Advanced
Ear, Nose & Throat Associates
Hearing & Balance Center

NEW PATIENT FORM

Personal Information

Today's Date: _____ Account #: _____SSN: _____

First Name: _____ MI: _____ Last Name: _____

Address: _____

Zip Code: _____ City: _____State: _____

Date of Birth: _____ Age: _____ Marital Status: _____

Sex: _____ May we leave information on your answering machine or voicemail? ☐ Yes ☐ No

Primary Phone: (number you wish to be reached at): _____ Other #: _____

Email Address: _____

Occupation: _____ Work #: _____

Employer: _____ Full Time Student: ☐ Yes ☐ No

In the event of an emergency please contact:

Name: _____ Relationship: _____ Phone #: _____

Name of Parent/Guardian (if patient is a minor): _____

Who Referred you? ☐ Physician ☐ Family ☐ Friend ☐ Phone Book ☐ Insurance Co. ☐ Other: _____

Referring Physician's Name: _____ Phone No: _____

Address: _____

Insurance Information

Please present your insurance card(s) to the receptionist.

Primary Insurance: _____ Insured's Name: _____

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Policy #: _____ Group#: _____

Employer: _____ SSN: _____ DOB: _____

Secodary Insurance: _____ Insured's Name: _____

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Policy #: _____ Group#: _____

Employer: _____ SSN: _____ DOB: _____

NOTICE REGARDING INSURANCE CLAIMS/PAYMENTS:

If we are filing insurance for your visit, we must have complete information and any required referral at the time of the visit. If you cannot provide the information, we will be unable to file your insurance and payment in full will be required.

Payment of your charges cannot be determined until the claim is submitted to your insurance company. Payment will be based on your individual health plan, and the amount applied to your plan deductible and/or coinsurance will be your responsibility. Procedures that are excluded from coverage, based on your plan's determination of medical necessity, will also be your responsibility. Your office visit co-pay is due at the time of the visit and, in many cases, covers only the office visit charge. Any procedures performed will be considered surgery by your insurance company and deductibles and coinsurance may apply.

For all other patients, payment is required at the time of service. We will provide you with the necessary documentation to file for reimbursement upon your request.

I have read the above information and understand that I am responsible for payment for services I receive.

Patient/Guardian Signature: _____ Date: _____

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PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This information is important. **Please complete every item.** Your doctor needs to know you have carefully reviewed every section of this form. This information will be entered into the computer; you are welcome to a copy of the report if you wish.

Patient's Last Name: _____ First: _____ MI: _____

Sex: ☐ Male ☐ Female Date of Birth: _____ Height: _____ Weight: _____

Name of Primary Care Physician: _____

Pharmacy Preference (include location): _____

REASON FOR TODAY'S VISIT: _____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

Name of Medication	Dosage	How Often Taken

ARE YOU ALLERGIC TO ANY MEDICATION? ☐ Yes ☐ No. If yes, please list below:

Name of Medication	Type of Reaction

SURGERIES AND HOSPITALIZATIONS

Have you ever had any problems with anesthesia (being numbed or put to sleep)? ☐ Yes ☐ No
If yes, please list type of problems:

_____

List any surgeries you have had (including dates):

_____

Have you ever been hospitalized for non-surgical reasons? ☐ Yes ☐ No
If yes, list reasons for hospitalizations:

_____

Current or Most Recent Occupation: _____

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RECORDS RELEASE/REQUEST

Name: _____
(Doctor/ Hospital)

Address: _____

City: _____ State: _____ Zip: _____

Phone#: _____ Fax#: _____

I hereby authorize the release of my:

- ☐ Operative Reports
- ☐ Laboratory Reports
- ☐ Discharge Summaries
- ☐ Hospital Notes
- ☐ Office Notes
- ☐ Radiographic Films
- ☐ Radiographic Reports
- ☐ Audiograms

☐ Other _____

I request copies of such be transferred:
☐ To ☐ From

ADVANCED EAR, NOSE & THROAT ASSOCIATES, P.C.
9250 N. 3RD STREET, SUITE 2025
PHOENIX, AZ 85020
PHONE: (602) 944-3311

☐ Ben E. Leff, M.D. ☐ Deven S. Gujrathi, M.D.

