SOUTHWEST IDAHO
ENT
Ear Nose and Throat, P.A.

To our new patients:

Welcome to Southwest Idaho Ear Nose and Throat. Our physicians strive to provide the best possible care for all patients, and part of this process is obtaining accurate demographic and health history information. In order to expedite the check-in process for your appointment, we have included the necessary forms for you to complete in advance.

Please fill out your paperwork completely and bring it with you to your appointment, and arrive 15 minutes early. If desired, you may fax your paperwork to our office at (208) 367-3979 prior to your appointment. Your insurance cards will be required at check-in, and we encourage you to find and submit the most recent copy of your card. This includes Medicare and Medicaid as well. If your insurance plan (including Medicaid) requires a referral, please follow up to ensure that it is in our office so that your appointment will not need to be rescheduled. Payment will be required at the time of service for your portion (co-pay and deductible amounts) of the charges.

Please feel free to contact our office with any questions you may have. Our physicians and staff look forward to caring for you and your family. Thank you for choosing Southwest Idaho Ear Nose and Throat.

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PATIENT RIGHTS AND RESPONSIBILITIES

POLICY: This is to ensure that all patients receiving care in this facility shall have his/her rights observed, respected and enforced by the health care providers of this facility from clinical staff to business staff and any other personnel that has contact and/or provides services to the patient. The following are the rights of the patient receiving care in this facility.

1. The patient shall be informed verbally and in writing of his/her rights in advance of the date of the procedure, in terms that the patient can understand. A signature acknowledging receipt of verbal and written notification of these rights in advance of the day of the procedure will be obtained by the patient and or legal guardian and placed in the patient's chart as part of the permanent medical record.

2. The patient will be informed of the services offered at the Surgery Center, the names of the professional staff and their professional status of who is providing and/or responsible for their care, including information on the facilities provisions for emergency and after hours and emergency care.

3. The patient will be informed of the fees and related charges, including the payment, fee, deposit and refund policy of the Surgery Center and any charges not covered by third-party payers or by the Surgery Center's basic rate.

4. The patient will be informed of other health care and educational institutions participating in the patient's treatment.

5. The patient will be informed of the identity and the function of these institutions, and he/she has the right to refuse the use of such institutions.

6. The patient will be informed, in terms that the patient can understand, of his/her complete medical/health condition or diagnosis, the recommended treatment, treatment options, including the option of no treatment, risks of treatment and expected results. If this information would be detrimental to the patient's health or if the patient is not capable of understanding the information, then the information will be provided to the patient's next of kin or guardian. This release of information to the next of kin or guardian along with the reason for not informing the patient directly will be documented in the patient's chart.

7. The patient will participate in the planning of his/her care and has the right to refuse such care and medication. Upon refusal it will be documented in the patient's chart.

8. The patient will be included in experimental care if the patient has agreed to such and gives written and informed consent touch treatment, or when a guardian has consented to such treatment. The patient also has the right to refuse such experimental treatment, including the investigation of new drugs and medical devices.

9. The patient has the right to voice grievances or recommend changes in policies and services to the Surgery Center personnel, the governing authority and/or outside representatives of the patient's choice, free from restraint, interference, coercion, discrimination or reprisal.

10. The patient will be free from mental and physical abuse, free from exploitation and free from use of restraints unless they a reauthorized by a physician for a limited period of time to protect the patient or others from harm. Drugs and other medications shall not be used for discipline of patients or for convenience of the Center's personnel.

11. The patient will be assured of confidential treatment of information about him/herself. Information in the patient's medical record shall not be released to anyone outside the facility without the patient's approval, unless another health care facility to which the patient was transferred requires that information, or unless the release of the information is required or permitted by law, a third party payment contract or a peer review, or unless the information is needed by the Idaho Department of Health for statutorily authorized purposes. The facility may release data about the patient for studies containing aggregated statistics when the patient's identity is masked.

12. The patient will receive courteous treatment, consideration, respect and recognition of the patient's dignity, individuality and right to privacy, including, but not limited to, auditory and visual privacy. The patient's privacy shall also be respected when facility personnel are discussing the patient.

13. The patient will not be required to work for the facility unless the work is part of the patient's treatment and is performed voluntarily by the patient. Such work shall be in accordance with local, State and Federal laws and rules.

14. The patient has the right to exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, or any attendance at religious services, shall be imposed upon any patient.

15. The patient has the right to expect and receive appropriate assessment management and treatment of pain as an integral component of that person's care.

