OTOLARYNGOLOGY PLASTIC SURGERY ASSOCIATES

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Welcome to our practice.

We look forward to aiding you with your healthcare needs.

As a Healthcare facility, we will continue to abide by CDC and the State of PA Health Department guidelines and require you to wear a mask while in our office.

We must insist that the attached paperwork be completed before you come into the office. We have limited seating due to social distancing and are trying to limit time spent in our waiting room to minimize your exposure to others. If you come, for your appointment, without the paperwork completed you may be asked to re-schedule your appointment.

Upon completion of the forms, you can send them back to our office by mail, **IF** your appointment is 7-10 days from receipt of the paperwork. You may also fax your paperwork with a cover sheet to 215-348-1732. If time does not allow, please bring the completed paperwork with you to your visit. As stated above, if your paperwork is not completed you may be asked to reschedule your appointment.

We are affiliated with Doylestown Hospital and Grand View Hospital. Please let us know if you have had any procedures or testing done at either location and we will obtain copies for your record. Please bring copies of testing/procedures from any other facility with you.

If you are being seen for sinus issues and have had a CT scan of your sinuses, please bring a copy of the disc with you for review by the doctor.

If your insurance requires a referral to be seen, you must call and request it from your Primary Care (family) Doctor. Your doctor may require 48-72 hours to process your request. Our NPI# for your referral is 1487717575.

We realize this paperwork takes time and we appreciate your thoroughness.

Sincerely,

Otolaryngology Plastic Surgery Associates, PC

OTOLARYNGOLOGY PLASTIC SURGERY ASSOC., P.C.

NEW PATIENT PAPERWORK

NAME: _____
Last, First, Middle Initial

ADDRESS: _____

_____

_____

Please only provide phone numbers you will answer or check for a message

CELL PHONE # _____

HOME PHONE #_____

EMAIL: _____
(only used for reminders and/or newsletter)

DATE OF BIRTH: _____

SEX: ☐M ☐F

Identify As: _____

INSURANCE INFORMATION

Insurance: _____

Insurance ID: _____

Group Name & Number: _____

Subscriber ☐ Yes ☐No

If you are not the subscriber complete below:

Subscriber name: _____

Subscriber D.O.B. _____

Are you or your spouse covered by any other insurance Plans? ☐Yes ☐No

If yes, please provide the name and ID number below:

_____

SOCIAL SECURITY #: _____

MARITAL STATUS: ☐ Single ☐Married ☐Divorced

☐Domestic Partner ☐Widow

FULL-TIME STUDENT: ☐YES ☐NO

IS PATIENT IN HOSPICE CARE? ☐YES ☐NO

REFERRING DOCTOR: _____

PRIMARY CARE PHYSICIAN:

_____

RACE: PLEASE CHECK ANY BOX THAT APPLIES

☐White
☐Black/African American
☐American Indian/Alaska Native
☐Asian
☐Native Hawaiian/Other Pacific Islander
☐Unknown
☐Decline to answer

ETHNICITY: PLEASE CHECK A BOX
☐Spanish/Hispanic Origin
☐Not Hispanic or Spanish Origin
☐Unknown
☐Decline to answer

PREFERRED LANGUAGE (if other than English)

_____

IMPORTANT

LOCAL PHARMACY NAME:

_____

PHARMACY LOCATION: _____

_____

MAIL IN PHARMACY: _____

ARE YOU EMPLOYED? ☐YES ☐NO

EMPLOYER: _____

HOW DID YOU HEAR ABOUT US?

☐PRIMARY CARE PHYSICIAN

☐INTERNET

☐FAMILY MEMBER _____

☐FRIEND _____

OTOLARYNGOLOGY PLASTIC SURGERY ASSOC. P.C.

FINANCIAL POLICY

PATIENT NAME: _____

Thank you for choosing us as your health care provider. Our priority is that you receive comprehensive care and treatment to restore you to good health. Outlined below is information to assist you in understanding your financial responsibility in relation to our Financial Policy.

REFERRALS:
At all times, it is the *responsibility of the patient* to ensure we (OPSA) have received a referral prior to your visit in our office. It is also the *responsibility of the patient* to confirm that all pre-certifications or authorizations, needed for a surgery or test, have been obtained by OPSA, prior to proceeding with any planned surgery or testing. If the proper referrals, pre-certifications or insurance authorizations are not in place, at the time of a scheduled office visit, surgery, or testing, cancellation and rescheduling may be necessary.

