Westwood Ear, Nose & Throat, P.C.
Registration Form

Patient Information

Patient's Last Name	First Name , Middle Initial	Circle One	Circle One	Marital status
		Mr. Mrs. Ms.	Sex: M F	Single, Mar, Sep

If patient is a minor, parent or guardian name and employer information:				
Social Security	Birthdate	Home Phone #		CellPhone #
Mailing Address		City	State	Zipcode	Spouse/partner name
Email Address		Patient's Employer and Phone Number		
Who Referred You?			Phone #:	

Primary Care Doctor?	Provider Phone #:

How did you hear about us? Doctor Billboard Relative/Friend Internet TV Other:______________

Allergies to Medications?	Pharmacy Name	Location	
INSURANCE INFORMATION	PLEASE GIVE YOUR LICENSE/ID AND INSURANCE CARDS TO THE RECEPTIONIST		
Insurance Subscriber	Birthdate	Address (if different)	
Occupation	Employer	Employer Address	Employer Phone #
IN CASE OF EMERGENCY			
Name of relative or friend	Relationship	Phone#	

Race	**Ethnicity**	**Primary Language**	**Preferred Contact Method**
White	Hispanic or Latino	English	Email
Other	Not Hispanic or Latino	Spanish	Home
Native Hawaiian	Decline to State	Other	Mail
Other Pacific Islander		Decline to State	Mobile
Black or African American			Work
Asian			
American Indian			
Alaskan native			
Decline to State			

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Westwood Ear, Nose and Throat, P.C. or insurance company to release any information required to process my claims.

Patient/Guardian Signature ______________________ Date ________

Patient Name: **Account No.** **DOB:**

Patient Medical History (p. 1): Please provide the following medical information to the best of your ability:

Date: **Age:**	**List any ALLERGIES TO MEDICATIONS:**
What are your concerns for today's visit?:	

Past Medical History:

1) Please check the "Yes" or "No" box to indicate if you have any of the following illnesses; for "Yes" answers, please explain

	Yes	No	
Diabetes	☐	☐	
Hypertension (high blood press)	☐	☐	
Thyroid Problems	☐	☐	
Heart Disease/cholestrol probs	☐	☐	
Heart palpitation	☐	☐	
Respiratory problems	☐	☐	
Stomach or intestinal problems	☐	☐	
Allergy problems/therapy	☐	☐	
Kidney problems	☐	☐	
Neurological problems	☐	☐	
HIV / Hepatitis	☐	☐	
Other Medical Diagnosis	☐	☐	

2) Please list any operations (and dates) you have every had *(including tonsils & adenoids)*:

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3) Please list any current medications (and amounts, times per day):
(include aspirin, antacids, vitamins, hormone replacement, birth control, herbal supplements, OTC nasal sprays/cold/sinus/allergy meds):

Social History:	Yes	No	**Please list details below:**
Do you smoke: List how much	☐	☐	
If no, did you smoke previously?	☐	☐	
How many times/week do you drink alcohol?			
What type of alcohol do you prefer?			
What is your occupation?			

Family History:

Please check the "Yes" or "No" box to indicate whether any relatives have any of the following illnesses:
If yes, please indicate which relative(s) have the problem

	Yes	No	
Hearing problems	☐	☐	
Allergy	☐	☐	
Nasal Polyps	☐	☐	
Cancer	☐	☐	
Bleeding disorder	☐	☐	
Anesthesia problems	☐	☐	
Heart problems	☐	☐	

Reviewed by:

Date: ____/____/____

Patient Name: Account No. DOB:

Patient Medical History (p. 2): Please provide the following medical information to the best of your ability:

Review of Systems:

1) **Please check the "Yes" or "No" box to indicate whether you presently have any of the following symptoms:**
2) **For any "yes" responses, please check the "current" box if this symptom relates to the reason for your visit today.**