_____
PRINT NAME OF PATIENT DOB

FROM: _____ TO: _____
DATE OF RECORDS

_____
SIGNATURE DATE

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AGREEMENT OF FINANCIAL RESPONSIBILITY

Thank you for choosing us as your health care provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

- Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, checks, credit cards and pre-approved insurance for which we are a contracted provider.
- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits, any exclusions in your insurance policy and any pre-authorization requirements of your insurance company.
- It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- If we have a contract with your insurance company, we will bill your insurance company first, less any co-payment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company.
- If we do not contract with your insurance company, you will be expected to pay for all services rendered at the time of your visit.
- Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that services rendered will be covered by your insurance company.
- Please understand some insurance coverages have out-of-network benefits that have coinsurance charges, higher co-payments and limited annual benefits. If you receive services as part of an out-of-network benefit, your portion of financial responsibility may be higher than the in-network rate.
- Please be sure to provide our office with at least 24 hours notice if you need to cancel an appointment to avoid the cancellation or no show fee of $150.

I have read the financial policies contained above, and my signature below serves as acknowledgment of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

Signature of Patient/Responsible Party	Date
Name of Patient/Responsible Party (please print)	Relationship to Patient

9250 N 3RD STREET, SUITE 2025, PHOENIX, AZ 85020
OFFICE (602) 944-3311 | FAX (602) 944-1968
www.AZadvancedENT.com

NOTICE OF PRIVACY PRACTICES

To Our Patients

This notice describes how health information about you may be used and disclosed, and how you can get access to your health information. This is required as a result the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following information: how we may use and disclose your health information, our obligations concerning the use and disclosure of your health information, your privacy rights.

Treatment. Physicians and staff may use or disclose your health information in order to treat you or to assist others in your treatment. Additionally, we may disclose your health information to others who may assist in your care, such as your spouse, children and parents in compliance with state and federal laws.

Payment. Our practice may use your health information to bill and collect payment for the services you receive from us. We may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose this information to obtain payment from third parties that may be responsible for such costs, such as family members. We may also use your health information to bill you directly for services and items.

Healthcare operations. We may need to use and disclose your health information to be able to run our practice at the highest clinical standards and as effectively as possible. This could be used to evaluate the performance of our physicians and staff, to determine if our treatment plans are effective, or determine if there are other services we should be offering. We may also compare our clinical data with other practices, medical faculty, technicians and others for teaching and learning purposes. We will strive to remove information that identifies you from this medical information.

Disclosure required by law. Our practice will use and disclose your health information when we are required to do so by federal, state or local law.

Appointment reminders and sign-in sheets. We may want to call you by phone for appointment reminder purposes. Please advise us if you do not want us to call and leave appointment reminder messages at your home, possibly on your answering machine, or with any co-worker at your place of work. We may also use a sign-in sheet at the front desk, for purposes of logging our patients as they arrive. We will make all efforts to shield this information from the view of others.

The following circumstances may require us to use or disclose your health information:

- To public health authorities and health oversight agencies that are authorized by law to collect information.
- For lawsuits and similar proceedings in response to a court or administrative order.
- If required to do so by a law enforcement official.
- When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.

If you are a member of U.S. or foreign military forces (including veterans) and if then required by appropriate authorities.

- To federal officials for intelligence and national security activities authorized by law.
- To Correctional Institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
- For Workers Compensation and similar programs.

Below are your rights regarding your health information:

1. You can request our practice to communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information to certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request. If we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make a decision about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Advances Ear, Nose & Throat Associates Physicians.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Advanced Ear, Nose & Throat Associates Physicians. You must provide us with a reason that supports your request for amendment.
5. You are entitled to receive a copy of this notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, contact Advanced Ear, Nose & Throat Associates Physicians.
6. You have the right to file a complaint about our practice with the Secretary of the Department of Health and Humans Services. To file a complaint, contact Advanced Ear, Nose & Throat Associates Physicians. All complaints must be submitted in writing, you will not be penalized for filing a complaint.
7. You have the right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted in applicable law.

If you have any questions regarding this notice or our health information policies, please contact Advanced Ear, Nose & Throat Associates Physicians at (602) 944-3311.

Patient Signature: _____ Date: _____