EAR, NOSE & THROAT
ALLERGY & IMMUNOLOGY AUDIOLOGY SPEECH PATHOLOGY
ASSOCIATES OF NEW YORK, P.C.
www.nyents.com

PATIENT INTAKE FORM

Patient's Last Name_____ First Name_____ Middle Initial _____

Date of Birth _____ Age _____ Gender: Female ☐ Male ☐

Address_____ Apt.#_____ City _____

State _____ Zip _____ Home Phone _____ Cell Phone _____

Business Phone_____ E-mail Address _____

Employer_____ Employer Address _____

Medical Doctor Name_____ Medical Doctor Telephone _____

Medical Doctor Fax_____ Medical Doctor Address _____

Language_____ Race_____ Ethnicity _____

Emergency Contact_____ Phone # _____

PRIMARY MEDICAL INSURANCE

Insurance_____ Patient's ID # _____

Group Name (if applicable)_____ Group # (if applicable) _____

Policy Holder Name_____ Policy Holder SSN_____ Policy Holder DOB _____

SECONDARY MEDICAL INSURANCE

Insurance_____ Policy Holder ID #_____ Patient's ID # _____

Group Name (if applicable)_____ Group Number (if applicable) _____

Policy Holder Name_____ Policy Holder SSN_____ Policy Holder DOB _____

OTHER COVERAGE

Is this visit covered by Workers' Comp?_____ No Fault? _____

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information

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

WHAT IS THE MAIN REASON YOU ARE HERE TODAY? Ear _____

Nose _____ Throat _____

PHARMACY INFORMATION (Include Address &/or Phone)

_____

I understand that my medication history may be obtained utilizing electronic information exchange and that this protected health information may provide valuable information for my healthcare provider. I hereby authorize Ear, Nose & Throat Associates of New York, P.C. 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.

MEDICATIONS YOU ARE TAKING (Prescription, over-the-counter or herbal): ☐ **No Current Medications**

List of Medication(s)	Dosage	List of Medication(s)	Dosage	List of Medication(s)	Dosage
1.		4.		7.	
2.		5.		8.	
3.		6.		9.	

ALLERGIES TO MEDICATIONS: ☐ **No Allergies to Medications**

_____

SMOKING STATUS & SOCIAL HISTORY

Tobacco Use? ☐ Yes ☐ No ☐ Former Amount per day? _____ Quit Date? _____
Exposed to secondhand smoke? ☐ Yes ☐ No

Alcohol Consumption? ☐ Yes ☐ No Type: _____ Amount per day? _____
Caffeine Consumption? ☐ Yes ☐ No Type: _____ Amount per day? _____

FAMILY HISTORY: If no family history of disease, please complete last column.

ADD/ADHD	☐	Depression	☐	Migraines	☐	Mother:	
Alcoholism	☐	Developmental Delay	☐	Obesity	☐	Alive & Well	☐
Allergies	☐	Diabetes	☐	Osteoarthritis	☐	Deceased	☐
Alzheimer's Disease	☐	Eczema	☐	Osteoporosis	☐	Father:	
Asthma	☐	Hearing Deficiency	☐	Seizure Disorder	☐	Alive & Well	☐
Blood Disease	☐	Hypertension	☐	Thyroid Disease	☐	Deceased	☐
CAD (Coronary Artery Disease)	☐	Irritable Bowel Syndrome	☐	Vascular Disease	☐	Brother/Sister:	
Cancer Type: _____	☐	Kidney Disease	☐	Other: _____		Alive & Well	☐
CVA (Stroke)	☐	Mental Illness	☐			Deceased	☐