		Yes	No	Current		Yes	No	Current
ALLERGY	sneezing	☐	☐	☐	post-nasal drip	☐	☐	☐
	environmental allergy	☐	☐	☐				
ENT	ear pain or itch	☐	☐	☐	ear drainage	☐	☐	☐
	hearing loss	☐	☐	☐	ear noises	☐	☐	☐
	vertigo	☐	☐	☐	lightheadedness	☐	☐	☐
	nasal congestion	☐	☐	☐	sinus pressure or pain	☐	☐	☐
	sense of smell problem	☐	☐	☐	problem snoring, apnea	☐	☐	☐
	hoarseness	☐	☐	☐	throat pain	☐	☐	☐
	throat clearing	☐	☐	☐	throat dryness/itching	☐	☐	☐
RESPIR.	cough	☐	☐	☐	coughing blood	☐	☐	☐
	wheezing	☐	☐	☐	shortness of breath	☐	☐	☐
EYES	eye pain	☐	☐	☐	watery or itchy eyes	☐	☐	☐
GI	difficulty swallowing	☐	☐	☐	heartburn	☐	☐	☐
NEURO	headache	☐	☐	☐	passing out	☐	☐	☐
GENERAL	chills	☐	☐	☐	weight loss or gain	☐	☐	☐
	fatigue	☐	☐	☐	daytime sleepiness	☐	☐	☐
ENDO	feel warmer than others	☐	☐	☐	feel cooler than others	☐	☐	☐
HEME/LYM	swollen glands	☐	☐	☐	sweating at night	☐	☐	☐
	bleeding problems	☐	☐	☐	easy bruising	☐	☐	☐
CARDIAC	chest pain	☐	☐	☐	palpitations	☐	☐	☐
MSK	joint aches	☐	☐	☐	muscle aches	☐	☐	☐
GU	frequent urination	☐	☐	☐	painful urination	☐	☐	☐
SKIN	rash	☐	☐	☐	hives	☐	☐	☐
	itching	☐	☐	☐	skin or hair changes	☐	☐	☐
PSYCH	depression	☐	☐	☐	anxiety or panic	☐	☐	☐

PLEASE STOP HERE

Reviewed by:

60 Westwood Avenue
Waterbury, CT 06708
Tel: (203) 574-5997
Fax: (203) 574-5987

29 Hospital Hill Road
Sharon, CT 06069
Tel: (860) 364-1264
Fax: (203) 574-5987

17 Commons Drive
Litchfield, CT 06759
Tel: (860) 567-2000
Fax: (860) 567-2009

TO OUR PATIENTS WITH **COPAYMENTS AND HIGH DEDUCTIBLES:**

Please note that as of **January 1, 2014** copays and deductibles are **mandated** by your insurance company.

Therefore, our office will be collecting these payments **at the time of service**.

THANK YOU

Westwood Ear, Nose, & Throat

SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

Patient Name: ______________________________

Chart Number: ______________________ Date of Birth: ______________

I accept full financial responsibility for charges incurred today if:

1. The service rendered or supplies used/purchased are not covered under my insurance plan;
2. My insurance plan requires that I pay a deductible, co-payment, or there is a co-insurance;
3. There are charges that have resulted because I have failed to provide <u>current</u> and valid insurance policy information; or
4. My insurance plan requires that I obtain a <u>referral</u> prior to my visit and I do not have one in place.

I agree:

1. That payment be made to Westwood Ear, Nose & Throat P.C. (Westwood ENT) by my insurance carrier for services rendered or product received;
2. And I understand that Westwood ENT may use and disclose medical information about me for services and procedures so they may be billed and collected from an insurance agency or any third party;
3. To pay for my co-pay and other charges that are not covered by my insurance carrier today or make financial arrangements satisfactory to Westwood ENT for payment;
4. To pay for any returned check fees incurred by Westwood ENT;
5. If I am the parent/guardian bringing a child for treatment, that I am responsible for all fees incurred by the child;
6. If an account is sent to collection or attorney for collection, to pay collection expenses and attorney's fees.

