Mt. Hood ENT & Allergy

Darryk W. Barlow, MD FACS
Board Certified in Otolaryngology

Rikki Green, AuD
Doctor of Audiology
The Hearing Center at Mt. Hood ENT

John W. Topping, MD
Board Certified in Otolaryngology

Hello and thank you for choosing Mt. Hood ENT & Allergy.

Please print and fill out our **Patient Registration Forms** (and **Sleep Forms** if you are being seen for sleep problems).

Please bring the forms with you to your appointment. This will save you time when you check in.

Do not email the forms – this is not a secure or HIPAA compliant way to transfer your sensitive information.

Thank you for your help and we look forward to seeing you.

Please contact us if you have any questions.

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Visit our website for location and parking information.

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1/12/2016

Mt. Hood ENT & Allergy Patient Information

Account #		Today's Date:

PATIENT LAST NAME	FIRST NAME, MIDDLE	SSN	SUFFIX

ADDRESS 1	CITY	STATE	ZIP CODE
ADDRESS 2	CITY	STATE	ZIP CODE

HOME TEL #	EXT	WORK TEL #	EXT	CELL #	SEX	AGE

BIRTH DATE	EMPLOYMENT STATUS & EMPLOYER	E-MAIL

CURRENT VISIT

USUAL PROVIDER	REFERRING PHYSICIAN	PRIMARY CARE PHYSICIAN

MARITAL STATUS	RACE	ETHNICITY	LANGUAGE	HIPAA NOTICE SIGNED

REASON FOR VISIT	ADVANCE DIRECTIVE AND LOCATION	OPT OUT?

REFERRAL SOURCE	ACCIDENT TYPE/DATE/TIME/LOCATION	ACCT TYPE

GUARANTOR INFORMATION

NAME	SUFFIX	RELATIONSHIP TO PATIENT	SEX	BIRTHDATE	SSN

ADDRESS 1	CITY	STATE	ZIP CODE
ADDRESS 2	CITY	STATE	ZIP CODE

HOME TEL #	WORK TEL # & EXT	CELL #	EMPLOYER	

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT #1	SUFFIX

PHONE #1	PHONE #2	PHONE #3	RELATIONSHIP TO PATIENT

EMERGENCY CONTACT #2	SUFFIX

PHONE #1	PHONE #2	PHONE #3	RELATIONSHIP TO PATIENT

INSURANCE INFORMATION

1	CARRIER NAME	CARRIER ADDRESS			
	CERTIFICATE ID NUMBER	GROUP NAME	CLAIM/GROUP NO.	CARRIER PHONE NO.	COVERAGE TYPE
	SUBSCRIBER NAME	SUBSCRIBER D.O.B.	SUBSCRIBER SSN	RELATIONSHIP TO PATIENT	
2	CARRIER NAME	CARRIER ADDRESS			
	CERTIFICATE ID NUMBER	GROUP NAME	CLAIM/GROUP NO.	CARRIER PHONE NO.	COVERAGE TYPE
	SUBSCRIBER NAME	SUBSCRIBER D.O.B.	SUBSCRIBER SSN	RELATIONSHIP TO PATIENT	

Mt. Hood ENT & Allergy
Past Medical History

Date: _____

Patient Name: _____ **DOB:** _____ **Age:** _____

Primary Care Physician: _____ Referring Physician: _____

How did you hear about our office? _____

Reason for today's visit: _____

Pharmacy (Telephone # and Address): _____

Medication Allergies	**Type of Reaction**
Food Allergy	
Surgical tape	

Current Medications (or provide list of medicines)	**Dose**

Do you use **tobacco**? Y : N What type? _____ How much? ____ packs/day How many years? ____ If quit, when? _____
Do you drink **alcohol**? Y : N How much? _____
Could you be **pregnant** now? Y : N

Occupation: _____

Medical History - Have you ever suffered from these problems? (Please circle Yes or No)

Allergies / hayfever	Y : N	Ear infections	Y : N	Sinus infections	Y : N
Asthma	Y : N	Hearing loss	Y : N	Sleep apnea	Y : N
Bleeding problems	Y : N	Heart disease	Y : N	Stroke	Y : N
Cancer, if yes, Type	Y : N	High blood pressure	Y : N	Strep throat	Y : N
		HIV / AIDS	Y : N	Tonsillitis	Y : N
		Kidney disease	Y : N	TMJ / Jaw joint problems	Y : N
		Liver disease	Y : N	Thyroid disorder	Y : N
		Hepatitis C	Y : N	Tuberculosis	Y : N
		Pulmonary disease	Y : N	Other	
Diabetes	Y : N	Reflux	Y : N		

Previous Surgery

Adenoidectomy	Y : N	Angioplasty / stents	Y : N	Anesthesia problems	Y : N
Tonsillectomy	Y : N	Heart surgery	Y : N	If yes, type of reaction:	
Ear tubes	Y : N	type			
Ear surgery, other	Y : N	Appendectomy	Y : N	Other operations:	
Septoplasty	Y : N	Gallbladder	Y : N		
Sinus surgery	Y : N	Hernia repair	Y : N		
Thyroid surgery	Y : N	Hysterectomy	Y : N		

Family History – Have any of your blood related relatives ever suffered from these problems?

