Pikes Peak ENT LLC

P: (719) 301-3800
F: (719) 301-3855
Admin@PikesPeakENT.com

PATIENT PROFILE

First Name:_____ Last Name:_____ DOB:___/___/_____ Sex:____Marital Status:_____

Address: _____ City:_____ State:____ Zip:_____

Cell Phone:_____ Home Phone:_____ Work Phone: _____

Email:_____ Who can we thank for referring you? _____

Emergency Contact Name & Phone Number: _____

Employer:_____ Employer Address:_____

Is the patient the guarantor of the insurance policy or financially responsible for their medical care? ☐Yes ☐No If No, please provide Guarantor information below. If Yes, you may write "Self" in the space "Guarantor Full Name" below and leave the rest blank. Guarantor

Full Name:_____ DOB:_____ Relationship:_____

Phone:_____ Email:_____ SSN:_____

Mailing Address:_____ City:_____ State:____ Zip:_____

Employer:_____ Employer Address:_____

Primary Insurance Company:_____ Co-Pay for Specialty Care Visit: $_____ Met Deductible? ☐ Yes ☐No

Address:_____ Insurance Phone #:_____

Member ID:_____ Group ID:_____ Plan Name:_____

Secondary Insurance Company:_____ Co-Pay for Specialty Care Visit: $_____ Met Deductible? ☐Yes ☐No

Address:_____ Insurance Phone #:_____

Member ID:_____ Group ID:_____ Plan Name:_____

What is your preferred pharmacy? _____

Preferred Pharmacy's Address (please include street number): _____

I give my consent for the staff of Pikes Peak ENT to leave a message via my preferred method, stated below, regarding appointments and / or surgery reminders. ☐ **Cell Phone** ☐ **Home Phone** ☐ **Work Phone** ☐ **Text**

If you give us consent, we can obtain a list of your prescription medications that have been prescribed through most retail pharmacies. I give Pikes Peak ENT permission to obtain my medication information from Sure Scripts. ☐Yes ☐No

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We ask for Race, Ethnicity, and Language information to better serve you and because we are required to ask by Insurance Providers. You may decline to provide this information. ☐ **I decline to provide this information.**

Primary Language _____ **Secondary Language** _____

Race: ☐American Indian ☐Asian ☐Black / African American ☐European ☐ Filipino ☐Japanese ☐Korean ☐Pacific Islander ☐White

Ethnicity: ☐ Not Hispanic / Latino ☐ Cuba ☐ Dominican ☐ Hispanic/ Latino or Spanish ☐ Latin American ☐ Mexican ☐ Central American ☐ Puerto Rican ☐ South American ☐ Spainard

Patient Signature:_____ Date_____

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Patient Name: _____

What brings you in to see us? _____

How long has this been a problem? _____

Allergies to Medications, Latex, or Foods. Please list the reaction you had to each item listed

_____

_____

_____

Past Medical History

- ☐ Anemia
- ☐ Asthma
- ☐ Problems with Anethesia
- ☐ Bleeding Disorder
- ☐ Cancer
- ☐ COPD
- ☐ Diabetes
- ☐ Emphysema
- ☐ Fibromyalgia
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Sleep Disorder
- ☐ Stroke
- ☐ Thyroid Problems

Other: _____

_____

Social History

Do you smoke or vape? ☐ Yes ☐ No # of Packs a day___ # of years _____ Quit Date:_____

If you've quit, congratulations! Please still enter total years and quit date

Do you chew tobacco? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No # of drinks / week _____

Do you use caffeine? ☐ Yes ☐ No # of cups / day _____

Do you use marijuana? ☐ Yes ☐ No # of years ____

Do you take opioids? (Percocet, Norco, etc.) ☐ Yes ☐ No # of years ____

Family History

- ☐ Allergies
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Cancer _____ Type
- ☐ Diabetes
- ☐ Difficulty with Anethesia
- ☐ Hearing Loss
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Strokes
- ☐ Thyroid Disorders
- ☐ Other: _____

Surgical History - Surgery and Year Performed

- ☐ Adenoidectomy _____
- ☐ Appendectomy _____
- ☐ Cardiac Surgery _____
- ☐ Ear Tubes _____
- ☐ Esophagus Surgery_____
- ☐ External Ear Surgery _____
- ☐ Eye Surgery _____
- ☐ Facial Cosmetic Surgery _____
- ☐ Inner Ear Surgery _____
- ☐ Middle Ear Surgery _____
- ☐ Nasal Septum Surgery _____
- ☐ Neck Surgery _____
- ☐ Nose Surgery _____
- ☐ Salivary Gland Surgery _____
- ☐ Sinus Surgery _____
- ☐ Throat Surgery _____
- ☐ Tonsillectomy _____