ASSIGNMENT OF BENEFITS:
Signing the Assignment of Benefits authorizes your insurance company to make payment directly to the treating medical provider (OPSA). We will submit a claim to the insurance company on your behalf, however, if the insurance company does not pay your balance in full, within 30 days, we may ask that you contact them. Co-pays are due at the time of service, this includes any due for a dependent child visit, the accompanying adult will be responsible on the day of service. You will be billed for any deductibles, co-insurance or non-covered services, as dictated by your insurance company benefit.

NO-SHOW APPOINTMENTS:
Our schedules are very busy and we work to accommodate our patients. We ask that you give us the courtesy of 24 hours' notice when cancelling an appointment. If we don't hear from you and you do not show up for your scheduled visit, we reserve the right to charge a fee of $20.00. Payment is required prior to rescheduling the missed appointment.

FORMS:
There is a fee of $12.00 for completion of forms. We cannot list all forms here, the following is a small sample of the types of forms we complete; school physical, camp, sports, disability, return to work, gym releases and FMLA. You should discuss what you need with our billing representatives. Payment is due upon completion of forms.

COLLECTIONS:
You will receive a statement if you are responsible for a balance on your account. Accounts are considered delinquent if unpaid after 90 days and will be turned over to a collection agency without notice. You will be responsible for all reasonable collection costs at the time the account is considered delinquent.

For your convenience, we accept Visa, Mastercard, Discover, American Express, check, cash or money order. There will be a $25.00 fee for returned checks.

If you have any questions about our Financial Policy, please contact our billing office at 215-368-5290.

My signature below acknowledges receipt and understand of my obligations, based on my insurance and the above Financial Policy of Otolaryngology Plastic Surgery Assoc., P.C.

Patient or (Guardian Signature) _____ Date: _____

OTOLARYNGOLOGY PLASTIC SURGERY ASSOC. P.C.

FINANCIAL POLICY

PATIENT NAME: _____

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits to be paid directly to the undersigned physicians of Otolaryngology Plastic Surgery Assoc., P.C. I am financially responsible for the non-covered services. I authorize the physician to release any information required, to my insurance company, for payment of services rendered. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. I certify that this information is true and correct to the best of my knowledge. I will notify Otolaryngology Plastic Surgery Assoc., P.C. of any change in my health insurance.

Patient Signature: _____ Date: _____

HIPAA Policy

HIPPA Privacy Questions

We will ask you to sign an electronic signature pad to confirm that you have been informed of our HIPAA Privacy Policy. Our HIPAA Policy is posted in the waiting room and on our website www.ent-drs.com. A copy is available upon request.

Please select Y-Yes or N-No to tell us how we can communicate with you.

Leave appointment message on:			**Leave other medical info on:**		
Home Phone	Y	N	Home Phone	Y	N
Cell Phone	Y	N	Cell Phone	Y	N
Mobile Text	Y	N	With another person	Y	N
With another person?	Y	N			

Please indicate below the name and relationship of anyone we are allowed to share your private health information (PHI) with.

I authorize OPSA to share my PHI with the individuals listed below:

_____ (name and relationship)

_____ (name and relationship)

OTOLARYNGOLOGY PLASTIC SURGERY ASSOC., P.C.
INSURANCE RESPONSIBILITY

PATIENT NAME: _____

You, and/or your referring physician, have determined that you require the expertise of Otolaryngology Plastic Surgery Associates to diagnose and treat your ear, nose or throat problem. We appreciate the opportunity to help you in achieving a good outcome. As specialist in Otolaryngology, we will provide the necessary testing and treatment to diagnose you and help you to improve your current health problem.

Listed below are *some* of the procedures and treatments that *may* be done during your office visit. Your insurance company may choose to process these procedures and treatments differently than an office visit. We will bill your insurance for the visit and any procedure or treatment you require. *Your insurance* will determine if you are required to pay any additional co-pay, deductible or co-insurance.

It will be your responsibility to pay the additional co-pay, deductible or co-insurance as dictated by your insurance company.

Below is a list of the most common office procedures/treatments we provide.

- 30901 Control of Nasal Hemorrhage, Simple
- 30903 Control of Nasal Hemorrhage, Complex
- 31231 Diagnostic Nasal Endoscopy
- 31237 Nasal Endoscopy Surgical with Debridement (Unilateral or Bilateral)
- 31238 Nasal Endoscopy with Cautery of Blood Vessels
- 31575 Flexible Laryngoscopy
- 69210 or G0268 Removal of Impacted Cerumen
- 69420 Myringotomy
- 69433 Myringotomy and Tube Placement
- 92557 Audiogram
- 92567 Tympanogram

Your signature below acknowledges receipt and understanding of your insurance obligations.