Allergies / hayfever	Y : N	Diabetes	Y : N	Sleep apnea	Y : N
Asthma	Y : N	Ear infections	Y : N	Snoring	Y : N
Bleeding problems	Y : N	Hearing loss	Y : N	Thyroid disorder	Y : N
Cancer, if yes, Type	Y : N	Heart disease	Y : N	Other:	
		Anesthesia reaction	Y : N		
		type			

		Mt. Hood ENT & Allergy		Review of Systems	
Do you have any of the following? Please circle Yes or No					
General		**Sleep Problems**		**Neurologic**	
chills	Y : N	excessive daytime sleepiness	Y : N	disorientation	Y : N
fatigue	Y : N	gasping/choking	Y : N	fainting	Y : N
fever	Y : N	insomnia, can't fall asleep	Y : N	headaches	Y : N
night sweats	Y : N	sleep apnea–stop breathing	Y : N	lightheaded sensation	Y : N
weight gain > 10 lbs	Y : N	snoring	Y : N	spinning / motion sensation	Y : N
weight loss > 10 lbs	Y : N			trouble walking	Y : N
				unsteadiness	Y : N
Skin		**Neck / lymph nodes**		weakness	Y : N
itch	Y : N	lymph nodes enlarged	Y : N		
rash	Y : N	neck mass	Y : N	**Psychiatric**	
Eyes		neck pain	Y : N	anxiety	Y : N
double vision	Y : N	neck swelling	Y : N	depression	Y : N
excessive tearing	Y : N	salivary glands enlarged	Y : N	increased stress	Y : N
eye pain	Y : N			panic attacks	Y : N
vision loss	Y : N	**Respiratory**			
		bloody sputum	Y : N	**Endocrine**	
Ears		chronic cough	Y : N	cold intolerance	Y : N
ear drainage	Y : N	wheezing	Y : N	heat intolerance	Y : N
ear fullness	Y : N			thyroid problems	Y : N
ear pain	Y : N	**Cardiology**			
ear infections, recurrent	Y : N	chest pain	Y : N	**Hematology**	
hearing loss	Y : N	palpitations	Y : N	abnormal bleeding	Y : N
loud noise exposure	Y : N	extremity swelling	Y : N	easy bruising	Y : N
type:					
ringing ears / tinnitus	Y : N	**GI**			
sensitivity to loud sound	Y : N	abdominal pain	Y : N		
		difficulty swallowing	Y : N		
Nose		heartburn or regurgitation	Y : N		
nasal congestion	Y : N	nausea	Y : N		
nosebleeds	Y : N	vomiting	Y : N		
post nasal drainage	Y : N				
runny nose - clear	Y : N	**Musculoskeletal**			
runny nose - discolored	Y : N	joint pain	Y : N		
sneezing	Y : N				
sinus pain	Y : N				
sinus pressure	Y : N				
Mouth					
oral ulcers	Y : N				
teeth clenching	Y : N				
teeth grinding	Y : N				
teeth pain	Y : N				
Throat					
frequent throat clearing	Y : N				
hoarseness	Y : N				
phlegm in throat	Y : N				
sore throats	Y : N				

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Financial Policy

As a service to our patients, we would like to outline our policy toward the payment of service. Payment on your account is due within 30 days of your health insurance or the responsible party. Although insurance billings are done as a courtesy for you, we hold you responsible for your account.

Your co-payment is due at the time of your office visit.

We will do everything we can to ensure payment by your insurance and help you as best as possible.

Any outstanding balance not paid by insurance after 90 days is your responsibility.

If we are not billing your insurance company, the cost of the visit is due at the time of service unless you have made other arrangements with our billing department.

Accounts that are 60 days old are considered delinquent.

A finance charge of $3.00 per month or interest of 1½% per month (whichever is greater) will be added to cover the cost of additional handling.

I, _____acknowledge the policies and financial
Name of patient/responsible party

requirements and agree to pay all charges not covered by insurance or other contract medical programs.

Signature_____ Date_____

6/29/15

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Questions to Frequently Asked Questions About Your Health Insurance Coverage

Q: How much will my office visit cost?
A: The cost of your visit with your otolaryngologist will vary depending on the type of visit and scope of treatment involved. You can expect to be charged for an office visit which entails a history of the nature of your concern, an exam and a discussion of your treatment options.