Other Surgeries: _____

_____

_____

_____

_____

Medications and Supplements

If you need more space, you may write on the back and write "Cont." on the last line below

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

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SYSTEMS REVIEW

Please check Yes to any symptoms you have had in the past 3 months

CONSTITUTIONAL

N	Y	
☐	☐	Pregnant
☐	☐	Fatigue (Tire Easily)
☐	☐	Fever or Chills
☐	☐	Significant Weight Loss

EYES

N	Y	
☐	☐	Worsening Vision
☐	☐	Blurred Vision
☐	☐	Double Vision
☐	☐	Eye Pain
☐	☐	Red Eyes
☐	☐	Dry Eyes

Other_____

EARS

N	Y	
☐	☐	Difficulty Hearing
☐	☐	High Sensitivity to Loud Sounds
☐	☐	Ear Pain
☐	☐	Tinnitus (ringing in the ears)
☐	☐	Ears Feel Pressured
☐	☐	Discharge from the ears

Other_____

NOSE

N	Y	
☐	☐	Frequent Nose Bleeds
☐	☐	Nasal Discharge
☐	☐	Post Nasal Drip
☐	☐	Nasal Congestion
☐	☐	Nasal Obstruction

☐ Left Side ☐ Right Side

☐	☐	Sinus Pressure

Other_____

MOUTH / THROAT

N	Y	
☐	☐	Bleeding Gums
☐	☐	Dry Mouth
☐	☐	Mouth Ulcer
☐	☐	Bad Breath
☐	☐	Snoring
☐	☐	Sore Throat
☐	☐	Hoarseness
☐	☐	Lump in the Throat
☐	☐	Constantly Clearing the Throat

Other_____

NEUROLOGIC

N	Y	
☐	☐	Frequent Headaches
☐	☐	Seizures
☐	☐	Numbness
☐	☐	Weakness
☐	☐	Spinning Dizziness (Vertigo)
☐	☐	Lightheadedness
☐	☐	Memory Lapses or Loss
☐	☐	Decreased Sense of Smell
☐	☐	Taste Disturbances (unusal taste of food)
☐	☐	Abnormality of Walk (wobbly/unsteady)
☐	☐	Difficulty Keeping one's balance
☐	☐	Legs Feel Restless

Other_____

CARDIOVASCULAR

N	Y	
☐	☐	Chest Pain
☐	☐	History of Murmur
☐	☐	Difficulty breathing on exertion
☐	☐	Palpitations
☐	☐	Edema

Other_____

RESPIRATORY

N	Y	
☐	☐	Wheezing
☐	☐	Shortness of breath
☐	☐	Hemoptysis
☐	☐	Sleep Apnea

Other_____

G.I.

N	Y	
☐	☐	Vomiting
☐	☐	Heartburn
☐	☐	Painful Swallowing
☐	☐	Difficulty Swallowing
☐	☐	No Appetite
☐	☐	Abdominal Pain
☐	☐	Jaundice
☐	☐	Diarrhea
☐	☐	Constipation
☐	☐	Other_____

HEMATOLOGIC / LYMPHATIC

N	Y	
☐	☐	Swollen Glands
☐	☐	Easy Bruising
☐	☐	Excessive Bleeding

Other_____

PYSCH

N	Y	
☐	☐	Depression
☐	☐	Anxiety
☐	☐	Disturbing Sleep
☐	☐	Restless Legs

Other_____

MUSCULOSKELETAL

N	Y	
☐	☐	Muscle Aches
☐	☐	Joint Pain / Arthralgias

Other_____

INTEGUMENTARY

N	Y	
☐	☐	Rash
☐	☐	Itching
☐	☐	Dry Skin
☐	☐	Growths / Lesions

Other_____

ENDOCRINE

N	Y	
☐	☐	Intolerance to Cold
☐	☐	Intolerance to Heat

Other_____

ALLERGIC / IMMUNOLOGIC

N	Y	
☐	☐	Frequent Sneezing
☐	☐	Runny Nose
☐	☐	Nasal Itching
☐	☐	Eye Itching

Other_____

GENITOURINARY

N	Y	
☐	☐	Difficulty Urinating
☐	☐	Pain During Urination
☐	☐	Incontinence (Urinary Loss of Control)
☐	☐	Hematuris (Blood in Urine)
☐	☐	Increased Urinary Frequency

Other_____

What is your Height? _____ Weight _____

Patient Name Printed _____ Date:_____

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Name _____

FINANCIAL POLICIES

1. Private Insurance: You are responsible for deductibles, copays, coinsurance, any non-covered services including out-of-network charges specific to your plan, and items considered not medically necessary by your insurance company. Copays and deductible amounts are due at time of service. Balances are due 30 days after receipt of payment from your insurance company. If you or your insurance carrier makes payment exceeding your balance, reimbursement will be remitted.

