



1) Complete each line entirely or indicate N/A      2) Print clearly      3) Complete ALL pages

**PATIENT INFORMATION**

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

City, State Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ [ ] preferred

Cell Phone: \_\_\_\_\_ [ ] preferred

Work Phone: \_\_\_\_\_ [ ] preferred

**Can We Leave Detailed Phone Messages?**

Please Mark All That Apply: [ ] Home [ ] Cell [ ] Work

Email: \_\_\_\_\_

**Preferred Method of Contact:**

[ ] Home Phone [ ] Cell Phone [ ] Text Messaging [ ] Email

Gender: [ ] M [ ] F      Date of Birth: \_\_\_\_\_

Marital Status: [ ] Married [ ] Single [ ] Other \_\_\_\_\_

Preferred Language: [ ] English [ ] Other \_\_\_\_\_

Race: [ ] White [ ] Black/African American  
[ ] Asian [ ] Other \_\_\_\_\_

Ethnicity: [ ] Non-Hispanic [ ] Hispanic [ ] Other \_\_\_\_\_

**PATIENT EMPLOYMENT**

Employer/School: \_\_\_\_\_  
[ ] Employed [ ] Retired [ ] Unemployed [ ] Student

Emergency Contact: \_\_\_\_\_

Phone: \_\_\_\_\_

Relation: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Address/Or Street Location: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Is Your Referring Physician The Same As Your Primary Care Physician? [ ] Y [ ] N

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Please List Any Other Specialists You Currently See**

Specialist: \_\_\_\_\_ Phone: \_\_\_\_\_ Specialty: \_\_\_\_\_

Specialist: \_\_\_\_\_ Phone: \_\_\_\_\_ Specialty: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Policy ID: \_\_\_\_\_ Group#: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_

Relationship To Patient: [ ] Self [ ] Spouse [ ] Parent [ ] Other: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy ID: \_\_\_\_\_ Group#: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_

Relationship To Patient: [ ] Self [ ] Spouse [ ] Parent [ ] Other: \_\_\_\_\_



Patient Name: \_\_\_\_\_ DOB \_\_\_\_\_

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**BILLING AND FINANCIAL POLICY**

Every attempt is made to comply with insurance company’s requirements. Since policies and benefits differ among every type of insurance and the plans within them, we are unable to know the specifics of your policy. Insurance companies inform all participants that it is ultimately the patient’s responsibility to verify benefits and coverage information prior to having any services rendered. Valley ENT, PC cannot guarantee the cost of services performed will be covered by your insurance. To limit the charges that you may be responsible for please ensure that we always have up to date information regarding your insurance coverage.

\_\_\_\_\_ **Initial** All patients are responsible for payment at the time of service. This includes co-pays, and any other patient responsibility such as deductibles, and /or any coinsurance amount if it applies. We collect based off the contracted allowed amount we have with your insurance.

\_\_\_\_\_ **Initial** Patients are responsible for billed amounts due in the event that we are not contracted with their insurance plan, they do not have insurance, there is not a valid referral on file, or if there is a claim denial from the insurance company that we are unable to resolve.

\_\_\_\_\_ **Initial** Please be aware that certain procedures performed in our office are not included under the standard office visit. These procedures are billed separately and in addition to office visit charges. Some insurance companies will classify these procedures as “surgery”. At times these charges will go towards the deductible, and not be covered under a copay. The physicians of Valley ENT only perform these procedures when deemed medically necessary to best diagnose and treat our patients. It is ultimately the patient’s responsibility to know how their insurance benefits are applied. These procedures can consist of Nasal or Throat endoscopes, Hearing exams, Ear Cleanings, Microscope exam, and many other procedures. If you have any question regarding what may be done during your visit or the procedure codes, please don’t hesitate to ask the front office or medical assistant.

\_\_\_\_\_ **Initial** Non-payment of past due amounts may result in your scheduled appointment being re-scheduled to a later time when you are able to bring your account to current, or make payment arrangements.

\_\_\_\_\_ **Initial** If any uncollected balance is not paid in full within 90 days of receiving a statement, we reserve the right to turn your account over to a collection agency. Valley ENT offers payment plans if you cannot pay your balance in full. The responsible party or guarantor of the account will be responsible for all collection fees, including legal expenses.

\_\_\_\_\_ **Initial** A \$40.00 fee will be applied to your account should your check be returned by the bank as unpaid.

\_\_\_\_\_ **Initial** There is a \$25.00 fee for FMLA forms that need to be completed outside of having surgery and any physician dictated letters for personal use. Attorney fees may vary in price per request.

\_\_\_\_\_ **Initial** NO SHOW/ CANCELLATION POLICY: There will be a \$50.00 fee charged for no shows or cancelled appointments with less than a 24hour notice.