Q: If my physician performs a procedure is this included in the office visit charge?
A: No. In order to more fully address your concerns your physician may recommend a procedure such as a biopsy, hearing test, ear cleaning, endoscopy (looking with a scope), allergy testing, allergy shots or surgery. Office visit fees are billed separately from procedure fees so if there is a procedure performed during your office visit there will be a separate fee.

Q: How are the office visit fees and procedure fees determined?
A: The fees are determined through a contract with your insurance company. Each office visit and procedure is assigned a code (called a CPT code) developed by the American Medical Association. These codes are used by ALL insurance plans, including Medicare, to process your medical claim. The physician will record the level of office visit performed and CPT codes for any procedures that were performed. We do not determine what will be paid for each office visit or procedure code, this has been pre-determined by your insurance company.

Q: How do I know how much I will owe for each visit?
A: We understand that insurance coverage can be confusing at times. Fees that are charged by our office may apply to your to deductible or co-insurance (i.e. out of pocket expenses). If your physician recommends a procedure during your visit you may choose to have this performed at the same time or, if you are concerned about the fees associated with this, you may request the procedure code (CPT code) and you may contact your insurance company regarding your out-of-pocket expenses before proceeding.

Q: Can I get a discount on what I owe for my office visit in or procedure.
A: No. In an effort to keep the cost of medical care down the fees that we have agreed upon with your insurance company have already been discounted. We cannot, by contract, discount them further.

Q: Why didn't my insurance company cover my visit?
A: All insurance companies have the same disclaimer: "Coverage is not a guarantee of payment". The term 'covered' is different than that of 'payment'. 'Covered' when referring to medical services means that your insurance is going to allow the service(s) received and will process your claim according to your specific plan benefits. Reasons for non-payment could be any of the following, just to name a few: non-covered service, deductible, co-insurance or cost share, co-pay, plan exclusions, etc. As an example, often times the office visit will be allowed and paid by the insurance plan but the procedure performed that same day is applied to the deductible. Given the number of insurance companies and the numerous networks and benefit packages it is not possible for us to know exactly what your benefits are. Questions regarding your specific benefits are better directed to your health insurance plan.

Q: What if I am unable to pay in full at this time?
A: We accept all major credit cards. If you have concerns about the fees you owe we recommend you contact your insurance company and you may also call our billing specialist and we will do everything possible to give you the assistance you need. We are committed to working with you so that you can receive the high quality health care you deserve.

jwt, 12-15-14

Notice of Privacy Practices
Acknowledgement

Patient Name: _____

1. **HIPAA Privacy Notice** -- I have received a copy of the Mt. Hood ENT & Allergy Notice of Privacy Practices. I understand that Mt. Hood ENT & Allergy has the right to change its Notice of Privacy Practices from time to time to comply with current changes mandated by the Department of Health and Human Services. I may contact Mt. Hood ENT & Allergy at any time to obtain a current copy of the Notice of Privacy Practices.

2. **Communication with others involved with your care** -- Consent is given to our healthcare professionals to disclose to a family member, other relative, close personal friend or any other person you identify, health information directly relevant to that person's involvement in your care or payment related to your care. Yes ___ No ___

   Name(s) of person authorized to receive health information:

   _____

   _____

   _____

3. **Community Exchange Consent –** Consent is given to our healthcare professionals to exchange and/or transfer medical information/Continuity of Care Record from one provider to the next, and from one facility to the next which includes electronic access and transmission. Consent is also given to accept incoming patient data from other provider's electronic health records which includes electronic access and transmission. Yes ___ No___

4. **Acquired Medication History Consent –** I understand that my medication history may be obtained utilizing an electronic information exchange and that this protected health information may provide valuable information for my healthcare provider. I hereby authorize Mt. Hood ENT & Allergy to access my medication history without limitation or exclusion as is required and/or reasonably advisable to disclose, process, retrieve, transmit, and view for the purpose of the transmission of an electronic prescription issued by a provider authorized by law to prescribe, as necessary for my care and treatment. Yes___ No___

Patient/Guardian Signature: _____Date:_____

Legal Representative/Relationship: _____Date:_____

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Assignment of Benefits

Authorization to Pay Benefits to Physician: I authorize the release of medical or other information necessary to process health insurance claims.

I also request payment of benefits to myself or to my Provider, Mt. Hood ENT & Allergy when he/she accepts assignment.

Authorization to Release Medical Information. I hereby authorize my Provider, Mt. Hood ENT & Allergy to release any information necessary for my course of treatment.

Patient Name: _____

_____ _____
Signed (patient or parent if minor) Date

6/29/15