2. Private Pay: Please make payment for your care at each patient visit.

3. Medicare: Our office will submit your Medicare charges to Medicare and your secondary insurance, if applicable. You are responsible for co-insurance, co-pays and any You are responsible for co-insurance, co-pays, and any non-covered services.

Guarantee of Payment

1. I understand that I am responsible for payment of all fees and services rendered, irrespective of insurance coverage or other responsibilities. **NOTE:** We will bill your primary insurance. If insurance does not pay in a timely manner (within 90 days from the date of service and insurance filing), the insured will be expected to pay the balance and then pursue reimbursement from the insurance company. I understand there is a $50 fee for any returned check for NSF (non-sufficient funds). **The guarantor of each account is ultimately responsible for payment in full of the account.**

2. I have been advised that if my commercial insurance carrier / HMO / Medicare plan claims that the services I receive from Pikes Peak ENT, LLC, are not considered reasonable and medically necessary for my care, I will be responsible for the payment of these services

3. I understand that my insurance plan may require my primary care physician to obtain an **authorization number** for the services that I receive from the providers. I have been advised that if I did not request a referral and authorization from my PCP in advance, my insurance plan may deny payment for services and I will be responsible for payment of all services.

4. I understand that it is my responsibility to determine if the provider is a network physician for my **specific insurance plan** even if I have been advised that he is contracted with most commercial insurance companies. I understand that I may be responsible for paying out-of-network fees if relevant.

ASSIGNMENT

1. I assign the benefits from my insurance carriers to this office for the medical/surgical benefits to which I am entitled.

2. I request that payment of authorized Medicare benefits be made on my behalf to Pikes Peak ENT, LLC (PPENT) for any service furnished to me by these providers.

RELEASE OF INFORMATION

1. I authorize PPENT to release to my insurance carrier(s) any information needed to determine benefits payable for services.

2. I authorize PPENT to release any information regarding my evaluation and treatment to my Referring/PC Providers.

3. I authorize any physician, hospital, laboratory or x-ray facility to release to PPENT any and all medical information, hospital records, laboratory studies or x-rays that may be requested. A copy of this authorization is as binding as the original.

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES

_____ (initial) **I have read and understand the PPENT Financial & Privacy Policies.**

I authorize Pikes Peak ENT to discuss my private health information with the following persons:

Name: _____ Relationship:_____ Phone:_____

Name: _____ Relationship:_____ Phone:_____

_____ _____
Signature Date

_____ _____
Signature of Patient's Representative Relationship

9475 Briar Village Point COLORADO SPRINGS, CO 80920-7919

Phone: (719) 301-3800 Fax: (719) 434-7370

PRACTICE POLICIES

1. Our office will file claims with insurance carriers with whom we have contracts; however, the guarantor is responsible for all fees, regardless of insurance coverage.

2. Insurance cards are required to bill. No card is no insurance, therefore non-emergency appointments must be rescheduled or the full amount due must be paid at the time of completed services.

3. It is the insured's responsibility to know your health plan and its benefits; some plans do not cover certain procedures. All in-office surgical procedures, i.e. scopes, wax removal, biopsies, etc. are not part of your office visit, these procedures are billed separately. Please be advised, we are a specialist's office and most insurance plans require a referral from your PCP.

4. Co-payments are due at the time of service. A portion of your deductible will be collected at the time of service.

5. We accept cash, **Checks up to $100.00 ONLY**, Amex, Visa, MasterCard and Discover.

6. A service charge of $35 is rendered for all returned checks.

7. New appointments will not be scheduled until all account balances are current.

8. Accounts more than 90 days past due, may be turned over to a collection agency. Any costs or legal fees to recover due services are also the responsibility of the guarantor.

9. Please be advised our office will not become involved in any legal agreements between divorced or separated parents, unless legally required.

10. Patients arriving over 15 minutes late may be rescheduled for a later time or wait to be seen after doctor is done with other patients.

