

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: <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Other: _____	Policy Holder's Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> 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 _____

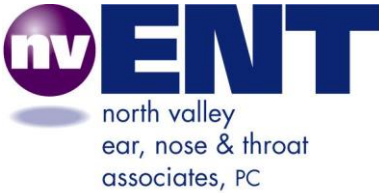
BENEFIT ASSIGNMENT/ACKNOWLEDGEMENT OF PRIVACY PRACTICES

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.

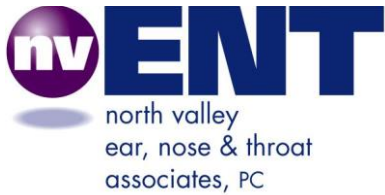
The law requires your acknowledgement of this relationship by signing and dating this form in the space provided below. This original document will be kept with your medical record.

ACKNOWLEDGEMENT

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

Patient / Guardian

Date



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 \$30.00** 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

North Valley Ear, Nose, and Throat
PATIENT HISTORY

Date _____

M.A. _____

Time In _____

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

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: _____