North Valley Ear, Nose & Throat Associates
PATIENT REGISTRATION

Patient: First Name: ______________________________ Last Name: ______________________________ MI: _______

Date of Birth: _________________________ SS#: _________________________________ Sex: Male ☐ Female ☐

Address: ____Email:______________________________________

City: ______________________________________ State: __________________________ Zip: ____________________

Home Phone: ______________________________________ Cell Phone: ____

Employer: ____ Work Phone: _____________________________________

Marital Status: (circle one) M S W D Spouse's Name: ______________________________________

Primary Care Physician: ______________________________ Physician's Phone #: _______________________________

Referring Physician: _______________________________ Additional Physicians: ________________________________

RESPONSIBLE PARTY (IF NOT SELF)

Name: ____ Relationship to Patient: __________________________

Address: ____ Date of Birth: __________________________________

City: ____ Social Security #: _______________________________

Home Phone: _______________________________________ Cell Phone: ____________________________________

Employer: ____ Work Phone: __________________________________

PRIMARY INSURANCE COMPANY	**SECONDARY INSURANCE COMPANY**
Insurance Company: ____________________________	Insurance Company: ____________________________
ID#: ____________________Group #: ______________	ID#: ____________________Group #: ______________
Policy Holder's Name: ___________________________	Policy Holder's Name: ___________________________
Policy Holders Birth Date: ________________________	Policy Holders Birth Date: ________________________
Policy Holder's Relationship to Patient:	Policy Holder's Relationship to Patient:
☐ Self ☐ Parent ☐ Spouse ☐ Other: ____________	☐ Self ☐ Parent ☐ Spouse ☐ Other: ____________

PATIENT COMMUNICATION & AUTHORIZATION

Best Method of Contact for Patient/Guardian. Please check ONE: ☐ Home ☐ Cell ☐ Work

Emergency Contact Name: __________________________________ Relationship to Patient: ___________________

Best Contact Phone: ______________________________________ Other Phone: ______________________________

***Other than yourself, to whom may we release your protected health or billing information? (Provide first and last name, relationship, and the best contact phone number).**

NAME____ PHONE____

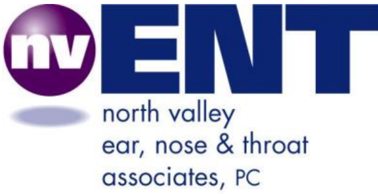
BENEFIT ASSIGNMENT/ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I hereby authorize the staff of North Valley Ear, Nose & Throat Associates, P.C. ("NVENTA") to provide medical services, either regular, telemedicine or emergent, as may be determined by my physician to be in my best interest (or the best interest of my dependent if I am signing as a parent or guardian). I authorize payment of medical benefits to NVENTA. I agree that all charges for medical services rendered that are not directly paid by my insurance will also be my responsibility. I hereby authorize NVENTA to release the necessary information regarding me to my health plan in order to complete and process my insurance claims. In the event it becomes necessary for NVENTA to forward my account balance to an outside collection agency, I understand I will be responsible for a collection fee in the amount of 40% of my outstanding balance.

I hereby acknowledge that I have been presented with a copy of North Valley Ear, Nose & Throat's NOTICE OF PRIVACY PRACTICES.

____ __________________________________

Patient/Responsible Party Date



Peter C. Kaiser, MD
Michael T. Gutman, MD
Joseph A. Chiara, MD
board certified
otolaryngology, head & neck surgery

Patient Name________________________________

Dear Patient:

We are required to inform you if we have financial interest in an entity to which we refer patients and to disclose such interest to patients in advance of making the referral.

Therefore, in compliance with the requirements of this law, we are informing you that some physician members of North Valley Ear, Nose and Throat Associates, PC, have a direct financial interest in one or more of the following: Surgery Center of Peoria, North Valley Surgery Center, and Desert Ridge Outpatient Surgery Center.

The law requires your acknowledgement of this relationship by signing and dating this form in the space provided below. This original document will be kept with your medical record.

