on gifts, promotional materials or incentives provided to medical or health professionals (California Health & Safety Code § 119402). The enactment of this new legislation will impose new disclosure requirements specifically onto physicians and their employers regarding physicians' financial relationships with pharmaceutical and medical device manufacturers.

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov. For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.

_____ _____

Patient Signature Date

Sometimes it can be difficult to determine if your sinus symptoms are the result of allergies and the common cold or if pressure, pain and dizziness are being caused by chronic sinusitis. To help you determine which sinus treatment is the right option for you, take a moment to answer the questions below.

Circle "yes" if you have had any of the following symptoms for 10 days or longer:

Facial pressure or pain	YES
Headache pain	YES
Congestion or stuffy nose	YES
Thick, yellow-green nasal discharge	YES
Low fever (99-100 degrees)	YES
Bad breath	YES
Pain in your teeth	YES

DURATION AND FREQUENCY

Have you experienced these symptoms for 12 or more consecutive weeks?	YES
Have you experienced these symptoms for 10 or more days four or more times (with periods of no symptoms) in the last twelve months?	YES

If you answered yes to three or more of the symptom descriptions, and yes to either extended (12+ weeks) or repeated (4+ times) outbreaks, you may suffer from chronic or recurrent sinusitis. An examination by an ear, nose, and throat specialist is strongly encouraged.

Be sure to ask your ENT specialist about balloon sinus dilation—it may be the lasting treatment option that's right for you.

If you have facial pain or pressure, please place an "X" on the face below to show where you are feeling that pain or pressure:

Please **rate your current facial pain/pressure** on a scale of 1 to 5, 1 being no pain, and 5 being the most pain you have ever felt.

5
MOST PAIN EVER

On what date did you first start experiencing these symptoms?

Learn more about your options at **www.SinusSurgeryOptions.com.**

entellus MEDICAL™

XprESS™ may be used to treat certain conditions affecting the sinus above your eyebrows and behind your cheeks and eyes. Your physician will need to determine if your condition is one that may benefit from XprESS. Possible side effects include but are not limited to post-operative bleeding; pain and swelling; allergic reaction to anesthesia or other medications administered during the procedure; or infection. Your condition may not respond to this treatment. To learn more about this procedure and the potential risks, ask your physician.

Caution: Federal (USA) law restricts this device to sale by or on the order of a physician.

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Sleep Assessment

Your physician is requesting that you complete this Sleep Assessment Form. Quality Sleep is an important part of your overall health and well being.

Date _____ **Name:** _____ **Phone Number :** _____

Home Address: _____

Physician Name:_____

1. Have you been told that you snore?	Yes ___	No ___
2. Do you wake up tired in the morning?	Yes ___	No ___
3. Do you wake up with headaches in the morning ?	Yes ___	No ___
4. Do you wake up with dry mouth in the morning ?	Yes ___	No ___
5. Have you ever been told that you stop breathing at night?	Yes ___	No ___
6. Do you feel the need for a nap in the afternoon?	Yes ___	No ___
7. Do you awaken from sleep with shortness of breath or rapid heartbeat?	Yes ___	No ___
8. Do you take medication for high blood pressure?	Yes ___	No ___
9. Do you have Diabetes or have you been told you are Pre - Diabetic?	Yes ___	No ___
10. Are you having trouble losing weight ?	Yes ___	No ___
11. Do you suffer from Gastric reflux (Gerd) ?	Yes ___	No ___
12. Does your family have a history of death in sleep?	Yes ___	No ___
13. Is your neck size larger than 15.5 (female) or 17.0 (male)	Yes ___	No ___
14. Have you ever been diagnosed with Obstructive Sleep Apnea?	Yes ___	No ___
15. Are you currently being treated for sleep apnea?	Yes ___	No ___
13a. If yes, are you using your apparatus every night, all night ?	Yes ___	No ___

Epworth Sleepiness Scale

How likely you are to doze off are while doing the following activities? Please use the following scale: 0 = never, 1 = slight, 2 = moderate, 3 = high. Circle one of the following numbers

1. Being a passenger in a motor vehicle for an hour or more	0 1 2 3
2. Sitting and talking to someone.....	0 1 2 3
3. Sitting and reading.....	0 1 2 3
4. Watching TV.....	0 1 2 3
5. Sitting inactive in a public place.....	0 1 2 3
6. Lying down to rest in the afternoon.....	0 1 2 3
7. Sitting quietly after lunch without alcohol.....	0 1 2 3
8. In a car, while stopped for a few minutes in traffic...	0 1 2 3
Total score	_____

Physician Signature: _____ **Date:**_____