Signature – Patient/Responsible Party: _____

PRINT NAME SIGNED ABOVE: _____

OTOLARYNGOLOGY PLASTIC SURGERY ASSOC., P.C.
MEDICAL HISTORY

PATIENT NAME: _____ HEIGHT: _____ WEIGHT: _____

Why are you here today? _____

What Laboratory do you use: ☐Quest Diagnostics ☐Lab Corp. ☐Other: _____

ALLERGIES

Latex Allergy: ☐YES ☐NO

MEDICATION ALLERGIES: ☐NO ☐YES – If yes, what? _____

CURRENT MEDICATIONS

If you are not taking any PRESCRIPTION MEDICATIONS, PLEASE CHECK THIS BOX ☐

LIST ALL PRESCRIPTION MEDICATIONS YOU ARE TAKING – If you need more room please list on a separate sheet.

Medication	Dosage	How often taken

If you use any over the counter medications or supplements, please list below

Over the Counter Medications/Supplements	Dosage	How often taken

SOCIAL HISTORY

TOBACCO USER: ☐NO ☐YES – ☐tobacco ☐pipe ☐cigars ☐other _____

If yes, how many? # Per day_____ # Per week _____

☐FORMER TOBACCO USER- How long? _____

ALCOHOL INTAKE: ☐NO ☐YES If yes, how many drinks per day? _____ or week _____

CAFFEINE INTAKE: ☐NO ☐YES If yes, how many caffeinated drinks per day? _____

☐COFFEE ☐TEA ☐SODA ☐ENERGY DRINKS

VACCINES

FLU: ☐YES - If yes, when? Month/Year_____ ☐NO

PNEUMONIA: ☐YES – If yes, when? Month/Year _____ ☐NO

COVID19: ☐YES – If yes, when? Month/Year _____ ☐Pfizer ☐Moderna ☐J&J

☐NO

OTOLARYNGOLOGY PLASTIC SURGERY ASSOC., P.C.
MEDICAL HISTORY

PATIENT NAME: _____

FAMLY HISTORY:

ALLERGIES	☐NO	☐YES	☐MOTHER	☐FATHER	☐SISTER	☐BROTHER	☐SON	☐DAUGHTER
ASTHMA	☐NO	☐YES	☐MOTHER	☐FATHER	☐SISTER	☐BROTHER	☐SON	☐DAUGHTER
BLOOD DISEASE	☐NO	☐YES	☐MOTHER	☐FATHER	☐SISTER	☐BROTHER	☐SON	☐DAUGHTER
CANCER- TYPE_____	☐NO	☐YES	☐MOTHER	☐FATHER	☐SISTER	☐BROTHER	☐SON	☐DAUGHTER
DIABETES	☐NO	☐YES	☐MOTHER	☐FATHER	☐SISTER	☐BROTHER	☐SON	☐DAUGHTER
ECZEMA	☐NO	☐YES	☐MOTHER	☐FATHER	☐SISTER	☐BROTHER	☐SON	☐DAUGHTER
HEARING DEFICIENCY	☐NO	☐YES	☐MOTHER	☐FATHER	☐SISTER	☐BROTHER	☐SON	☐DAUGHTER
MIGRAINES	☐NO	☐YES	☐MOTHER	☐FATHER	☐SISTER	☐BROTHER	☐SON	☐DAUGHTER
RENAL DISEASE	☐NO	☐YES	☐MOTHER	☐FATHER	☐SISTER	☐BROTHER	☐SON	☐DAUGHTER
SEIZURE DISORDER	☐NO	☐YES	☐MOTHER	☐FATHER	☐SISTER	☐BROTHER	☐SON	☐DAUGHTER
OTHER: _____	☐MOTHER	☐FATHER	☐SISTER	☐BROTHER	☐SON	☐DAUGHTER		

PAST MEDICAL/SURGICAL HISTORY:

CARDIOVASCULAR

Coronary Artery Disease	☐NO	☐YES
Heart Attack	☐NO	☐YES
Elevated Cholesterol	☐NO	☐YES
High Blood Pressure	☐NO	☐YES
Stroke	☐NO	☐YES

