PATIENT INFORMATION							
Patient's Legal Name	Last			First		MI.	TODAY'S DATE
Age	Birthdate		Sex	Patient's SSN		How did you hear about our office?	
Race		Ethnicity		Language Preference		Email Address:	
Patient's Address	Street		City		State	Zip	Home Phone ( )
Patient's Employer				Patient's Occupation			Business Phone ( )
Employer's Address	Street		City		State	Zip	Cell Phone ( )
Spouse's Name		Spouse's SSN:					Spouse Phone ( )
Emergency contact **other than spouse or parent name**				Relationship			Emergency Phone ( )
Responsible Party Name & Date of Birth							Relationship to Patient
Billing Address	Street		City		State	Zip	Home Phone ( )
Father's Name (if patient is a child)		Social Security #		Employer's Name			Father's Work Phone ( )
Mother's Name (if patient is a child)		Social Security #		Employer's Name			Mother's Work Phone ( )
Family Physician's Name			Phone No. ( )			Has anyone in your **immediate** family been seen before?	
Name of Referring Physician If Other Than Family Doctor			Phone No. ( )			If Yes, Name:	
Primary Insurance ID:							
Ins. Co. Name		Policy Holder Name					
Policy Holder Date of Birth		Policy Holder Employer					
Secondary Insurance ID:							
Ins. Co. Name		Policy Holder Name					
Policy Holder Date of Birth		Policy Holder Employer					

PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS, INFORMATION RELEASE & CONSENT TO TREATMENT

I, the undersigned, authorize payment of medical benefits to Ear, Nose & Throat Consultants, LLC for any services furnished to me by the physicians. I understand I am financially responsible for any amount not covered by my insurance contract. I also authorize you to release to my insurance company 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.

I, knowing that I have a condition requiring diagnosis, treatment, or related medical care do hereby consent to such care, medical examination(s), operation(s), procedure(s), therapy sessions, photographs, and/or treatment by my attending physician(s), their assistant(s) or designee(s) as may be necessary in their professional judgment. I further acknowledge that no guarantees have been made to me as to the results of such care, medical examination(s), operation(s), procedure(s), therapy sessions and/or treatment.

Signature of Patient (if minor Parent or Legal Guardian Signature) _____ Date _____

Ear Nose & Throat
CONSULTANTS, LLC
Phone: 402-778-5250
Fax: 402-778-5216

FINANCIAL POLICY

Thank you for choosing Ear, Nose & Throat Consultants, LLC for your health care needs. All patients must accept our FINANCIAL POLICY before receiving treatment. Please understand that full payment of your bill is considered a part of your treatment.

1. We accept **CASH, CHECKS, VISA, MASTERCARD, DISCOVER and AMERICAN EXPRESS**.
2. **Co-payments as well as outstanding balances** are always due at the time of service, unless other arrangements have been made with the billing office. Our contractual agreement with your insurance carrier prevents us from waiving your required co-pay amount.
3. The balance of the account is **due within 15 days of the statement date** unless you have made other arrangements with the business office. An **Administration Fee of $10.00** will be applied to your account if full payment is not received by the statement due date. We will collect all outstanding account balances prior to each visit.
4. If you have **no insurance coverage, payment of 80% of charged fees are due at the time of the visit with a minimum payment of $150**.
5. **Routine diagnostic procedures** that are customary to our specialty and are a necessary part of your treatment may be applied toward your deductible or coinsurance depending on your individual insurance plan. It is the responsibility of the patient to know their coverage details.
6. Payment for **elective services** will be required 48 hours prior to service and will not be filed with your insurance company until after they are rendered.
7. A **$25.00 service charge** will be assessed for returned checks. If your check is returned, you will be required to pre-pay in full by cash, Visa, MasterCard, Discover, or American Express for additional services.
8. **Call to correct any billing errors promptly.** If you ignore our billing statements or telephone calls, we can only assume that you do not intend to pay for the medical services that were provided in good faith, and your account will be forwarded to an outside collection agency.
9. **Referrals** – some insurance plans require that a referral from the primary care physician be obtained prior to being seen. It is the responsibility of the patient to obtain this referral. If a referral has not been obtained you may be responsible for a larger portion of your bill.
10. **Personal Injury** – we will not be a party to any litigation suits filed for personal injuries. We require payment in full and any payment from litigation is to besought by you for reimbursement.
11. **Work-Related Injuries** – pre-authorizations for care is the responsibility of the patient. If the prior authorization is not obtained, you are responsible for full payment at the time of service. If your workers compensation carrier has not paid your account within 45 days of the date of service, the owed balance will become the responsibility of the patient.