16. The patient has the right to information regarding credentialing of Health Care Professionals at the Center.

17. The patient shall be informed verbally and by written notice the date of the procedure, of his/her physicians' financial interest or ownership in the ASC; the signed copy of patient acknowledgement and notification of the physician financial interest or ownership will be placed in the patient's chart as part of the permanent medical record.

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Patient's Legal Name: First _____ Middle _____ Last _____ ☐ Male ☐ Female

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____ Ext. _____ D.O.B. _____

Email Address _____ Marital Status ☐ M ☐ S ☐ D ☐ W

Primary Care Physician _____ Referring Physician _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ Caucasian ☐ Hispanic or Latino

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other _____ Preferred language _____

Patient's Employer _____

Spouse's Name _____ Date of Birth _____ Employer _____

Work Phone _____ If Applicable, Patient's Legal Guardian _____

Father's Name (IF MINOR) _____ D.O.B. _____

Father's Home Address _____ City, State, Zip _____ Phone _____

Father's Employer _____ Occupation _____ Work Phone _____

Mother's Name (IF MINOR) D.O.B. _____

Mother's Home Address _____ City, State, Zip _____ Phone _____

Mother's Employer _____ Work Phone _____

PRIMARY INSURANCE COMPANY NAME _____ Phone _____

Subscriber Name _____ Relationship to Subscriber ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Step Parent ☐ Other

Subscriber D.O.B. _____ Group No. _____ I.D. No. _____

SECONDARY INSURANCE COMPANY NAME _____ Phone _____

Subscriber Name _____ Relationship to Subscriber ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Step Parent ☐ Other

Subscriber D.O.B. _____ Group No. _____ I.D. No. _____

To whom may we disclose your health information (e.g. appointment times, test results, financial) if you are not available?

Name _____ Relationship _____

Whom may we contact in case of an emergency? Name _____

Relationship _____ Phone _____

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FINANCIAL POLICY

Our practice is committed to providing the best treatment possible for our patients. Our charges are usual and customary for our specialty. Your insurance policy is a contract between you and your insurance company. It is the patient's responsibility to know what services are covered under their insurance policy. **Full payment is due at the time of service for all co-pays, co-insurance or any deductible amounts.** We are not affiliated with any hospital, and we are unable to accept their approval for financial assistance. We do not offer a sliding fee scale for our charges. If you require financial assistance from our office or want to arrange a payment plan, please contact our billing office at 208-367-6950. We accept cash, check, Visa, Mastercard, American Express, Discover and CareCredit.

If you do not cancel 24 hours prior to your appointment time or arrive to your appointment more than 15 minutes late, you will be charged a no-show fee of $50.

Southwest Idaho Ear Nose and Throat, PA uses third party agencies to collect on accounts that are past due. Returned checks are subject to an additional fee and will be sent to a third-party agency if not paid in full after receiving notification.

The physicians at Southwest Idaho Ear Nose and Throat may need to perform additional testing during your visit. In order to accurately diagnose and treat your medical condition, your physician may prescribe diagnostic tests such as hearing and balance tests, nasal endoscopy, laryngoscopy, CT scans, biopsies and/or other diagnostic testing including cerumen removal (ear cleaning). Each insurance policy processes these tests differently and charges may be applied to your deductible and/or co-insurance or co-pay. Every effort will be made to obtain any required authorization prior to your testing. If you wish to discuss charges prior to testing, please ask to speak with the billing staff.

I authorize the release of any information necessary to determine liability for payment to obtain reimbursement on any insurance claim. I request that payment of authorized benefits be made on my behalf. I assign benefits to which I am entitled including private insurance and other health plans to Southwest Idaho Ear Nose and Throat, PA. This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges that are not paid by insurance including all diagnostic testing.

I hereby authorize Southwest Idaho Ear Nose and Throat, PA to appeal any incorrect insurance payment. I release Southwest Idaho Ear Nose and Throat, PA from all legal responsibility or liability that may arise from this authorization. **I AGREE TO THE ASSIGNMENTS AND ACKNOWLEDGE MY FINANCIAL RESPONSIBILITIES DISCUSSED ABOVE.**

x _____ DATE: _____
Responsible Party Signature

HIPAA Notice of Privacy Practices
I acknowledge the receipt of Southwest Idaho ENT, PA's notice of privacy practices.