GASTROINTESTINAL

Hepatitis	☐NO	☐YES
Gastroesophageal Reflux	☐NO	☐YES

GENITOURINARY

Renal Failure (acute)	☐NO	☐YES

EAR/NOSE/THROAT: (HEENT)

Cataracts	☐NO	☐YES
Glaucoma	☐NO	☐YES
Chronic Ear Infections (Otitis Media)	☐NO	☐YES
Hearing Loss	☐NO	☐YES
Right Ear ☐		
Left Ear ☐		
Currently Using Hearing Aid/Aids	☐NO	☐YES
Sinus Problems (Chronic Sinusitis)	☐NO	☐YES
Nasal Polyps	☐NO	☐YES
Nasal Allergies	☐NO	☐YES
Recurrent Tonsillitis	☐NO	☐YES
Tinnitus	☐NO	☐YES
Vertigo	☐NO	☐YES
History of Falls	☐NO	☐YES

OTOLARYNGOLOGY PLASTIC SURGERY ASSOC., P.C.
MEDICAL HISTORY

PATIENT NAME: _____

PAST MEDICAL/SURGICAL HISTORY:

HEMATOLOGIC
Anemia ☐NO ☐YES
Bleeding Disorder ☐NO ☐YES

IMUNOLOGIC
Seasonal Allergies ☐NO ☐YES
Type: _____
Food Allergies ☐NO ☐YES
Type: _____
HIV/AIDS ☐NO ☐YES
Multiple Sclerosis ☐NO ☐YES

INTEGUMENTARY
Eczema/Psoriasis ☐NO ☐YES

INFECTIOUS DISEASE:
Mononucleosis ☐NO ☐YES

METABOLIC/ENDOCRINE
Diabetes ☐NO ☐YES
Type: _____
Thyroid Deficiency ☐NO ☐YES
(Hypothyroidism)
Thyroid excess ☐NO ☐YES
(Hyperthyroidism)

MUSCULOSKELETAL
Arthritis ☐NO ☐YES

NEOPLASTIC
Cancer ☐NO ☐YES
Type: _____

NEUROLOGIC
Migraine ☐NO ☐YES
Parkinson's ☐NO ☐YES
Seizure Disorder ☐NO ☐YES

OBSTETRIC
Currently Pregnant ☐NO ☐YES
If yes – Due Date _____

PSYCHIATRIC
Depression ☐NO ☐YES
Drug Addiction ☐NO ☐YES

PULMONARY
Asthma ☐NO ☐YES
COPD/Emphysema ☐NO ☐YES
Sleep Apnea ☐NO ☐YES
Tuberculosis ☐NO ☐YES

OTHER: _____

INJURY Date: _____
Head ☐NO ☐YES
Facial Fracture ☐NO ☐YES

Injury Due to: ☐MVA ☐Work related

OTOLARYNGOLOGY PLASTIC SURGERY ASSOCIATES, P.C.
Review of Systems – Check any new symptoms since your last visit

Patient Name _____ **Date** _____

General Health Problems
☐Fever ☐Night sweats ☐Unintentional Weight Loss

Ear Problems
☐Ear Drainage ☐Hearing Loss ☐Ear infections ☐Itchy ☐Wax ☐Ringing/noise in ears ☐Ear Pain

Nose & Sinus Problems
☐Chronic Congestion ☐Nosebleeds ☐Runny nose ☐Postnasal Drip ☐Facial Pain

Mouth & Throat Problems
☐Difficulty Swallowing ☐Snoring ☐Sore Throat ☐Hoarseness

CARDIOVASCULAR - Heart & Circulation Problems
☐Chest Pain ☐Hypertension ☐High Cholesterol ☐Heart Attack

RESPIRATORY - Lung or Respiratory Problems
☐Shortness of Breath ☐Wheezing ☐Cough ☐Sleep Apnea ☐Asthma

GI -Stomach problems
☐Abdominal Pain ☐Heartburn ☐GERD

NEUROLOGICAL - Brain or nervous system problems
☐Headache ☐Seizures ☐Weakness ☐Dizziness

ENDOCRINE - Glands & Hormone Problems
☐Intolerance to heat or cold ☐Diabetes ☐Thyroid problems

HEMATOLOGIC - Blood or Lymph Nodes Problems
☐Bleeds excessively after injury ☐Bruises easily

IMMUNOLOGICAL
☐Immune deficiency ☐HIV/Hepatitis