I UNDERSTAND AND AGREE TO THE TERMS OF THIS FINANCIAL POLICY.

_____ _____

Print Patient Name **Patient Date of Birth**

_____ _____

Signature of Patient or Patient Representative **Date**

Ear Nose & Throat
CONSULTANTS, LLC
Phone: 402-778-5250
Fax: 402-778-5216

Procedures in office

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. Insurance carriers often classify these procedures as surgery and apply the charges to your calendar year deductible. This is plan specific with your insurance and may result in insurance payment for an office visit, but NOT a procedure. In such cases, payment of the procedure will be due from the patient. Be assured that we are following all federally accepted billing and coding guidelines.
The physicians of ENT Consultants only perform procedures when deemed medically necessary to best diagnose and treat our patients. If you are presenting with sinus, throat/voice complaints, or have had past sinus surgery, there is a good chance that our providers will determine it necessary to perform one of these procedures to properly diagnosis an.

Examples of in-office procedures include:

- CPT 31231 Nasal Endoscopy
  - This procedures uses a flexible or rigid scope attached to a light source to view areas of the nasal cavities that cannot be viewed by the physician using the nasal speculum and head mirror.
- CPT 31575 Flexible Laryngoscopy
  - This procedure involves passing a long thin flexible fiber optic scope through the nasal cavity and into the throat. Their fiber optic scope enables the physician to visualize areas of the throat not readily seen using laryngeal mirrors.
- CPT 31237 Nasal Endoscopy with Debridement or biopsy
  - This a similar procedure to 31231 with the removal of crusting and or tissue and debris material.
  - This procedure is commonly performed after sinus surgery and is a billable encounter.

Please speak with the billing office if you would like to know an estimate of what your carrier allows for these procedures prior to their completion.

Patient Name (Please print):_____

Patient/Guardian Signature: _____ Date: _____

Ear Nose & Throat
CONSULTANTS, LLC

Notice of Privacy Practices & Alternate Communications

The Notice of Privacy Practice describes how medical/protected health information about you may be used and disclosed and how you can get access to this information.

In summary, as a patient you have the right to access your protected health information. You also have the right to request corrections to your information, request your information be restricted, and request confidential communication. We want to assure you that your medical/protected health information is secure with us. You also have a right to request a detailed Notice of Privacy Practice of the Medical Practice named at the top of this page at any time.

*****In accordance with my right for protected health information, I give you permission to discuss my protected health information with the following people (please include name, relationship, and phone number):**

NAME	RELATION	CONTACT INFORMATION

*****In accordance with my right for protected health information, my preferred method of communication is:**

❑ **Phone:**_____ ❑ **Patient Portal (see receptionist)** ❑ **postal mail**

*****Can we leave a message on this phone number?** ❑ **Yes** ❑ **No**

In the event that we are unable to contact you via your preferred method of communication, how do you want to be contacted?

_____

_____

_____

I acknowledge that I was notified of my HIPAA rights and my right to obtain its full details. I also have exercised my right to name or not name any alternate individuals to receive my protected health information as well as indicated my preferences regarding how I would like to receive my protected health information.