**BY SIGNING THIS FORM, YOU AGREE TO ALL THE INFORMATION LISTED ABOVE, AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS YOUR CLAIMS AND AUTHRORIZE PAYMENT OF MEDICAL BENEFITS TO Valley ENT, PC OR SUPPLIER FOR SERVICES RENDERED.**

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Above



**PHI ACKNOWLEDGEMENT**

\_\_\_\_ Initial I acknowledge that I have been offered a copy (available at front desk) of the Privacy Rules from Valley ENT, PC, and authorize the following list of people who may receive my Protected Health Information. I understand that I may revoke this authorization at any time by giving written notification to the office.

These people along with any referring, or primary care physicians listed on the patient information sheet may receive my Protected Health Information:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Relationship to Patient: [ ] Spouse [ ] Child [ ] Parent [ ] Other

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Relationship to Patient: [ ] Spouse [ ] Child [ ] Parent [ ] Other

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Relationship to Patient: [ ] Spouse [ ] Child [ ] Parent [ ] Other

\_\_\_\_ Initial I acknowledge and understand that the information provided will be kept in my confidential medical record and abided by until revoked by me in writing or in person at Valley ENT. It is my responsibility to notify my health care provider if any information has changed.

**NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Above

**OFFICE USE ONLY**

I attempted to obtain the patient’s signature in acknowledgement on this Notice of Privacy Practices Acknowledgement but was unable to do so as documented below.

Date: \_\_\_\_\_ Reason: \_\_\_\_\_



**SUMMARY OF PATIENT RIGHTS AND RESPONSIBILITIES**

**RIGHTS. During your visit with Valley ENT, you have the RIGHT to:**

- Be treated with dignity, respect, and consideration.
- Not be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or source of payment.
- Receive treatment that supports and respects the patient’s individuality, choices, strengths, and abilities.
- Receive privacy in treatment and care of personal needs.
- Review, upon written request, the patient’s own medical record within a reasonable time frame.
- Receive a referral to another healthcare institution if the outpatient treatment center is unable to provide physical health services or behavioral health services for the patient.
- Participate or have the patient’s representative participate in the development of or decisions concerning treatment.
- Participate or refuse to participate in research or experimental treatment.
- Receive assistance from a family member, representative, or other individual in understanding, protecting, or exercising the patient’s rights.
- Express a complaint regarding your care or any violation of your rights without being subjected to discrimination or reprisal.
- A patient is not to be subjected to—
  - Abuse
  - Neglect
  - Exploitation
  - Coercion
  - Manipulation
  - Sexual abuse
  - Sexual assault
  - Seclusion
  - Restraint, if not necessary to prevent imminent harm to self or others
  - Misappropriation of personal and private property by an outpatient treatment center’s personnel, member, employee, volunteer, or student

If you have questions or concerns, you may also call the AZ Dept. of Health Services at 602-364-3030.

**RESPONSIBILITIES. During your visit with Valley ENT, in the spirit of mutual trust and respect, you also have certain**

**RESPONSIBILITIES. We ask that you:**

- Provide, to the best of your knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and any other health matters.
- Report unexpected changes in your condition to the responsible practitioner.
- Report whether you clearly comprehend a contemplated course of action and what is expected of you.
- Follow the treatment plan recommended by the practitioner primarily responsible for your care, and inform your physician whether there are obstacles that would preclude the execution of the treatment plan.
- Accept and ensure that the financial obligations of the health care are fulfilled as promptly as possible.
- Provide the necessary information and documentation requested by the Registration Representative, including name change, address, phone number, and insurance information.
- Show behavior that is respectful and considerate of other patients, families, visitors, and personnel of Valley ENT and understand that any abusive or disrespectful behavior could result in your dismissal from VENT care.
- Notify registration staff if treatment is related to a work injury.

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Above



Patient Name: \_\_\_\_\_ DOB \_\_\_\_\_

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**PATIENT REVIEW OF SYSTEMS**

Please check **YES** or **NO** to each section if you **CURRENTLY** have or do not have the following symptoms:

<b>ENT</b>	<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>
Hearing Loss			Facial pain		
Ringing in the ears			Loss of smell		
Room spinning dizziness			Postnasal drip		
Ear pain			Snoring		
Ear discharge			Difficulty swallowing		
Runny nose			Pain with swallowing		
Hard to breathe through nose			Hoarseness		
Itchy nose			Nose bleeds		
Lump in neck					

<b>Neurologic</b>	<b>Yes</b>	<b>No</b>	<b>Cardiovascular</b>	<b>Yes</b>	<b>No</b>
Headaches			Chest pain		
Numbness			Palpitations		
Weakness			Shortness of breath		
Blurred vision					
Double vision					