ACKNOWLEDGEMENT

I have read this acknowledgement and understand the contents of this notice:

____

Patient / Guardian Date

tel: 602-688-6500 fax: 602-867-3144 web: northvalleyent.net
main office and mailing address: 3805 East Bell Road, Suite 5800 Phoenix, AZ 85032-2160
additional location: 6320 W Union Hills Dr Building A Ste 170 Glendale, AZ

Peter C. Kaiser, MD
Michael T. Gutman, MD
Joseph A. Chiara, MD
board certified
otolaryngology, head & neck surgery

FINANCIAL POLICY

Dear Patient / Responsible Party,
We realize that from time to time questions may arise about our Financial Policy. This notice is designed to communicate with you and hopefully reduce any confusion or misunderstanding.

INSURANCE:

1. Effective 11/01/2020, all patients are automatically enrolled to receive their billing statements online (if an email was provided). Patients can opt out of this by logging into their patient portal. Patients will receive paper statements in the mail if they opt out of receiving online statements.
2. You are directly responsible for payment of your medical care and you are expected to pay any co-pay, non-covered, or deductible amounts at the time of service. Your insurance may not pay for all of your health care costs. Most insurance policies include some “non-covered services”. This does not mean that the test or care is not necessary. Rather, it means that the insurance carrier will not pay for it. Please keep in mind that the insurance policy is a contract between you and the insurance company. The physician has no control over what the insurance carrier does or does not cover.
3. **Some procedures done in the office today to help treat or diagnose your condition may have an additional charge applied to them beyond the cost of an office visit. You will be responsible for any additional copay, deductible or co-insurance amounts your insurance company applies as your responsibility to these services.**
4. In order to bill your insurance company for your medical visit, you must provide our office with your insurance card and photo identification. **If you cannot provide this information, please expect to pay at the time of the office visit for services rendered or reschedule your appointment.**

BILLING:

1. As a courtesy to you, we will bill your insurance company. To do this, we must have a copy of your insurance card, photo I.D. and current address and phone. If your insurance changes, it is your responsibility to provide us with current insurance information.
2. If your insurance company denies your claim, you will receive a statement for the amount due and payable immediately.
3. In addition to co-payments or deductibles, you are responsible to pay for denied or non-covered services as determined by your insurance company. If our office is an “out of network provider” for your insurance carrier, the non-covered services and deductibles are usually higher. Your insurance company, not our office, determines these amounts.
4. **A Fee of $50.00** will be assessed to your account in the event you do not show for your appointment or cancel at least 24 hours prior to the scheduled time. All checks returned unpaid by the bank will also be charged this fee.
5. After your insurance has paid and the patient balance is determined, you will be billed for the remaining balance. If you default on your responsibility, deemed by your insurance company or lack of insurance, your account balance will be sent to an outside collection agency for further collection action and credit reporting. You will be assessed a collection fee of 40% of your outstanding balance.

SURGERY AND / OR PROCEDURES:

1. Prior to surgery or procedures, our office verifies your insurance coverage. If your insurance company determines that you are responsible for a deductible/coinsurance for your surgery/procedure, our office will contact you to arrange for payment prior to the surgery/procedure. ***Surgical cases canceled within one week (7 days) of surgery will be assessed a $200.00 fee. In some cases, we may not reschedule your surgery.***

Please realize that maintaining financial viability is the only way our office can continue providing you, and others, quality service. Your understanding and cooperation enable us to deliver the type of healthcare you deserve and expect.

I UNDERSTAND AND ACKNOWLEDGE THIS FINANCIAL POLICY

______________________________	______________________________	______________
Patient/Responsible Party Signature	**Print Patient Name**	**Date**

Date ________________

M.A. ________________

Time In ______________

North Valley Ear, Nose, and Throat
PATIENT HISTORY

Thank you for completing the following confidential history form. It will help us greatly in the overall evaluation of your problem. We will develop your history further in a few minutes in the examining room. Until then and thereafter, if you have any questions, do not hesitate to ask. IF YOU HAVE MEDICAL RECORDS AND/OR TEST REPORTS FOR US TO REVIEW, please give them to the front desk at the time of check in.

