Ear, Nose & Throat Center of Utah

New Patient Paperwork

Please print and bring with you

Ear, Nose & Throat Center of Utah

Notice of Privacy Practices

My signature below confirms that I have received a copy of the Intermountain Ear, Nose & Throat Specialists Notice of Privacy Practices that provides detailed information on how my Protected Health Information (PHI) may be used and disclosed. I acknowledge that Intermountain Ear, Nose & Throat Specialists reserves the right to amend the Notice of Privacy Practices periodically. I understand that I may obtain a current copy of the Notice of Privacy Practices by contacting the office staff at any time. I understand that Intermountain Ear, Nose & Throat Specialists, LLC will disclose my PHI to other health care practitioners and facilities involved in my medical care. Intermountain Ear, Nose & Throat Specialists, LLC will also disclose my PHI to my health insurance carrier to support payment for my medical services. I understand by signing below I am not giving authorization for my PHI to be released to anyone, including myself. I understand that my signature simply indicates my receipt of the Notice of Privacy Practices. I understand that I must file a written request in order to obtain a copy of my PHI, and that a HIPAA compliant release must be completed before my PHI will be shared with any third party not referenced above.

Signature of Patient (or Parent/Legal Guardian/ Authorized Representative):

_____

Date: _____ Patient Name (print): _____

Consent to Share Health Status, Treatment, or Payment Information

If you would like to have information regarding your condition, treatment, or account discussed with another person (such as your spouse, parent, friend, etc.) please complete the following information. This consent may be revoked at anytime by notifying the office verbally or in writing.

We can share your personal health and billing information with your treating physicians and your insurance, please do not indicate them below.

Name: _____ Date of Birth: _____

Relationship: _____ Phone: _____

Name: _____ Date of Birth: _____

Relationship: _____ Phone: _____

Ear, Nose &Throat Center of Utah

Patient Conditions of Treatment and Financial Agreement

This document is an agreement between Intermountain Ear, Nose and Throat Specialists (or "Intermountain ENT") and the Patient and/or the Patient's Guarantor ("You"). In consideration of the health care services provided to you or the Patient and on all other accounts for future health care by Intermountain ENT, you agree as follows:

1. CONSENT FOR TREATMENT. You consent to health care, including radiology/CT, audiology procedures, anesthesia, medical, surgical, and/or diagnostic treatment by Intermountain ENT, it's physicians, medical assistants, and staff, as directed by the patient's physician, or consultants selected by that physician. You understand that the practice of medicine is not an exact science and that diagnosis and treatment may involve risk of injury. You acknowledge that no one has made any guarantee to you about the result of treatment or examination by Intermountain ENT.

2. FINANCIAL AGREEMENT. You agree to pay your Intermountain ENT bill in full within 30 days of receipt of your statement. You will be charged Intermountain ENT's regular fees, or if you have health insurance or health benefits coverage, the rate Intermountain ENT has negotiated with that benefit provider. A financial deposit (that will be applied toward your total bill) will be required before seeing your doctor if insurance or other arrangements are not in place prior to service. This deposit does not represent the total charges for the visit. Extended payments should be discussed with the business office. You agree to pay 1 ½% interest per month if your account becomes more than 30 days past due. Acceptable forms of payment are cash, check, VISA, MasterCard, American Express, or money order. For any account not paid in 60 days you agree to pay a recovery charge of up to 40%. If lntermountain ENT refers your account to an attorney or collection agency, you agree to pay attorney's fees and collection expenses.

3. INSURANCE SUBMISSION AND ASSIGNMENT OF BENEFITS. You authorize lntermountain ENT to apply, on your behalf, to Medicare, Medicaid, or any other insurance for payment of Intermountain ENT's health care services. You confirm that the information you have provided to allow Intermountain ENT to apply for payment by any health care insurance or benefit is correct. You authorize insurance, health plan, or statutory benefits, settlements and judgments to which you are entitled in connection with your Intermountain ENT health care services to be paid directly to Intermountain ENT. In consideration of the health care services provided, you give Intermountain ENT an irrevocable assignment to all rights you have in your insurance, health plan, statutory benefits, settlements and judgments for which you are entitled, as necessary for payment for your Intermountain ENT health care service. You agree that you are financially responsible for charges that are not covered by this assignment and that you are responsible for satisfying any conditions necessary for insurance or health benefits.

