PROLIANCE SURGEONS® | EASTSIDE EAR, NOSE AND THROAT

Bellevue Office
1800 116th Ave NE
Suite #102
Bellevue, WA 98004
Phone: 425-451-3710
Fax: 425-451-2636

Kirkland Office
12333 NE 130th Lane
Suite #440
Kirkland, WA 98034
Phone: 425-899-3838
Fax: 425-899-3844

Redmond Office
8301 161st Ave NE
Suite #200
Redmond, WA 98052
Phone: 425-869-4855
Fax: 425-869-4858

Patient Registration Form

PATIENT NAME:_____ _____/_____/_____ _____
(First) (M) (Last) (Birthday) (Age)

Address:_____
(Street) (City) (State) (Zip Code)

Social Security #:_____ ☐ M ☐ F **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Parent/Guardian: _____ Home Phone # ( )_____
(First) (M) (Last)

Patient's Employment: _____ Work Phone # ( )_____

Occupation:_____ Cell Phone # ( )_____

EMERGENCY CONTACT PERSON OTHER THAN ABOVE NAMES:_____
Name Phone Number Relationship

Race: ☐ Caucasian ☐ Hispanic or Latino ☐ African American ☐ Asian ☐ Multiracial ☐ Other:_____ ☐ Decline to Answer

Ethnicity: ☐ Hispanic or Latino ☐ Non Hispanic or Latino ☐ Decline to Answer

Language: ☐ English ☐ Mandarin (Cantonese) ☐ Mandarin (Chinese) ☐ French ☐ Japanese ☐ Korean ☐ Russian ☐ Somali ☐ Spanish ☐ Vietnamese ☐ American Sign Language ☐ Other:_____ ☐ Decline to Answer

TO RESPECT YOUR PRIVACY, HOW CAN WE REACH YOU REGARDING YOUR HEALTH INFORMATION, LAB TEST RESULTS, MEDICATION BILLING?

Choose all that apply: Preferred Daytime phone#

1) Leave message on voice mail: ( )_____
☐ Home ☐ Cell ☐ Work

2) ☐ Do not leave message on voice mail

3) Leave message with:_____
Name Relationship

X_____
Signature

Patient Email Address:_____

PREFERRED LOCAL PHARMACY

Name:_____

Address: _____

_____

Phone Number: ( )_____

Referring Provider:_____

PCP Provider:_____
(Primary Care Physician Name)

PAYMENT IN FULL IS DUE AT TIME OF SERVICE UNLESS INSURANCE CARD(S) PROVIDED

PRIMARY INSURANCE NAME:	**ID#:**	**GROUP #:**
Policyholder/Employee Name:	Policyholder DOB:	Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other
SECONDARY INSURANCE NAME:	**ID#**	**GROUP #:**
Policyholder/Employee Name:	Policyholder DOB:	Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING

Assignment Release Financial Agreement: I authorize treatment of the above named person and agree to pay all the fees for such treatment. I hereby authorize my insurance benefits to be paid directly to the provider of services and I am financially responsible for the non-covered services. I also authorize the physicians to release any information requested. I understand that my Insurance may deny payment for any reason including but not limited to the following: services not authorized by Primary Care Provider, services not authorized/covered by insurance co., referral from PCP's office at specialist office at time of appointment. I acknowledge that failure to meet my financial obligations may result in the referral of my account to a collection agency. ****** Any unpaid balance over 60 days are subjected to late fees ******

WE RESERVE THE RIGHT TO CHARGE $50.00 FOR CANCELED OR NO SHOW APPOINTMENTS WITHOUT 24 HOURS ADVANCE NOTICE.

_____ _____/_____/_____
Patient Signature (If patient is minor/Parent or Legal Guardian) Date

PROLIANCE SURGEONS® | EASTSIDE EAR, NOSE AND THROAT

Bellevue Office
1800 116th Ave NE Suite #102
Bellevue, WA 98004
Phone: 425-451-3710
Fax: 425-451-2636

Kirkland Office
12333 NE 130th Lane Suite #440
Kirkland, WA 98034
Phone: 425-899-3838
Fax: 425-899-3844

Redmond Office
8301 161st Ave NE Suite #200
Redmond, WA 98052
Phone: 425-869-4855
Fax: 425-869-4858

www.eastsideent.com

Please note that in many instances your visit today, and on subsequent visits, could include a charge for more than just an office visit. Many times the services rendered in the office, such as scopes used for diagnostic purposes, hearing test, biopsies, aspirations, excision of lesions, insertion of ear tubes, injection procedures into the ear or nose, ultrasound of neck, are charged separately from the office visit and may be deemed as a deductible or co-share item. Your insurance company requires that we bill our services using a coding system known as CPT (Current Procedural Terminology). The endoscopic exams and procedures rendered are found in the "surgery" section of the CPT code book and your insurance explanation of benefits may identify these items as "surgery". This does not mean we are implying you had an operation, this is merely the way the CPT code book is organized for ease of use by both the insurance companies and the physicians.