Signature: _____ Date: _____

Is your visit the result of accident? YES ☐ NO ☐ Date of injury _____ Description _____

Is this a Worker's Compensation claim? YES ☐ NO ☐ Claim Number _____

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CHILD

Patient's Name: _____ D.O.B. _____

Referring Physician: _____

Name and Location of Pharmacy Used: _____

What is the doctor seeing your child for today? _____

List all current medication including any over the counter (OTC) medications or supplements that your child is taking.

☐ Not taking any medications

NAME OF MEDICATION	DOSAGE

List any drug allergies or medicines your child cannot take.

☐ No known drug allergies

NAME OF MEDICATION	TYPE OF REACTION

Does your child have known allergy to any of the following? ☐ NONE

☐ Latex ☐ Iodine ☐ Tape ☐ Contrast Agents (Dye) ☐ Other _____

Please Describe

Allergies

☐ None
☐ Dust
☐ Moldy Places
☐ Pollen
☐ Cut Grass
☐ Animals
☐ Exercise
☐ Foods
☐ Smoke/Fumes
☐ Outside in Spring and/or Fall
☐ Outside on Windy Days
☐ Air Conditioning

Allergy Testing

☐ Never Done
☐ Skin Blood
☐ Negative
☐ Where Testing Done

Allergy Injections

☐ Never Done
☐ In the Past
☐ Currently

Other Allergies/Problems Not Listed

_____
_____
_____
_____

PAST HEALTH HISTORY

Please indicate any diseases or problems that your child has had or been diagnosed with by a doctor.

☐ No Major Illnesses

Congenital (Birth) Problems
☐ Down Syndrome
☐ Heart Defect
☐ Prematurity (# of weeks)
☐ Other _____

Childhood Diseases
☐ Mumps
☐ Measles
☐ Chicken Pox
☐ Other _____

Cancer
☐ Lung Cancer
☐ Breast Cancer
☐ Throat Cancer
☐ Leukemia
☐ Other _____

Head and Face
(not incl. brain or nervous system)
☐ Tension/Stress Headache
☐ Other _____

Ears
☐ Chronic or Frequent Infection
☐ Fluid
☐ Hearing Loss
☐ Vertigo
☐ Other _____

Nose and Sinuses
☐ Chronic Sinusitis
☐ Deviated Septum
☐ Nasal Polyps
☐ Allergies
☐ Other _____

Mouth and Throat
☐ Chronic Tonsillitis
☐ Cleft Palate
☐ Sleep Apnea
☐ Vocal Polyps
☐ Other _____

Heart
☐ Atrial Fibrillation
☐ Chest Pain/Angina
☐ Heart Attack
☐ High Blood Pressure
☐ Mitral Valve Prolapse
☐ Heart Murmur
☐ Pace Maker
☐ Other _____

Lungs
☐ Asthma
☐ COPD/Emphysema
☐ Cystic Fibrosis
☐ On Oxygen
☐ Other _____

Digestive
☐ GERD/Reflux
☐ Hepatitis
☐ Diverticulitis
☐ Hemorrhoids
☐ Other _____

Skin
☐ Eczema
☐ Psoriasis
☐ Acne
☐ Other _____

Neurologic
☐ Headaches
☐ Stroke
☐ Multiple Sclerosis
☐ Other _____

Glands and Hormones
☐ Diabetes
☐ Thyroid Problem
☐ Other _____

Blood Disorder
☐ Low White Blood Cells
☐ Bleeding Disorder
☐ Anemia
☐ Low Platelets
☐ Other _____

Immune Disorder
☐ Rheumatoid Arthritis
☐ Sjogrens
☐ CREST
☐ HIV
☐ Other _____

Psychiatric History
☐ Depression
☐ Anxiety
☐ Mania
☐ Schizophrenia
☐ Other _____

SURGERIES/INJURY

Has your child ever had problems with anesthesia (being put to sleep for surgery)? ☐ Yes ☐ No

Please list any surgeries your child has had.

☐ No Surgery

Name of Operation: _____ Date: _____

Please list any admissions to a hospital other than the above.