MEDICAL HISTORY: Have you ever been DIAGNOSED with any of the following? ☐

Adjustment Disorder - Anxiety	☐	Gastroesophageal Reflux	☐	Prostate Enlargement	☐
Anemia	☐	Glaucoma	☐	Recurrent Tonsillitis	☐
Asthma	☐	Hearing Loss	☐	Renal Failure (Acute)	☐
Bronchitis	☐	Hepatitis	☐	Sinus Problems (Chronic Sinusitis)	☐
Cancer Type: _____	☐	Hernia	☐	Sleep Apnea	☐
Cataracts	☐	High Blood Pressure (Hypertension)	☐	Thyroid Deficiency (Hypothyroidism)	☐
Chronic Ear Infections (Otitis Media)	☐	Kidney Stones (Nephrolithiasis)	☐	Thyroid Excess (Hyperthyroidism)	☐
COPD	☐	Major Depression	☐	Tinnitus	☐
CAD (Coronary Artery Disease)	☐	Migraine	☐	Tuberculosis	☐
Diabetes Type: _____	☐	Mononucleosis	☐	Vertigo	☐
Elevated Cholesterol (Hyperlipidemia)	☐	Nasal Allergies	☐	Other: _____	
Emphysema	☐	Nasal Polyps	☐		

Patient Name: _____ **DOB:** _____

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

SURGICAL HISTORY: Have you ever had any of the following surgeries?

☐ **No Surgical History**

ENT Surgery ☐ If yes, please list type of surgery:

Ear _____

Nose _____

Throat _____

Abdominal Surgery	☐	Liver Surgery	☐
Brain Surgery	☐	Lung Surgery	☐
Arm or Leg Surgery	☐	Mid/Lower Back Surgery	☐
Head/Facial Surgery	☐	Neck Surgery	☐
Heart Surgery	☐	Stomach Surgery	☐
Kidney Surgery	☐		

GENERAL ALLERGIES: ☐ No Allergies

Do you have any food allergies?	☐ Yes	☐ No	If yes, type: _____
Do you have any allergies?	☐ Yes	☐ No	If yes, type: _____
Have you ever had an allergy test?	☐ Yes	☐ No	
Have you ever taken allergy shots?	☐ Yes	☐ No	
If yes, are you still taking them?	☐ Yes	☐ No	How much relief from shots? ☐ minimal ☐ partial ☐ significant

REVIEW OF SYSTEMS: Please mark where applicable

Blood or Lymph nodes problems

Yes	No	
☐	☐	Easy Bleeding
☐	☐	Easy Bruising

Brain or Nervous system problems

Yes	No	
☐	☐	Focal Weakness
☐	☐	Headache
☐	☐	Numbness
☐	☐	Seizures

Ear problems

Yes	No	
☐	☐	Dizziness
☐	☐	Drainage
☐	☐	Ear pain
☐	☐	Exposure to Excessive Noise
☐	☐	Hearing loss
☐	☐	Infections
☐	☐	Itchiness
☐	☐	Ringing /Noise in Ears

Eye problems

Yes	No	
☐	☐	Double
☐	☐	Vision Itchy
☐	☐	Eyes Redness

General health problems

Yes	No	
☐	☐	Fatigue
☐	☐	Fever
☐	☐	Night Sweats
☐	☐	Weight Loss
☐	☐	Weight Gain

Glands & Hormone problems

Yes	No	
☐	☐	Cold Intolerance
☐	☐	Heat Intolerance
☐	☐	Neck Enlargement/Goiter

Heart or circulation problems

Yes	No	
☐	☐	Blacking Out
☐	☐	Chest Pain
☐	☐	Heart Murmur
☐	☐	Irregular Heartbeat/Palpitations
☐	☐	Swelling of Ankles/Edema

Lung or respiratory problems

Yes	No	
☐	☐	Cough
☐	☐	Shortness of Breath
☐	☐	Wheezing

Mouth & Throat problems

Yes	No	
☐	☐	Difficulty Swallowing
☐	☐	Hoarseness
☐	☐	Sleep Apnea
☐	☐	Snoring
☐	☐	Sore Throat
☐	☐	Sores/Ulcers in Mouth