For most patients, your plan requires you to pay a copay at the time of your visit. You may also receive a bill from our office for an amount that has been deemed part of your deductible or co-share amount. These balances are due upon receipt of your bill and will receive a billing fee if not paid within the billing cycle.

We are providing this letter to assist in interpreting the billing and explanation of benefits that you may receive. Please contact your health plan if you need further information regarding the way in which they processed your claim.

I acknowledge receipt of this information.

Patient Name: _____ Date:_____/_____/_____
(Please print)

Patient, Parent or Guarantor signature:_____

PROLIANCE SURGEONS® | EASTSIDE EAR, NOSE AND THROAT

Patient Financial Responsibilities

Proliance Eastside Ear, Nose & Throat, a division of Proliance Surgeons is committed to providing you with the highest quality medical care. Because patients are ultimately responsible for the charges associated with their care, even when insurance is in place, you may find the following information helpful. We realize you have choices for your medical care and appreciate your choosing PEENT.

Patient Responsibilities:

You can help ensure an efficient experience by assisting with the following:

- Providing us with your picture identification, insurance card and Social Security number to enable us to submit your claims timely and accurately
- Knowing your insurance benefits and limitations
- Ensuring there is an authorization for our providers to treat you if it is required by your insurance, including obtaining a referral
- Providing us with copies of any pertinent medical records, including tests (MRI/CT/Arthrogram) and x-rays
- Paying your estimated portion of the charges at the time of service
- Paying any additional amount owed when due
- Completing required incident/accident forms within 30 days of date of service
- Maintaining a current account with Proliance Surgeons at all times
- Providing us with at least 24 hours advance notice should you need to cancel or reschedule an appointment

Please note that co-payments, co-insurance and deductibles are a contractual agreement between you and your insurance carrier. We cannot change or negotiate these amounts.

Insured Patients:

We will bill your primary and secondary insurance carrier in a timely manner. If you are disputing payment with your insurance carrier or have a balance over $100.00 with us, you must notify our business office and make payment arrangements.

Co-Pays/Deductibles/Co-Insurance – Please be prepared to pay for your portion of the charges on the date of service. Office procedures (e.g., casting, scopes, tests, x-rays) will be billed separately from the office visit.

Surgery – If surgery is indicated, a pre-payment of both physician and facility fees is required for all elective, non-emergent procedures prior to the surgery being performed. Your out-of-pocket cost is estimated based on your benefits and our fees. Anesthesia and other providers are separate fees.

Non-Participating Insurance – If we do not participate in the insurance you have, we will file a claim as a courtesy. All unpaid claims will become your responsibility 45 days following filing and be immediately due and payable.

Uninsured Patients

Office Visits – A $255.00 deposit is required prior to the appointment. If visits and services are paid in full at the time of service, we offer a 20% discount (see exclusions below). Office procedures (e.g., casting, scopes, tests, x-rays) will be billed separately from the office visit.

PROLIANCE SURGEONS®

Surgery – For uninsured patients having surgery, we offer a 20% discount when charges are paid before or on the day of service (see exclusions below).

Exclusions – The discounts referenced above do not apply in cases of cosmetic procedures, motor vehicle accidents, third party insurance claims or in other cases when the patient may be reimbursed in full.

Private pay patients who receive retroactive Medicaid coverage need to immediately notify our business office.

Motor Vehicle Accidents (MVA) Insured and Third Party Patients

We do not extend discounts for MVA-insured accidents, third party insurance claims or in other cases when patients may be reimbursed in full. We will bill the MVA insurance carrier one time. The bill becomes your responsibility if not paid by the carrier in 30 days. We regret that we are not in a position to confer with attorneys or defer payment obligations while a case settles. If your personal injury protection benefit on your MVA policy is exhausted, we will bill your private insurance at your request provided we are furnished the necessary information at the date of service.

Workers' Compensation

If your visit is work-related, we will need the case number and carrier name prior to your visit in order to bill the workers' compensation insurance carrier. If your workers' compensation claim is not yet accepted and you have no other insurance, we require a $255.00 deposit that will be refunded after the claim has been opened.

Other Charges

No Show – Please provide us with at least 24 hours advance notice if you need to cancel or reschedule an appointment. We may charge a fee for missed appointments.

Please provide us with at least 48 hours advance notice if you need to cancel or reschedule an appointment and an interpreter has been scheduled. Otherwise, you may be charged for the interpreter.