☐ No Hospitalization

Reason for Hospitalization: _____ Date: _____

FAMILY HISTORY

☐ Family History Unknown

Do any of your child's BLOOD RELATIVES have a history of:

☐ Problems with Anesthesia, malignant hypothermia
☐ Hearing Loss after age 20
☐ Hearing Loss before age 20
☐ Heart Problems
☐ Bleeding/Clotting Problems
☐ Cancer
☐ Other Major Health Problems

_____
Please Describe

☐ No family history problems known

SOCIAL HISTORY

Marital status of parents: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Is child adopted? ☐ Yes ☐ No

Names of child's parents:

_____

_____

Names of child's siblings: _____

_____

_____

REVIEW OF SYSTEMS/SYMPTOMS

Please indicate any other symptoms that your child has now or has had in the RECENT past.

General
☐ None
☐ Fever
☐ Sleeping Problems
☐ Unintentional Weight Loss

Allergy Symptoms
☐ None
☐ Dust
☐ Moldy Places
☐ Pollen
☐ Cut Grass
☐ Animals
☐ Exercise
☐ Foods
☐ Smoke/Fumes
☐ Outside in Spring and/or Fall
☐ Outside on Windy Days
☐ Air Conditioning

Allergy Testing
☐ Never Done
☐ Skin Blood
☐ Negative
☐ Where Testing Done
_____

Allergy Injections
☐ Never Done
☐ In the Past
☐ Currently

Other Allergies/Problems Not Listed
☐ _____
☐ _____
☐ _____
☐ _____
☐ _____

_____
Please Describe

Facial/Eye Problems
☐ None
☐ Headaches
☐ Facial Pain
☐ Facial Weakness
☐ Vision Changes Not Corrected by Glasses
☐ Other Facial or Eye Problems:

_____
Please Describe

Ear Problems
☐ None
☐ Ear Pain
☐ Ear Drainage
☐ Hearing Loss
☐ Dizziness
☐ Ringing in Ears (Tinnitus)
☐ Other Ear Problems:

_____
Please Describe

Nose Problems
☐ None
☐ Nasal Obstruction
☐ Nasal Congestion
☐ Bleeding from Nose
☐ Sinus Drainage
☐ Other Nose Problems:

_____
Please Describe

Mouth Problems
☐ None
☐ Voice Change/Hoarseness
☐ Loud Snoring
☐ Sore Throat
☐ Trouble Swallowing
☐ Other Mouth Problems:

_____
Please Describe

Neck Problems
☐ None
☐ Neck Mass
☐ Other Neck Problems:

_____
Please Describe

Heart Problems
☐ None
☐ Chest Pain
☐ Lightheadedness
☐ Other Heart Problems:

_____
Please Describe

Lung Problems
☐ None
☐ Frequent Cough
☐ Difficulty Breathing
☐ Other Lung Problems:

_____
Please Describe

Stomach/GI Problems
☐ None
☐ Abdominal Pain
☐ Heart Burn/Indigestion
☐ Other Stomach/GI Problems:

_____
Please Describe

Urinary or Female Health Problems
☐ None

_____
Please Describe

Bone/Muscle Problems
☐ None
☐ Painful Joints
☐ Other Bone/Muscle Problems:

_____
Please Describe

Breast or Skin Problems
☐ None

_____
Please Describe

Brain or Nerve Problems
☐ None
☐ Change in Smell
☐ Change in Taste
☐ Numbness
☐ Weakness
☐ Other Brain or Nerve Problems:

_____
Please Describe

Blood or Lymph Problems
☐ None
☐ Excessive Bleeding
☐ Other Blood or Lymph Problems:

_____
Please Describe

Immune Problems
☐ None
☐ Unusual Infections
☐ Other Immune Problems:

_____
Please Describe

Other Medical Problems Not Listed _____
Cardiologist

☐ _____ _____
☐ _____ _____
☐ _____ _____

Please Describe

Patient Name: _____ Date of birth: _____

TESTS AND IMMUNIZATIONS

If you are not sure of the exact date of the test/procedure/immunization (month and day are not necessary), please list at least the year to the best of your recollection.

1. If you are a female patient between the ages of 24-64 yrs., when was your most recent cervical CA screening (pap test)? N/A or date:

_____

2. If you are a female patient between the ages of 42-69 yrs., when was your most recent Breast CA screening (mammogram)? N/A or date:

_____

3. If you are a patient between the ages of 50-70 yrs., when was your most recent Colorectal CA screening (Colonoscopy, Sigmoidoscopy or FOBT)? N/A or date: _____

4. If you are a patient 65 or older, when was your most recent pneumonia vaccination administered? N/A or date: _____

5. If you are a patient 6 months and older, when was your most recent influenza immuniza-tion administered? N/A or date:

_____

Patient Signature: _____

Date: _____