4. CO-PAY COLLECTION. Per your contract with your insurance company(s), all co-pays must be satisfied each and every visit. There can be no exceptions due to legally binding contracts and uniform compliance rules, Therefore, if your current (specialist, if applicable) co-pay is not collected at time of service, a $15.00 service charge will be added to your account balance to offset billing costs.

5. INSURANCE PLAN RESTRICTIONS. You understand it is your responsibility to contact your insurance company regarding your plan benefits and exclusions. Exclusions may include, but are not limited to, whether the doctor you are scheduled to see is a provider for your plan, whether certain tests are covered benefits, and if your plan requires a referral before seeing a specialist. Some plans have reduced benefits for restrictions, while others simply refuse to pay if you receive services outside of your contract. You are also responsible for all deductibles and charges not covered by your insurance as specified in your insurance plan contract.

6. SECONDARY INSURANCE. Having more than one insurer DOES NOT necessarily mean that your services are covered 100%. Secondary insurers have specific guidelines, stated in your contract with them, for what they will consider for payment in coordination with your primary insurance payment. We bill your secondary carrier as a courtesy. You are responsible for any balances after your insurance(s) has cleared. If the subsequent insurance carrier doesn't pay after 45 days, we may turn the balance due to your responsibility. Subsequent insurance billing may be subject to a billing fee of $5.00 per claim.

7. DIVORCE DECREES. This office is NOT a party to your divorce decree. Adult patients are responsible for their bill at the time of service. The responsibility for minors rests with the accompanying adult.

8. MINOR PATIENTS. The adult accompanying a minor and the parents (or guardians) of the minor are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless services have been pre-authorized by the parents (or guardians) and payment has been made before or at the time of service in accordance with item number 3 above.

9. LABORATORY, SPECIALIST AND FACILITY REFERRALS. During the course of treatment, your doctor may find it necessary to order additional tests or refer you to a different specialist for treatment. lntermountain ENT will make every effort to comply with your insurance plan's guidelines; however, it is your responsibility to inform us of any lab or facility restriction. It is your responsibility to verify whether you can see the physician and/or specialty service we refer you to. Our experience has been that, even with an "approval" from a pre-certifying entity from your insurance company, authorizations are not always a guarantee of benefits. Intermountain ENT will not be held responsible for decisions your insurance plan makes retroactively. Fees and insurance contracts of facilities and physicians not employed by lntermountain ENT are under separate contract and Intermountain ENT will not bear responsibility in any way.

10. RETURNED CHECKS. If a check or credit card transaction has been returned to us by your financial institution for insufficient funds, Intermountain ENT will reverse the payment amount and add a $30.00 service fee to cover our costs. This includes declined credit cards used for payment plans.

11 . BROKEN APPOINTMENTS. When you make an appointment, we reserve an increment of time to minimize time spent waiting to see the physician in our office. When a patient misses their appointment, it takes away precious time the physician could be spending treating another patient. As a result, Intermountain ENT reserves the right to charge a $30 fee for standard appointments and up to $75.00 for extended services including but not limited to in office procedures, CT, Audiology testing, dizziness workups, etc that are not canceled with a 24 hour notice.

BY SIGNING, YOU INDICATE THAT YOU HAVE READ, UNDERSTAND, AND AGREE TO THESE TERMS, YOU HAVE RECEIVED A COPY OF THIS DOCUMENT, AND THAT YOU ARE THE PATIENT, THE GUARANTOR, THE PATIENT'S LEGAL REPRESENTATIVE, OR LEGALLY AUTHORIZED TO SIGN THIS AGREEMENT AND ACCEPT THESE TERMS,

Patient Name (PLEASE PRINT)	Date
Signature of Patient or Legally-authorized Representative	Relationship to Patient

Ear, Nose & Throat Center of Utah

Patient History Form

Note: This is a confidential record and will be kept In your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

Today's Date _____/_____/_____ Date of Last Exam _____/_____/_____

Last Name _____ First Name _____ Middle _____

Social Security No. _____ Date of Birth _____/_____/_____

Chief Complaint

What is the main reason for your visit today (Describe your problem in detail)

_____

_____

History of Present Illness

Please answer the following questions

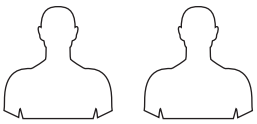
Location of the problem

Ear Nose Throat

Other _____

_____

Front Back



On a Scale of 1-10, with 10 being the most severe, circle the number that best describes the problem?