Forms – There may be a charge associated with our completion of some forms. We require payment of the charge before returning the completed form to you. A signed Release of Information may also be necessary. Please allow five business days for us to complete forms.

Payment

Payment Options – We accept cash, checks, major credit/debit cards and money orders for payment (no post-dated or third party checks). We charge a $40.00 NSF fee for any returned checks.

Delinquent Accounts – We charge 5% interest accruing monthly on balances over 45 days old. We may assign an account to collections if balances are unpaid after 120 days. Patients assigned to collections may be denied additional service.

Alternative Payment Arrangements – If you are unable to pay your balance when due, please contact our business office to make alternative arrangements. Any patient with a past due amount may be denied additional service until the amount is paid or the patient is complying with an alternative payment arrangement.

Bankruptcy/Prior Bad Debt – Patients who have previously filed for bankruptcy or never satisfied their payment obligations for prior episodes of care with [Practice Name] or other Proliance Surgeons care centers may be required to pay for their portion of new charges at the time of service.

Patient Name:_____ Date: ____/____/_____

Patient/Guarantor Signature

PROLIANCE SURGEONS® | EASTSIDE EAR, NOSE AND THROAT

HIPAA SHORT FORM NOTICE OF PRIVACY PRACTICES

We understand that health information about you and your health is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by this office, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make sure that health information that identifies you is kept private
- Give you this Notice of our legal duties and privacy practices with respect to health information about you; and
- Follow the terms of the Notice that is currently in effect.

How we may use and disclose health information about you:

- For treatment
- For payment
- For health care operations
- For appointment reminders
- As required by Law
- To avert a serious threat to health and safety
- As required by the Military or Veterans and Workers Compensation
- Public Health risks
- Health oversight activities
- Lawsuits and disputes
- Law enforcement
- Coroners, health examiners and funeral directors
- National Security and Intelligence activities
- Protective Services for the President and others
- Security Officials for Inmates

Your rights regarding Health Information about you:

- Right to Inspect and copy
- Right to Amend
- Right to an Accounting of Disclosures
- Right to Request Restrictions
- Right to Request Confidential Communications
- Right to a Paper copy of this Notice *(full Notice is available upon request)*

Changes to this Notice:

We reserve the right to change this Notice. We will post a copy of the current Notice in our facility with the current effective date on the first page.

Complaints:

If you believe that your privacy rights have been violated, you may file a complaint with us. All complaints must be in writing. Please contact the administrator at the location where you were treated to file a complaint.

Acknowledgment of Receipt of this Notice:

We will request that you sign a separate form acknowledging you have received a copy of this notice. This acknowledgment will become part of your records. This acknowledgment provides that you have declined to accept the Complete Notice and instead requested this Short Form. We post a copy of the Current Complete Notice of Privacy Practices in our facility, on our web site at address: www .proliancesurgeons.com, and you may also ask for a copy.

Last Update: September 16, 2008

PROLIANCE SURGEONS® | EASTSIDE EAR, NOSE AND THROAT

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose the medical information that we maintain about you. It also explains how you can access this information. By signing, you acknowledge that you have reviewed the Notice of Privacy Practices of Proliance Surgeons, Inc., P.S.

_____ _____

Signature of Patient or Guardian Date

_____

Printed Name

Effective: April 14, 2003 (Revised: September 23, 2013)

Patient Name:_____ **Dr.**_____ **Date**____/____/____

DOB:____/____/____ **Age:**_____ **Occupation:** _____ **Marital Status**_____

Patient medical history form. Please provide the following medical information to the best of your ability.

What problems are you here for today and are you in pain?_____

_____ **Current Height:** _____ **Weight:**_____

List any Allergies to Medications & Reaction ☐ **NKDA** (No Known Drug Allergies)

Medication Allergies	Type of Reaction	Other Allergies	Type of Reaction

Non-Medication Allergies: Please Circle if allergic to: Eggs, Peanuts, Seafood, Iodine, Latex, Tape, Contrast Dye, **other**_____

LIST ALL MEDICATIONS YOU ARE TAKING (Prescription, over-the-counter or herbal supplements) ☐ **NO MEDICATIONS**

Medication	Dosage	How often taken	Medication	Dosage	How often taken

Past Medical History

1). Please check the **"NO"** or **"YES"** box to indicate if you have any of the following illnesses; for **"YES"** answers please explain.