Musculoskeletal:

Yes	No	
☐	☐	Leg pain

Nose & Sinus problems

Yes	No	
☐	☐	Congestion
☐	☐	Facial Pain
☐	☐	Mouth Breathing
☐	☐	Nose Bleeds
☐	☐	Post Nasal Drainage
☐	☐	Runny Nose
☐	☐	Sneezing

Skin

Yes	No	
☐	☐	Contact Allergy
☐	☐	Itchy Skin/ Pruritus
☐	☐	Rash

Stomach problems

Yes	No	
☐	☐	Abdominal Pain
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Heartburn
☐	☐	Nausea
☐	☐	Vomiting/Goiter

Patient Name: _____ **DOB:** _____

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

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PATIENT HIPAA PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

INTRODUCTION
Ear, Nose & Throat Associates of New York, P.C. understands that your medical information is private and confidential. Further, we are required by law to maintain the privacy of "protected health information." This notice also discusses the uses and disclosures we will make of your protected health information. We must comply with the provisions of this notice as currently in effect, although we reserve the right to change the terms of this notice from time to time and to make the revised notice effective for all protected health information we maintain. This document is to serve as a brief abstract of the main HIPAA rules and regulations. You can always request copy of the complete U.S. Department of Health & Human Services "Summary of the HIPAA Privacy Rule" for full overview, from any Ear, Nose & Throat Associates of New York, P.C. Office Manager or you can access it on our website at www.nyents.com.

PERMITTED USES AND DISCLOSURES
You have the right to inspect and copy your health information. We can use or disclose your protected health information for purposes of treatment, payment and health care operations. For each of those categories of uses and disclosures, we have provided a description and example below. However, not every particular use or disclosure in every category will be listed.

Treatment means the provision, coordination or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health care provider to another. For example, a doctor treating you for a broken leg may need to contact a physical therapist to create the exercise regimen appropriate to your care.

Payment means the activities we undertake to obtain reimbursement for the health care provided to you, including billing, collections, claims management, determinations of eligibility and coverage and utilization review activities. For example, prior to providing health care services, we may need to provide information to you Third Party Payor about your medical condition to determine whether the proposed course of treatment will be covered. When we subsequently bill the Third-Party Payor for the services rendered to you, we can provide the Third-Party Payor with information regarding care if necessary to obtain payment. Federal or State law may require us to obtain a written release from you prior to disclosing certain specialty protected health information for payment purposes, and we will ask you to sign a release when necessary under applicable law.

Health care operations means the support functions of our practice related to treatment and payment, such as quality assurance activities, case management and administrative activities. For example, we may use your protected health information to evaluate the performance of our staff when caring for you. We may also combine health information about many patients to decide what additional services we should offer, what services are not deemed necessary and whether certain new treatments are effective. In addition, we may remove information that identifies you from your patient information so that others can use the unidentified information to study health care and health care delivery without learning who you are.

COMPLAINTS
Complaints about your privacy rights, or how Ear, Nose & Throat Associates of New York, P.C. has handled your health information should be directed to our Compliance Officer at 718.661.6636. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to: DHHS, Office of Civil Rights, 200 Independence Avenue, S.W., Room 509F HHH Building, Washington, D.C. 20201.

Patient Name:_____ **DOB:**_____

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

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received *Ear, Nose & Throat Associates of New York, P.C. Notice of Privacy Practices.*

Patient Name or Guardian of Minor: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Patient Refused to Sign (Staff Signature)_____

Reason for Refusal:_____Date:_____

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FINANCIAL AGREEMENT

Thank you for choosing Ear, Nose & Throat Associates of New York, P.C. as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e., address, name, insurance information, etc.).

Co-pays
The patient is expected to present an insurance card at each visit. All co-payments and past due balances are due at time of check-in unless previous arrangements have been made with Billing Team. We accept cash, check or credit cards. Absolutely no post-dated checks will be accepted.

