THE CENTERS FOR ADVANCED ENT CARE

Ramin Ipakchi, MD Alidad Arabshahi, MD Alex Cheng, MD
Stephen Bane, MD Collins Boateng, PA-C

14000 Crown Court Ste 201 **Woodbridge, VA 22193**
385 Garrisonville Rd Ste 208-209 **Stafford, VA 22554**
6371 Little River Turnpike 1st Floor **Alexandria, VA 22312**

SECTION 1 – GENERAL PATIENT INFORMATION (PLEASE PRINT IN BLACK OR BLUE INK ONLY)					
LAST NAME:	FIRST NAME:	MI:	Male □ Female□		
DATE OF BIRTH	PATIENT SOCAL SECURITY NUMBER:	HOME PHONE:	CELL PHONE:		
STREET ADDRESS:		MARITAL STATUS:	WORK PHONE:		
CITY:	STATE: ZIP:	PRIMARY CARE PHYSICIAN:			
EMPLOYER NAME:	OCCUPATION (Indicate If Student):	REFERRED BY:			
PHARMACY NAME & LOCATION:		E-MAIL ADDRESS:			
EMERGENCY CONTACT NAME:	RELATIONSHIP:	EMERGENCY PHONE NUMBER:			
IF MINOR, PARENT OR GUARDIAN'S NAME:		PARENT OR GUARDIAN'S DATE OF BIRTH:			

SECTION 2 – INSURANCE INFORMATION					
PRIMARY INSURANCE:			SECONDARY INSURANCE:		
SUBSCRIBER ID NUMBER:	GROUP NUMBER:		SUBSCRIBER ID NUMBER:	GROUP NUMBER:	
SUBSCRIBER'S FULL NAME:			SUBSCRIBER'S FULL NAME:		
SUBSCRIBER'S DATE OF BIRTH:	SOCIAL SECURITY NUMBER:		SUBSCRIBER'S DATE OF BIRTH:	SOCIAL SECURITY NUMBER:	
DO YOU HAVE A REFERRAL? □ I DO NOT NEED ONE □ YES □ NO	IS THIS AN HMO? □ YES □ NO		DO YOU HAVE A REFERRAL? □ I DO NOT NEED ONE □ YES □ NO	IS THIS AN HMO? □ YES □ NO	
RELATIONSHIP TO PATIENT: □ SELF □ SPOUSE □ CHILD □ OTHER _____			RELATIONSHIP TO PATIENT: □ SELF □ SPOUSE □ CHILD □ OTHER _____		

Race: Caucasian African American Asian Native American Other: _____ Refuse to report

SECTION 3 – INSURANCE, TREATMENT & PROCEDURE AUTHORIZATION AND PRIVACY STATEMENT:

Privacy Statement: I understand and agree that medical information may be released in the course of my care in accordance with the HIPAA Privacy Notice. I hereby authorize Potomac Ear, Nose & Throat, PLLC to release any information pertaining to my health care, test results, billing and/or accounting information to the following person(s) or agencies.
□ Myself □ My spouse □ My insurance company □ Other: _____
I hereby authorize this office to apply for benefits on my behalf for covered services rendered and I hereby irrevocably assign to the above-named provider all payments for medical services rendered. In the event my account is placed for collection, I agree to pay all costs and expenses including collections or attorney fees related to the collection thereof. I understand that I am responsible for paying my copay and balance at the time of my appointment.
I hereby authorize Potomac Ear, Nose & Throat, PLLC and/or doctors in charge of the patient to administer anesthetics, provide care and perform treatment deemed necessary. I understand that I am financially responsible for all co-payments and any charges for services rendered whether or not they are covered by my insurance company. Payment is expected at the time of service. I also understand that I am responsible for knowing the requirements of my insurance policy and any change in my insurance benefits or co-payments. A copy of this authorization shall be considered as valid as the original. During your ear, nose and throat evaluation, additional office procedures and tests may be recommended to assist with diagnosis and treatment of your medical condition. These procedures and tests will be billed to your insurance company. However, if the insurance company requires a separate Copay from the office visit, you will be billed the amount of the Copay for the procedure. Your insurance company may require that you pay additional amounts if you have not met your yearly deducible. Please be aware, that some of the office procedures and tests may show on your explanation of benefits as "surgical procedures". You may call your insurance company to determine what Co-Pay may be required for the associated procedures and test and their respective Procedure Code (CPT) for the **diagnostic tests** below. However, you will then have to make another appointment for another visit so that the procedure of the test may be done. **Diagnostic tests: 31231 - Nasal endoscopy 31575 - Flexible laryngoscope** (endoscopy of the throat and voice box)**31579 - Videostroboscopy** (evaluation of vocal cord vibration) **92557 - Audiogram** (Hearing test) **92567 - Tympanometry** (Evaluation of Ear Drum compliance) **10021 - Fine Needle Aspiration** (Needle Biopsy) **95922**-allergy Smell test. Other office procedures recommended for **treatment** may also require separate Co-Pay. List of procedures the physicians perform in the office are too exhaustive to list. Please ask your physician for the name of the procedure and CPT code should you wish to check with your insurance company prior to the procedure. By signing below, you acknowledge that you will be responsible for paying any additional Co-Pays and/or balances that your insurance company may require for any office procedure recommended by your physician. Your insurance company may require that you pay additional if you have not met your yearly deductible.