	NO	YES			NO	YES	
Hearing Problems	☐	☐	_____	Stomach or Intestinal Problems	☐	☐	_____
Hypertension (high blood pressure)	☐	☐	_____	Allergy Problems/Therapy	☐	☐	_____
Thyroid Problems	☐	☐	_____	Kidney Problems	☐	☐	_____
Heart Disease	☐	☐	_____	Neurological Problems	☐	☐	_____
Respiratory Problems	☐	☐	_____	Cancer (Type)	☐	☐	(year)_____
Bleeding Disorder	☐	☐	_____	History of MRSA	☐	☐	_____
Cholesterol	☐	☐	_____	Anesthesia Problems	☐	☐	_____
Diabetes	☐	☐	_____	Other Medical Diagnosis	☐	☐	_____

2). Please list any **surgeries** and **dates** you have ever had (including ear, nose & throat surgery). ☐ **NO SURGERIES**

Have you fallen more than twice in the past year? ☐ No ☐ Yes **If YES how many times:** _____

Can you climb two flights of stairs without stopping due to shortness of breath? ☐ No ☐ Yes

Have you had an EKG/ECG (Electrocardiogram)? ☐ No ☐ Yes Where/When _____

Have you had a blood transfusion ☐ No ☐ Yes

Do you see a Cardiologist? ☐ No ☐ Yes If yes, whom _____ Date of last visit ____/____/____

Do you excercise? ☐ No ☐ Yes How often? _____

Social History:	NO	YES	What type?	How Much?
Do you drink beverages with Caffeine?	☐	☐	_____	
Do you currently smoke Tobacco?	☐	☐	_____	
If **NO**, did you previously?	☐	☐	Year stopped?_____	
Do you chew Tobacco?	☐	☐	_____	
Do you drink Alcoholic beverages?	☐	☐	_____	
Do you use Recreational drugs?	☐	☐	_____	

Patient Name:_____ **DOB:**____/____/____

Patient medical history form: **Please provide the following medical information to the best of your ability.**

Check **"NO"** or **"YES"** if you have had any of these symptoms in the past.

Constitutional

NO	YES	
☐	☐	Chills
☐	☐	Fatigue
☐	☐	Fever
☐	☐	Night Sweats
☐	☐	Weight Gain
☐	☐	Weight Loss

Cardiovascular

NO	YES	
☐	☐	Chest Pain
☐	☐	Heart Murmur
☐	☐	Palpitations
☐	☐	Hypertension
☐	☐	Pacemaker

Metabolic/Endocrine

NO	YES	
☐	☐	Cold Intolerance
☐	☐	Heat Intolerance
☐	☐	Increased Thirst
☐	☐	Diabetes
☐	☐	Thyroid Problems

Head, Eyes, Ears, Nose, Throat

NO	YES	
☐	☐	Blurred Vision
☐	☐	Choking on Liquids
☐	☐	Choking on Solids
☐	☐	Double Vision
☐	☐	Dizziness
☐	☐	Drooling
☐	☐	Difficulty Swallowing
☐	☐	Ear Drainage
☐	☐	Hearing Loss
☐	☐	Hoarseness
☐	☐	Mouth Ulcers
☐	☐	Ear Pain
☐	☐	Throat Pain
☐	☐	Tinnitus (Ear Noises)
☐	☐	Vertigo
☐	☐	Visual Changes

Gastrointestinal

NO	YES	
☐	☐	Abdominal Pain
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Heartburn
☐	☐	Vomiting

Respiratory

NO	YES	
☐	☐	Sleep Apnea
☐	☐	Shortness of Breath
☐	☐	Snoring
☐	☐	Wheezing/Asthma/COPD/TB

Neurological

NO	YES	
☐	☐	Difficulty Falling Asleep
☐	☐	Difficulty Staying Asleep
☐	☐	Excessive Daytime Sleepiness
☐	☐	Non Restorative Sleep
☐	☐	Numbness In Extremities
☐	☐	Passing Out
☐	☐	Tingling
☐	☐	Tremor
☐	☐	Weakness
☐	☐	Seizures

Dermatologic

NO	YES	
☐	☐	Itching
☐	☐	Rash
☐	☐	Change in Mole
☐	☐	Skin Lesion

Hematologic

NO	YES	
☐	☐	Easy Bleeding
☐	☐	Easy Bruising
☐	☐	Lymphadenopathy
☐	☐	Blood Clots in Blood Vessels

Psychiatric

NO	YES	
☐	☐	Anxiety
☐	☐	Depression
☐	☐	Hallucinations

Family Medical History

Please check the **"NO"** or **"YES"** box to indicate whether any relatives have had any of the following illnesses:
If **YES,** please indicate which relative(s) have the problem.

	NO	YES	Mother	Father	Brother	Sister	MAT GM	MAT GF	PAT GM	PAT GF	OTHER/WHO
Hearing problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
Heart problems/Murmurs	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
Allergy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
Diabetes (type)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
Cancer (type)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
Bleeding Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
Anesthesia Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
DECEASED (cause)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
History of MRSA	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	(if yes, year)_____