Printed Name: _____

Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW IT CAREFULLY

Pikes Peak ENT, LLC uses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Your health information is contained in a medical record that is the physical property of **Pikes Peak ENT, LLC.**

How Pikes Peak ENT, LLC May Use or Disclose Your Health Information

For Treatment. **Pikes Peak ENT, LLC** may use your health information to provide you with medical treatment or services. For example, information obtained by a health care provider, such as a physician, nurse, or other person providing health services to you, will record information in your record that is related to your treatment. This information is necessary for health care providers to determine what treatment you should receive. Health care providers will also record actions taken by them in the course of your treatment and note how you respond to the actions. **Pikes Peak ENT, LLC** may use your health information when referring you to other health care professionals and facilities.

For Payment. **Pikes Peak ENT, LLC** may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third party payor, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment. **Pikes Peak ENT, LLC** may use your information to contact you about account balances. **Pikes Peak ENT, LLC** may use your information to access financial assistance programs for you that may help to defray the costs associated with your care or treatment.

For Health Care Operations: **Pikes Peak ENT, LLC** may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of the medical staff, risk or quality improvement personnel, and others to:

- Evaluate the performance of our staff;
- Assess the quality of care and outcomes in your cases and similar cases;
- Learn how to improve our facilities and services; and
- Determine how to continually improve the quality and effectiveness of the health care we provide.

Required by law. **Pikes Peak ENT, LLC** may use and disclose information about you as required by law. For example, **Pikes Peak ENT, LLC** may disclose information for the following purposes:

- For judicial and administrative proceedings pursuant to legal authority;
- To report information related to victims of abuse, neglect or domestic violence; and
- To assist law enforcement officials in their law enforcement duties;

Appointment Reminders and Treatment Calls. **Pikes Peak ENT, LLC** may contact you to provide appointment reminders or information about treatment plans, medication or test results, other health-related benefits and services that may be of interest to you. When contacts are made via telephone, messages will be left on answering machines with limited information.

Notification. **Pikes Peak ENT, LLC** may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family. **Pikes Peak ENT, LLC** health professionals and staff, exercising their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Business Associates. In some cases **Pikes Peak ENT, LLC** contracts with business associates to provide services on its behalf. An example includes arrangements with business associates of **Pikes Peak ENT, LLC** to provide collection or research services. **Pikes Peak ENT, LLC** may disclose your health information to such a business associate so that they can perform their respective job functions. To protect your health information, however, **Pikes Peak ENT, LLC** requires the business associate to safeguard your information.

Public Health. Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.

Decedents. Health Information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

Organ/Tissue Donation. Your health information may be used or disclosed for organ or tissue donation purposes.

Research. **Pikes Peak ENT, LLC** may use your health information for drug or research studies when an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your health. information has approved the research. **Pikes Peak ENT, LLC** may use information to identify qualified candidates for research. **Pikes Peak ENT, LLC** may use information to make contact with you to determine your interest in the research study/clinical trials.

Physician Board Certification. **Pikes Peak ENT, LLC** may use your health information to submit to the Professional Certification Board for purposes required for physicians' qualification to complete their specialty board examination.

Health and Safety. Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

Food and Drug Administration (FDA). **Pikes Peak ENT, LLC** may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs or replacement.

Government Functions. Specialized government functions such as protection of public officials or reporting to various branches of the armed services that may require use or disclosure of your health information.

Worker's Compensation. Your health information may be used or disclosed in order to comply with laws and regulations related to Worker's Compensation.

Other uses. Other uses and disclosures will be made only with your written authorization and you may revoke the authorization except to the extent **Pikes Peak ENT, LLC** has taken action in reliance on such.

Your Health Information Rights

You have the right to:

- Request a restriction on certain uses and disclosures or your information; however, **Pikes Peak ENT, LLC** is not required to agree to a requested restriction;
- Obtain a paper copy of this notice of information practices upon request;
- Inspect and obtain a copy of your health record;
- Request that your health record be amended;
- Request communications of your health information by alternative means or at alternative locations; and
- Receive an accounting of disclosures made of your health information.

Obligations of Pikes Peak ENT, LLC

Pikes Peak ENT, LLC is required to:

- Maintain the privacy of protected health information;
- Provide you with this notice of its legal duties and privacy practices with respect to your health information;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction on how your information is used or disclosed;
- Accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations.

Pikes Peak ENT, LLC reserves the right to change its information practices and to make the new provisions effective for all protected health information it maintains. Revised notices will be given to you upon your request.

Complaints

You may complain to **Pikes Peak ENT, LLC** and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.