Insurance Claims
Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company, we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

Participating Insurances:
It is the patient's responsibility to ensure provider accepts patient's insurance. A list of insurances accepted by the doctor and location you are scheduled to be treated at is available. You may request a list of participating insurances from the Office Manager. A general list of insurance payors we accept can also be found on our website at www.nyents.com.

NON-PARTICIPATION WITH YOUR INSURANCE.
You may receive certain services such as: Nasal Laryngoscopy, Direct Laryngoscopy; Alastat; and Imagining. The services provided are actively involved with your diagnosis and treatment and if Ear, Nose & Throat Associates of New York, P.C. does not participate with your insurance or your insurance does not cover these services, please see Office Manager for an estimate of the services to be provided prior to your visit.

If your insurance plan is one with which we are not a participating provider or your plan does not cover these services, you will be responsible for payment in full. However, as a courtesy, we will file your initial insurance claim and if not paid within 30 days you will be responsible

Referrals and Preauthorization
Certain health insurances (HMO,POS, etc.) require that you obtain a referral or prior authorization from you Primary Care Provider (PCP) before visiting a specialist. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company, and the balance will be your responsibility. Alternative payment arrangements or rescheduling of your appointment may be necessary if not obtained.

Self-pay Accounts
Self-pay accounts are patients without insurance coverage. Liability cases will also be considered self-pay accounts. We do not accept attorney letters or contingency payments. If there is a discrepancy with insurance and/or the patient's coverage is determined in-active at the time of service, the patient will be considered self-pay although the insurance may reinstate coverage at a later time. Self-pay patients will be required to pay in full at the time of service. Extended payment arrangements are available if needed. Please ask to speak with Office Manager to discuss a mutually agreeable payment plan. It is never our intention to cause hardship to our patients, only to provide them with the best care possible and the least amount of stress.

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FINANCIAL AGREEMENT (continued)

Motor Vehicle Accident (MVA) and Third-Party Billing
We do not do any third-party billing. Our relationship is with you and not with the third-party liability insurance (auto, homeowner, etc.) It is your responsibility to seek reimbursement from them. However, at your request, we will submit a claim to your primary health insurance carrier. You may receive an accident questionnaire from them to be completed by you. If the questionnaire is not returned to your medical insurance company and/or we receive a denial on your claim, you will be responsible for payment in full.

Workers' Compensation
It is the patient's responsibility to provide our office staff with employer authorization/contact information regarding a workers' compensation claim. If the claim is denied by the workers' compensation insurance carrier, it then becomes the patient's responsibility. At your request, we will submit the claim to your primary medical insurance carrier with a copy of the workers' compensation insurance denial. If your primary medical insurance carrier's claim is denied, you will be responsible for payment in full.

CANCELED OR NO-SHOW APPOINTMENTS
I understand that, based on the policy of the individual physician office, If I am 15 minutes late, Ear, Nose & Throat Associates of New York, P.C. will try to fit me into the schedule if there is an availability with my assigned provider. If unable to do so, my appointment will have to be rescheduled for another day.

Returned Checks
The charge for a returned check is $35 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check.

Minors
The parent(s) or guardian(s) is responsible for full payment and will receive the billing statements. A signed release to treat is required for unaccompanied minors.

Outstanding Balance Policy
It is our office policy that all past due accounts be sent two statements. If payment is not made on the account, a single phone call will be made to try to make payment arrangements. If no resolution can be made, the account will be sent to the collection agency, or attorney, and possible discharge from the practice. In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collection costs including attorney fees and court costs.

Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party.

This financial policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact us.

ASSIGNMENT OF BENEFIT AND RELEASE OF INFORMATION
I certify that the insurance information I have provided is correct and accurate and hereby authorized Ear, Nose & Throat Associates of New York, P.C. to submit claims to Medicare, Medigap, and commercial insurance payers on my behalf. I assign any payment and/or benefit from these payers for these services to Ear, Nose & Throat Associates of New York, P.C. I further authorize the release of any medical records necessary for the adjudication and payment of claims or any authorizations for services or procedures rendered or to be rendered.