<b>Respiratory</b>	<b>Yes</b>	<b>No</b>	<b>Gastrointestinal</b>	<b>Yes</b>	<b>No</b>
Cough			Nausea		
Shortness of breath			Vomiting		
Wheezing			Diarrhea		
			Blood in stool		

<b>Genitourinary</b>	<b>Yes</b>	<b>No</b>	<b>Musculoskeletal</b>	<b>Yes</b>	<b>No</b>
Frequent urination			Joint pain		
Nocturnal urination			Joint swelling		
Painful urination			Limited mobility		

<b>Integumentary</b>	<b>Yes</b>	<b>No</b>	<b>Psychiatric</b>	<b>Yes</b>	<b>No</b>
Dry skin			Sadness		
Changing of mole			Abnormal mood		
Itchy skin			Insomnia		
			Anxiety		

<b>General</b>	<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>
Fever			Anorexia		
Weight loss			Fatigue		
Night sweats					



Patient Name: \_\_\_\_\_ DOB \_\_\_\_\_

**Medical History**

Please check all that apply

Medical Problems (Illnesses)	
High blood pressure	<input type="checkbox"/>
Atrial fibrillation	<input type="checkbox"/>
Asthma	<input type="checkbox"/>
Sleep apnea	<input type="checkbox"/>
Acid reflux	<input type="checkbox"/>
Heart attack (MI)	<input type="checkbox"/>
Coronary artery disease	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>
Stroke	<input type="checkbox"/>
Kidney failure	<input type="checkbox"/>
DVT	<input type="checkbox"/>
HIV	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>
Hepatitis B or C	<input type="checkbox"/>
Cancer( Please write in):	<input type="checkbox"/>
Other medical problems not listed:	<input type="checkbox"/>

Past Surgeries (Operations)	Year	
Ear tubes	<input type="checkbox"/>	<input type="checkbox"/>
Tympanoplasty	<input type="checkbox"/>	<input type="checkbox"/>
Mastoidectomy	<input type="checkbox"/>	<input type="checkbox"/>
Sinus surgery	<input type="checkbox"/>	<input type="checkbox"/>
Septoplasty	<input type="checkbox"/>	<input type="checkbox"/>
Rhinoplasty	<input type="checkbox"/>	<input type="checkbox"/>
Tonsillectomy	<input type="checkbox"/>	<input type="checkbox"/>
Adenoidectomy	<input type="checkbox"/>	<input type="checkbox"/>
Thyroidectomy	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac stents	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac bypass	<input type="checkbox"/>	<input type="checkbox"/>
Gastric bypass or banding	<input type="checkbox"/>	<input type="checkbox"/>
Skin cancer	<input type="checkbox"/>	<input type="checkbox"/>
Kidney transplant	<input type="checkbox"/>	<input type="checkbox"/>
Other surgeries:	<input type="checkbox"/>	<input type="checkbox"/>

**Social History**

Please check all that apply

Employment	
Student	<input type="checkbox"/>
Not employed	<input type="checkbox"/>
Employed	<input type="checkbox"/>
Occupation:	<input type="checkbox"/>

Alcohol use	
Never	<input type="checkbox"/>
0-2 drinks/day	<input type="checkbox"/>
3 + drinks/day	<input type="checkbox"/>

Tobacco			
Never	<input type="checkbox"/>	Currently smoke	<input type="checkbox"/>
Former: Yr Started _____	<input type="checkbox"/>	< 1 pack/day	<input type="checkbox"/>
Yr Quit _____	<input type="checkbox"/>	1-2 packs/day	<input type="checkbox"/>
Vaping: Yr Started _____	<input type="checkbox"/>	3 + packs/day	<input type="checkbox"/>
Yr Quit _____	<input type="checkbox"/>		

**Family History**

Please check all that apply

Family History	Family member	Family member	
Asthma	<input type="checkbox"/>	Sinusitis	<input type="checkbox"/>
Hearing loss	<input type="checkbox"/>	Thyroid goiter	<input type="checkbox"/>
Bleeding disorder	<input type="checkbox"/>	Anesthesia problems	<input type="checkbox"/>
Stroke before 60	<input type="checkbox"/>	Heart attack before 60	<input type="checkbox"/>
Meniere's Disease	<input type="checkbox"/>	Thyroid cancer	<input type="checkbox"/>



Patient Name: \_\_\_\_\_ DOB \_\_\_\_\_

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**Current Medications**

NO Current Medications

Date: \_\_\_\_\_

Please include over the counter medications and supplements

Name of Drug	Strength	Frequency	What condition do you take this for?

**Drug Allergies**

NO Known Drug Allergies

Name of Drug	Reaction