Patient/Guardian Signature	**Date**

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PATIENT HISTORY FORM

Patient Name:	Date of Birth:
Reason for Visit:	

MEDICAL HISTORY - Please identify if you or your immediate family [**YOU**, **M**OTHER, **F**ATHER, AND **S**IBLING] have the following:

Please Circle Illness:					Please Circle				
Allergies	You	M	F	S	Kidney Problems	You	M	F	S
Asthma	You	M	F	S	Liver Problems	You	M	F	S
Back Problems	You	M	F	S	Low Blood Pressure	You	M	F	S
Bleeding Problems	You	M	F	S	Low Blood Sugar	You	M	F	S
Bronchitis	You	M	F	S	Meningitis	You	M	F	S
Cancer:	You	M	F	S	Mononucleosis	You	M	F	S
Type(s) of Cancer:					Nervous Breakdown	You	M	F	S
Chest Pain/Angina	You	M	F	S	Paralysis	You	M	F	S
Epilepsy	You	M	F	S	Peptic Ulcer Disease	You	M	F	S
Diabetes	You	M	F	S	Pneumonia	You	M	F	S
Emphysema	You	M	F	S	Polio Paralysis	You	M	F	S
Fibromyalgia	You	M	F	S	Pregnant (currently)	You			
Gallbladder Disease	You	M	F	S	Reflux Disease	You	M	F	S
Glaucoma	You	M	F	S	Rheumatic Fever	You	M	F	S
Hay Fever/Seasonal Allergy	You	M	F	S	Sickle Cell Trait	You	M	F	S
Hearing Loss	You	M	F	S	Stroke	You	M	F	S
Heart Attack	You	M	F	S	Thyroid Disease	You	M	F	S
Heart Murmur	You	M	F	S	Tuberculosis	You	M	F	S
Hepatitis	You	M	F	S	Other illnesses	You	M	F	S
Hiatal Hernia	You	M	F	S	MRSA	You	M	F	S
High Blood Pressure	You	M	F	S	_____	You	M	F	S
Irregular Heartbeat	You	M	F	S	_____	You	M	F	S
Jaundice	You	M	F	S	_____				

HOSPITALIZATIONS & SURGERIES - Please indicate the following:

Have you ever been hospitalized before? □ Yes □ No If so, when and for what?

Date: _____ For: _____

Date: _____ For: _____

Date: _____ For: _____

Have you ever had surgery before? □ Yes □ No

Date of Surgery	Name of Surgery	Date of Surgery	Name of Surgery
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

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REVIEW OF SYSTEMS – Please indicate current problems only

▫ Fever	▫ Weakness of arm/leg	▫ Joint Pain
▫ Weight loss	▫ Tingling/numbness hands/feet	▫ Skin Problems
▫ Weight gain	▫ Slurred Speech	▫ Difficulty with Urination
▫ Hearing changes	▫ Headaches	▫ Easy Bruising
▫ Nasal obstruction	▫ Difficulty sleeping	▫ Abnormal Bleeding
▫ Voice changes	▫ Cold intolerance	▫ Lymph node enlargement
▫ Lump in neck	▫ Heat intolerance	▫ Rash/Hives
▫ Vision loss	▫ Shortness of Breath	▫ Itchy Eyes/Nose
▫ Double vision	▫ Wheezing	▫ Depression
▫ Chest pain	▫ Nausea	▫ Mood Changes
▫ Palpitations	▫ Vomiting	▫ Cosmetic Issues

TOBACCO USE		**ALCOHOL USE**		**RECREATIONAL DRUGS**	
Have you ever smoked?	Y / N	Ever consumed alcohol?	Y / N	Do you use recreational drugs?	Y/N
Do you smoke now?	Y / N	Do you drink beer?	Y / N	Have you ever used them?	Y/N
# of years smoked	_____	Frequency/week			
# Of packs per day?	_____	Do you drink wine/liquor?	Y / N		
Do you chew tobacco?	Y / N	Frequency/week			
Other tobacco products?	Y / N				
Is there a smoker in the house?	Y/N				

Have you had a reaction to anesthesia? ▫ YES ▫ NO
If yes, was it ▫ difficult breathing ▫ difficulty waking from surgery ▫ other _____

MEDICATIONS – Please list all medications you are CURRENTLY taking:

▫ Not on any medications

Name of Medication	Dose of Medication	Frequency

Pharmacy name and telephone number currently using _____

ALLERGIES TO MEDICATIONS – Please list all allergies to medications

▫ No allergies to medications

Name of Medication	Allergic Reaction

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Billing Policies for Potomac ENT a Division of CADENT

ASSIGNMENT OF BENEFITS: I hereby assign to you, Potomac ENT, all medical benefits to what I am entitled, including Medicare or any other insurance plan. I hereby authorize said assignee, Potomac ENT, to release all information to secure payment, including appeals on my behalf to the Insurance Commission. I also authorize my insurance company to release any/all information to Potomac ENT that may be necessary to secure payment. I also understand that I am financially responsible for all charges my insurance company states are patient responsibility, including any deductibles and copayments and that payments are due at the time services are rendered. If Potomac ENT does not participate with my insurance company, I understand that I am responsible for all charges not paid by my insurance. I also understand that if I am signing on behalf of my minor dependent, that I am responsible for all charges rendered patient responsibility.