1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?

2 days ago 2 weeks ago 1 month ago

Other _____

Does anything help or make the problem worse?

Moving around Standing up Lying on my side

Other _____

How long does the problem last?

30 minutes 1 hour It's always there

Is anything else occurring at the same time?

YES NO If yes, please explain.

Nausea Rash Headaches

Other _____

Is the problem constant or variable?

If yes, please explain.

Nausea Rash Headaches

Other _____

Does the problem interfere with normal functions?

YES NO

If yes, please explain _____

_____

Physician use only: (Comments/Notes)

Past Medical & Social History

List all serious illnesses In your immediate family. (Example: diabetes, tuberculosis, breast cancer, heart disease, etc.)

_____ _____ _____

_____ _____ _____

_____ _____ _____

List any personal past illness and/or Surgeries and when they occurred.

Illness or Surgery Date

_____

_____

Do you smoke? Y N

If yes, how much? _____

Do you drink? Y N

If yes, how much? _____

Are you on any medications? Y N

If yes, list all _____

_____

Are you on a special diet? Y N

If yes, please explain _____

_____

Do you have allergies? Y N

If yes, please explain _____

_____

Physician use only: (Comments/Notes)

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Review of Systems

Do you now or have you had any problems related to the following systems? Circle YES or NO

Ears

Ear pain	Y	N
Drainage	Y	N
Change in hearing	Y	N
Hearing loss	Y	N
Ringing/head noise	Y	N
Dizziness	Y	N
Imbalance	Y	N
Ear infection	Y	N
Other _____		

Nose

Runny nose	Y	N
Stuffiness	Y	N
Bloody nose	Y	N
Nasal obstruction	Y	N
Sinusitis	Y	N
Altered sense of smell	Y	N
Other _____		

Throat

Hoarseness	Y	N
Sore throat	Y	N
Difficulty swallowing	Y	N
Voice change/problems	Y	N
Post nasal drainage	Y	N
Snoring	Y	N
Recurrent infection	Y	N
Other _____		

Allergy

Hives	Y	N
Post nasal drainage	Y	N
Nasal congestion	Y	N
Itchy nose	Y	N
Itchy eyes	Y	N
Itchy ears	Y	N
Sneezing	Y	N
Throat irritation	Y	N
Headaches	Y	N
Excessive fatigue	Y	N
Hairy coated or black tongue	Y	N
Chronic dyspepsia/heartburn	Y	N
Fatigue after meals	Y	N
Abdominal bloating/excessive gas	Y	N
Chronic yeast infections	Y	N
Other _____		

Respiratory

Coughing blood	Y	N
Pain with breathing	Y	N
Shortness of breath	Y	N
Wheezing	Y	N
Productive cough	Y	N
Other _____		

Cardiac

Chest pain	Y	N
Rapid/irregular heart beats	Y	N
Other _____		

Gastrointestinal

Appetite/weight change	Y	N
Blood in stool	Y	N
Bowel problems	Y	N
Canker sores	Y	N
Diarrhea	Y	N
Heartburn	Y	N
Other _____		

Constitutional

Fatigue	Y	N
Fever	Y	N
Night sweats	Y	N
Weight gain/loss	Y	N
Other _____		

Endocrine

Changes in growth	Y	N
Hair changes	Y	N
Heat/cold intolerance	Y	N
Excessive thirst	Y	N
Other _____		

Eyes

Blurred vision	Y	N
Double vision	Y	N
Other _____		

Neurological

Clumsiness	Y	N
Convulsion	Y	N
Headache	Y	N
Memory problems	Y	N
Migraine	Y	N
Numbness	Y	N
Seizures	Y	N
Other _____		

Skin

Skin growth/moles	Y	N
Ulcers/blemishes	Y	N
Slow healing wounds	Y	N
Very dry skin	Y	N
Other _____		

Hematological/Lymphatic

Anemia	Y	N
Bleed easily	Y	N
Bruise easily	Y	N
Joint pain	Y	N
Lymph node swelling	Y	N
Other _____		

Physician use only