Patient Signature: ______________________________

Parent/Guardian Signature: ______________________________

Date: ______________

Westwood Ear, Nose, & Throat

PATIENT INSURANCE & POLICIES AGREEMENT

Patient Name: ______________________________ Date of Birth: ______________

We would like to thank you for choosing Westwood Ear, Nose and Throat P.C. as your healthcare provider. Westwood Ear, Nose, & Throat P.C. is committed to providing you with the best possible medical care. We are sure that you understand that payment for this healthcare is your responsibility. The following information outlines your financial responsibilities related to payment for professional services.

For Our Patients with Medical Insurance Benefits: We participate in most major health plans. We have contracts with many HMO'S, PPO's, insurance companies and government agencies including Medicare and Medicaid. Our business office will submit claims for any services rendered to a patient who is a member of one of these plans and will assist you in any way we reasonably can to get your claims paid. It is the patient's responsibility to provide all necessary information before leaving the office. If you have a secondary insurance, we will automatically file a claim with them as soon as the primary carrier has paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please bring your insurance card with you at the time of your appointment. If you are insured by a plan we do business with but don't have an insurance card with you, payment in full for each visit is required until we can verify your coverage. If a patient is a member of an insurance plan with which we do not participate, payment in full is due at the time of service.

Co-payments: Your insurance company requires us to collect co-payments, co-insurance and deductible at the time of service. Waiver of such may constitute fraud under stated and federal law. Please help us in upholding the law by paying your co-payment at each visit. For your convenience, we accept cash, checks or the following credit cards: Visa, MasterCard, Discover and American Express. If you do not have your co-payment, your appointment may be rescheduled. Any outstanding balance on your account, after adjusting for all your insurance's responsibilities, will be billed to you.

Waiver of Patient Responsibility: It is the policy of practice to treat all patients in an equitable fashion related to account balance. The practice will not waive, fail to collect, or discount co-pays, co-insurance, deductibles, or other patient financial responsibility in accordance with state and federal law, as well as participating agreements with payers.

Non-Covered and Out of Network Services: Medical services that are considered by your insurance company to be non-covered, out of network, or not medically necessary will be your responsibility.

Covered Changes: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

For Our Patients With No Medical Insurance: If you do not have group or individual medical insurance, payment for all professional services is expected at the time of your visit. Please note, we do offer discounted fees for patients without health insurance.

Payment Plan: Please let us know if you are having difficulty paying your account. We may be able to help you by setting up a payment plan based on your financial hardship; please call (203) 574-5997 for assistance.

Late Arrivals: A patient who arrives more than 15 minutes after his/her appointment is considered a late arrival. A late arrival, not considered to be the responsibility of the Practice, will be registered and worked into the schedule as soon as possible. If the patient is more than 30 minutes late, the appointment may be rescheduled.

Appointment No-Shows: Any patient who fails to arrive for a scheduled appointment without canceling the appointment at least 24 hours prior to the scheduled time is considered a "no-show." A patient no-show may be charged $25.00, as set by the Practice, for failure to show.

Delinquent Balance Appointment: Patients with a delinquent balance are required to make payment in full for future services. A delinquent account is defined as a patient balance in excess of 120 days if patient has not made any payments or sought assistance via financial hardship during this time. If such payment is not made, services may be refused.

Nonpayment: All patient responsible balances that remain delinquent after 120 days, with no response to our request for payment, may be referred to a collection agency. Please be aware that if a balance remains unpaid, you and/or the guardian may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30 day period, our physician will only be able to treat you on an emergency basis. Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

Signature: ______________________________ Date: ______________

Westwood Ear, Nose, & Throat

WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ______________________________, hereby acknowledge that I have received a copy of the Notice of Privacy Practices. I understand that if I have further questions or complaints, I may contact the practice's Privacy Officer at (203) 574-5997.

I also understand that I am entitled to receive updates upon request if the Practice's Notice of Privacy Practices is amended or changed in a material way.

____

Signature

____

Relationship to Patient

____

Date

TO BE COMPLETED BY PRACTICE IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT FROM PATIENT

On ____________________, I attempted to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

[ ] Patient declined to sign this Written Acknowledgement.

[ ] Patient did not understand that request to sign the Written Acknowledgement.

[ ] Other (specify):

____

____

Name and title of employee

____

Date