Patient Signature (or person authorized to sign for patient)_____ **Date**_____

If authorized signer, relationship to patient:_____ **Date**_____

Witness_____

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NO-SHOW/SAME DAY CANCELLATION POLICY

We value our patients. That's why we schedule our appointments so that each patient receives the right amount of time to be seen by our physicians and staff. To help remind you of your upcoming appointment, Ear, Nose & Throat Associates of New York, P.C. provides complimentary appointment reminders prior to your visit.

If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule your visit, and accommodate those patients who are waiting for an appointment. As a courtesy to our office, as well as to those patients who are waiting to schedule with the physician, please provide more than 24-hours' notice of the need to cancel and/or reschedule your visit prior to the appointment time.

Office Visits

If you do not show for your appointment or cancel/reschedule your appointment the same day you were due to be seen, we may assess a $25 "no-show" service charge to your account. After three consecutive no-shows/same-day cancellation, you may not be eligible to book future appointments with the practice.

Surgeries

Due to the large block of time needed for surgery, and the administrative expenses to coordinate and this care, cancellation causes both hardship for the hospital and practice. If a surgery is not cancelled or rescheduled at least 72-hours in advance, a $150 "no-show" service charge will be made to your account.

Patient Responsibility

Please note, all "no-show" charges are not reimbursable by your insurance company. You will be billed directly for this charge following the month of the occurrence.

Acknowledgment

I understand the "no-show" policy of Ear, Nose & Throat Associates of New York, P.C. and understand that I must cancel or reschedule any appointment more than 24 hours in advance in order to avoid a potential no-show/same day cancellation charge.

Patient Name:_____

Patient Signature:_____

Date:_____

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Patient Communication

APPOINTMENT REMINDERS
Please note that Ear, Nose, & Throat Associates of New York, P.C. will be communicating all upcoming patient appointments by text, email and/or telephone.

CONSENT FOR EMAIL/TEXT OUTREACH
At times Ear, Nose & Throat Associates of New York, P.C. may use text or email for the below. During this outreach we will use the minimum necessary amount of protected health information for our communication.

Communication Outreach Examples:
1. Patient satisfaction surveys
2. Marketing information related to our services
3. Information related to the practice

INFORMED CONSENT
- If you consent to the use of email or text, you are responsible to opt out and withdraw consent if you decide that you no longer want to be sent email.
- You are responsible for protecting your password and access to your email account and any email you receive from Ear, Nose, & Throat Associates of New York, P.C. to ensure your confidentiality. Ear, Nose, & Throat Associates of New York, P.C. cannot be held liable if there is a breach of confidentiality caused your email account security.

☐ **Yes, I have read the above and consent to confidential email/text.**

Patient Signature_____ Date_____

Patient Printed Name _____

Email address_____ Cell number_____

If a parent is signing on behalf of a patient under 18, please complete the information:

Signature of Parent_____ Date_____

Printed Name of Parent _____

Parent Contact Details:

Home Phone_____ Work_____

Cell Phone_____ Email_____

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Authorization Form for Family Members/Friends
Granting Access to My Medical Information

I, _____ , give permission to Ear, Nose and Throat Associates of New York, P.C. to discuss and release my health information to the following people/person listed below:

NAME: _____

RELATIONSHIP: _____

By signing below I acknowledge that my complete medical record (including patient history, consults, office notes, treatment plans, referrals, billing records, insurance records and records sent to us by your other healthcare providers) can be made available to the above-named individual.

I understand that I may revoke this authorization at any time by notifying Ear, Nose and Throat Associates of New York, PC. in writing.

_____
Patient Name (Please Print)

_____
Patient Signature

_____
Date