I understand that in the event my account becomes past due (over 90 days) and all attempts to arrange payment have failed, my account will be turned over to a collection agency and/or attorney. I also understand that I will be responsible for all collection agency fees and/or attorney. I also understand that I will be responsible for all collection agency fees 22% of total past due amount and all other costs expended to the collection said amount. You may not be seen in the office until the balance has been paid full.

NO SHOW FEE: It is our policy to require appointment cancellations no later than **48 hours in advance in order to avoid a no-show charge of $50 for an office visit. Failure to notify Potomac ENT within this time limit or failure to show up for scheduled appointment can and may result in the following fees: procedures must be cancelled within 72 hours or a $150 fee will apply as follows: surgical appointment, VNG/ECOG/ABR, ultrasounds, oral appliances, cosmetics and any office procedures .** This charge cannot be billed to any insurance company, **IT IS YOUR RESPONSIBILITY**. You will receive a bill for fee and payment is expected prior to your next appointment. Return check fee of $35.

HMO PATIENTS: Potomac ENT is a specialty medical practice. **IT IS YOUR RESPONSIBILITY TO OBTAIN REQUIRED REFERRALS FROM YOUR PRIMARY CARE PHYSICIAN PRIOR TO EACH VISIT.** For return patients, if you are uncertain whether or not you have a valid referral on file, please call the office 48 hours prior to your visit to clarify the issue. Appointments will be rescheduled if required referrals are not presented prior to or on the scheduled appointment day.

PRIVACY NOTICE: My signature below confirms that I was given the opportunity to read, understand, and ask questions about Potomac ENT's Notice of Privacy Practices exhibited in the waiting room (copy given upon request). I hereby authorize Potomac ENT to release any information pertaining to my health care, test results, billing and/or accounting information to the following person (s) or agencies. I understand that I have a right to inspect and receive a copy of the disclosed material at a cost of $10 administration fee $0.50 per page for the first 50 pages and S0.25 per page after 50 pages. These charges are in accordance with the VA CODE A01-4V13. I also understand that Potomac ENT charges $25 to complete any additional forms.

I certify that I understand and agree with the above policies. I also certify that the information I have given is correct to the best of my knowledge.

Patient Name: _____ Date: _____

Patient signature: _____

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PRIVACY NOTICE

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other Individually identifiable Health Information (11H1) used or disclosed by us in any form are kept properly confidential. This Act gives you significant new rights to understand and control how your health information is used, HIPAA provides penalties for covered entities that misuse protected health information Protected Health Information (PHI) is defined as: "any information, whether oral or recorded in any medium, that is either created or received by a healthcare provider, health plan, public health authority employer, life insurance company, school or university or clearinghouse and that relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to and individual, or the past present or future payment for the provision of healthcare to an individual." This notice has been prepared to explain how we are required to maintain the privacy of your health information and how we may use and disclose your health information. Every patient must receive our new Privacy Notice and execute a new Consent Agreement. We may use and disclose your medical records only for each of the following purposes:

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review.

Health care operations include the business aspects of running a practice, such as quality assessment and improvement activities, auditing functions, cost management analysis, and customer service.

It is our policy to control access to your PHI; and even in cases where access is permitted, we exercise a "minimum necessary information" restriction to that access. We define the "minimum necessary information" as the minimum necessary to accomplish the intent of the request. Any other uses and disclosures will be made only with your written Authorization. An authorization differs from a Consent of Agreement in that it is very specific with regard to the information allowed to be disclosed or used, the individual or entity to which the information may be disclosed to, the intent for which it may be disclosed, and the date that it was initiated which may include the duration of the authorization. You may revoke such authorization in writing and we are required to honor and abide by the written request, except to the extent that we have already taken actions relying on your authorization. In addition, any results to be reviewed must be scheduled as an office visit with your provider.

I certify that I understand and agree with the above policies.

Patient Name: _____ Date: _____

Patient signature: _____

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PATIENT AUTHORIZATION FORM

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures and financial information. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Potomac ENT, a division of Cadent, to release my records and any information requested to the following individuals:

1. _____ Relation to Patient:_____
2. _____ Relation to Patient:_____
3. _____ Relation to Patient:_____
4. _____ Relation to Patient:_____

Authorization Regarding Messages (please check all that apply)

_____ I authorize you to leave a detailed message on my home or cell number regarding appointments

_____ I authorize you to leave a detailed message on my home or cell number regarding medical treatment, care, test results or financial information

_____I authorize you to leave a message with anyone who answers the phone

_____ Messages may only be left with _____

_____ _____
Patient Name (PRINT) Date

_____
Patient Signature

_____ _____
Witness (Office Staff) Date