_____ _____

Print Patient Name **Patient Date of Birth**

_____ _____

Signature of Patient or Patient Representative **Date**

ENT CONSULTANTS, LLC – MEDICAL HISTORY & SYMPTOMS

*****This information is needed to ensure that you receive the best care possible. *Please fill out completely. If any field is left blank, it will be assumed that the answer is "NO."******

NAME:_____ **DATE OF VISIT:**_____

PATIENT MEDICAL HISTORY:

Height:_____ Weight:_____ If female, are you or could you be pregnant?_____ If yes, # of weeks? _____

MEDICATION & PERSONAL MEDICAL HISTORY: *(MUST PROVIDE A LOCAL PHARMACY)*

Local Pharmacy with Address (i.e. Walgreens 90th & Dodge): _____

Mail-In Pharmacy: _____

MEDICATION ALLERGIES (LIST ALL):_____

_____

CURRENT MEDICATIONS:

MEDICATION	DOSE	FREQUENCY	WHAT CONDITION IS THIS MEDICATION TREATING?

OTHER PERSONAL ILLNESSES NOT LISTED ABOVE: _____

_____

SOCIAL HISTORY: (circle the appropriate answer)

Marital Status: Single Married Separated Divorced Widowed Declines to Answer

Alcohol Use: Never Rare Social Frequent Social Heavy Declines to Answer

Current Smoker? YES NO **Past Smoker?** YES NO **Chewing Tobacco User?** YES NO Declines to Answer

Recreational Drug Use: YES If yes, which substance?_____ NO Declines to Answer

FAMILY MEDICAL HISTORY (IF NONE OR UNKNOWN PLEASE INDICATE THIS BELOW):

Please, only include blood relatives!!!

DISEASE:_____ RELATIONSHIP: _____
(specify types of cancers) (specify family member)

DISEASE:_____ RELATIONSHIP:_____
DISEASE:_____ RELATIONSHIP:_____
DISEASE:_____ RELATIONSHIP:_____
DISEASE: _____ RELATIONSHIP: _____

PREVIOUS SURGERIES (LIST ALL AND IF NONE PLEASE INDICATE THIS BELOW):

_____

_____

CANCER SCREENINGS (year): Last Pap Smear:_____Last Mammogram:_____Last Colonoscopy: _____

IMMUNIZATIONS (year): Flu Vaccine:_____Pneumovax: _____

REVIEW OF TODAY'S SYMPTOMS: (Mark all that apply)

GENERAL	YES	CARDIO	YES	SKIN	YES	ALLERGY	YES
Headache		Chest pain		If yes, list:		Environmental	
List Other:		List Other:				Food	
				NEURO	**YES**	Hives/rash	
EYES	**YES**	**RESP**	**YES**	Dizzy		Itchy eyes	
If yes, list:		Cough		Poor Balance		Reacts to insects	
		Short of breath		List Other:		Sneezing	
ENMT	**YES**	Wheezing				Tongue swelling	
Hearing loss		List Other:		**PSYCH**	**YES**	List Other:	
Ear pain				If yes, list:			
Ear fullness		**GASTROINT.**	**YES**			**LIST ANY OTHER SYMPTOMS:**	
Ear drainage		Reflux		**ENDOCRINE**	**YES**		
Ringing		List Other:		Hot/cold intolerance			
Vertigo							
Runny nose		**URINARY**	**YES**	List Other:			
Congestion		If yes, list:					
Nose bleeds				**BLOOD**	**YES**		
Facial trauma		**MUSCULO.**	**YES**	Easy bleeding			
Throat pain		If yes, list:		Easy bruising			
Hoarseness				List Other:			
Swallowing issues							

CONSENT FOR INTRAMUSCULAR CORTICOSTEROID INJECTION THERAPY

As a patient of Ear, Nose & Throat Consultants, LLC, I understand that my provider may advise an intramuscular injection of corticosteroids as part of my treatment. By signing below, I acknowledge that I have been informed of the potential risks and benefits (listed below) to this form of treatment.

RISKS: atrophy of the muscle and surrounding fat at the injection site, swelling or blushing at the injection site, post injection dimpling, allergic reaction, elevated blood sugar, suppression of the immune system, insomnia
POSSIBLE BENEFTIS: relief of inflammation and discomfort, controls seasonal allergic rhinitis

I attest that I have read the above risks and benefits as well as attested to any of the listed contraindications. I also consent to receive intramuscular corticosteroids injections should my provider deem them necessary for my treatment.
Patient Name:_____Date of Birth: _____
Signature of Patient or Legal Representative_____Date _____