Name____ Age______ Date of Birth____________ ☐ Male / ☐ Female
Last First Middle Initial

Referred to this office by: __________________________________ Primary Care Physician: ______________________________

Specialists treating you: ____

Is it OK for us to leave a detailed message that may contain personal medical info on your home/cell phone number? ☐ Yes / ☐ No

For what problem did you come to see the provider today?

____

____

____

____

List any recent x-rays, labs or tests related to your visit: (type, date, facility, doctor) ☐ None

____

____

Any past history of: (if YES, please check and briefly elaborate below. If **NONE**, check here ☐)

☐ Asthma	☐ Diabetes	☐ Heart Trouble	☐ High Blood Pressure	☐ Bleeding Disorder	☐ HIV
☐ COPD	☐ GERD	☐ Liver Trouble	☐ High Cholesterol	☐ Kidney Disease	☐ Other (list below)

____

____

List any previous surgeries: ☐ None

____

____

What PRESCRIPTION medications do you take and why? ☐ None

____

____

____

What other NON-PRESCRIPTION (over the counter, herbal or homeopathic) medications do you take? ☐ None

____

____

Are you allergic to any medications? ☐ Yes ☐ No If Yes, please explain:

____

____

Social History**:**

Occupation____________________________ Do you live: ☐ Alone ☐ w/ Spouse ☐ w/ Family ☐ w/ Friends ☐ Assisted Facility

Smoking History: ☐ Never / ☐ Current / ☐ Former Vaping History: ☐ Never / ☐ Current / ☐ Former

If applicable, how long have you smoked/vaped? _________ yrs. How much? _________ packs per day

If applicable, when did you quit smoking/vaping? __________________ Any illicit drug use?_________________

Do you drink caffeinated beverages? ☐ Yes ☐ No # _______ drinks/day; Alcohol? ☐ Yes ☐ No # _______ drinks/day

Family History:	Age	Diseases/Conditions	Cause of Death
Father	________	______________________________	__________________
Mother	________	______________________________	__________________
Sibling (B or S)	________	______________________________	__________________
Sibling (B or S)	________	______________________________	__________________
Sibling (B or S)	________	______________________________	__________________

Review of Systems

_______________________________________ _________________
Patient Name Date of Birth

Please checkmark any of the following problems you are experiencing:

allergy to adhesive	❑	dyspnea (pain w/ breathing)	❑
allergy to latex	❑	fatigue	❑
allergy to shellfish/iodine	❑	fever	❑
joint replacement/spinal hardware	❑	cold intolerance	❑
mechanical valve	❑	heat intolerance	❑
pacemaker	❑	blurry vision	❑
dry mouth	❑	heartburn	❑
dysphagia (difficulty swallowing)	❑	increased urinary frequency	❑
hearing loss	❑	bruising	❑
hoarseness	❑	increased bleeding	❑
nasal obstruction	❑	new lesion	❑
odynophagia (painful swallowing)	❑	rash	❑
otalgia (ear pain)	❑	headache	❑
otorrhea (ear drainage)	❑	anxiety	❑
post nasal drip	❑	depression	❑
rhinorrhea (runny nose)	❑	cough	❑
tinnitus (ear ringing)	❑	shortness of breath	❑
vertigo	❑	blood thinners	❑
neck mass	❑	obstructive sleep apnea (OSA)	❑
neck pain	❑	dizziness	❑
increased infections	❑	snoring	❑
chest pain	❑	**none**	❑

1. Do others complain that you watch television with the volume too high? ❑ Yes ❑ No
2. Do you frequently have to ask others to repeat themselves? ❑ Yes ❑ No
3. Do you have difficulty understanding what is being said when in groups or noisy situations? ❑ Yes ❑ No
4. Are you unable to understand when someone talks to you from another room? ❑ Yes ❑ No

Please provide your pharmacy information below:

Name: ___________________________________

Location: ___________________________________

Phone: ___________________________________