



Potomac Ear, Nose & Throat, PLLC

Ramin Ipakchi, MD
Alidad Arabshahi, MD
Alex Y. Cheng, MD
2070 Old Bridge Rd, Suite 103
Woodbridge, VA 22192
Tel: (703) 499-8787

| SECTION 1 – GENERAL PATIENT INFORMATION (PLEASE PRINT IN BLACK OR BLUE INK ONLY) | | | | | |
|--|------------------------|-------------------------------------|-------------------------------------|-------------------------|--|
| LAST NAME | | FIRST NAME | MI | DATE | |
| DATE OF BIRTH | SOCIAL SECURITY NUMBER | | HOME PHONE | CELL PHONE | |
| STREET ADDRESS | | | MARITAL STATUS | WORK PHONE | |
| CITY | STATE | ZIP | | PRIMARY CARE PHYSICIAN | |
| EMPLOYER NAME: | | OCCUPATION (Indicate if Student) : | | REFERRED BY | |
| | | | E-MAIL ADDRESS | | |
| EMERGENCY CONTACT: | | RELATIONSHIP: | | EMERGENCY PHONE NUMBER: | |
| IF MINOR, PARENT OR GUARDIAN'S NAME: | | | PARENT OR GUARDIAN'S DATE OF BIRTH: | | |

| SECTION 2 – INSURANCE INFORMATION – Please have your insurance card available for copying when you are in the office. | | | |
|---|---|---|---|
| PRIMARY INSURANCE | | SECONDARY INSURANCE | |
| SUBSCRIBER I.D. NUMBER | GROUP NUMBER | SUBSCRIBER I.D. NUMBER | GROUP NUMBER |
| SUBSCRIBER'S FULL NAME | | SUBSCRIBER'S FULL NAME | |
| SUBSCRIBER'S DATE OF BIRTH | SOCIAL SECURITY NUMBER | SUBSCRIBER'S DATE OF BIRTH | SOCIAL SECURITY NUMBER |
| DO YOU HAVE A REFERRAL? <input type="checkbox"/> I DO NOT NEED ONE <input type="checkbox"/> YES <input type="checkbox"/> NO | IS THIS AN HMO? <input type="checkbox"/> YES <input type="checkbox"/> NO | DO YOU HAVE A REFERRAL? <input type="checkbox"/> I DO NOT NEED ONE <input type="checkbox"/> YES <input type="checkbox"/> NO | IS THIS AN HMO? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| RELATIONSHIP TO PATIENT <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER: | | RELATIONSHIP TO PATIENT <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER: | |

| SECTION 3 – DEMOGRAPHICS – Please check one from each category | | | |
|---|---|---|--|
| RACE | | LANGUAGE | ETHNICITY |
| <input type="checkbox"/> ASIAN | <input type="checkbox"/> HISPANIC | <input type="checkbox"/> ENGLISH | <input type="checkbox"/> HISPANIC/LATINO |
| <input type="checkbox"/> NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER | <input type="checkbox"/> OTHER RACE | <input type="checkbox"/> SPANISH | <input type="checkbox"/> NOT HISPANIC/LATINO |
| <input type="checkbox"/> WHITE/CAUCASIAN | <input type="checkbox"/> OTHER PACIFIC ISLANDER | <input type="checkbox"/> INDIAN(INCLUDES HINDI & TAMIL) | <input type="checkbox"/> REFUSED TO REPORT |
| <input type="checkbox"/> BLACK OR AFRICAN AMERICAN | <input type="checkbox"/> REFUSED TO REPORT | <input type="checkbox"/> OTHER: | |

| SECTION 4 – INSURANCE/TREATMENT AUTHORIZATION AND PRIVACY STATEMENT | |
|--|-------|
| Privacy statement: I understand and agree that medical information may be released in the course of my care in accordance with the HIPPA Privacy Notice. I hereby authorize Potomac Ear, Nose & Throat, PLLC to release any information pertaining to my health care, test results, billing and/or accounting information to the following person(s) or agencies. <input type="checkbox"/> Myself <input type="checkbox"/> My Spouse <input type="checkbox"/> My insurance company <input type="checkbox"/> Other: _____ | |
| I hereby authorize this office to apply for benefits on my behalf for covered services rendered and I hereby irrevocably assign to the above named provider all payments for medical services rendered. In the event my account is placed for collection, I agree to pay all costs and expenses including collection or attorney fees related to the collection thereof. I hereby authorize Potomac Ear, Nose & Throat, PLLC and/or doctors in charge of the patient to administer anesthetics, provide care and perform treatment deemed necessary. I understand that I am financially responsible for all co-payments and any charges for services rendered whether or not they are covered by my insurance company. Payment is expected at the time of service. I also understand that I am responsible for knowing the requirements of my insurance policy and any change in my insurance benefits or co-payments. A copy of this authorization shall be considered as valid as the original. | |
| PATIENT/ GUARDIAN SIGNATURE: | DATE: |



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Payment Policy

Thank you for choosing us as your ENT provider. We are committed to providing you with quality and affordable health care. In an effort to answer all of your billing and insurance payment questions we have developed this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

- Insurance:** We participate with most insurance plans, including Medicare and Medicaid. Knowing your insurance benefits and providing us with an up-to-date insurance card and a referral if required is your responsibility. Please contact your insurance company if you have any questions regarding coverage. If you are not insured by an insurance plan we do offer a self-pay option, payment in full is expected at each visit. If you are insured by a plan but do not have an up-to-date insurance card with you payment in full at each visit is required until we can verify your coverage.
- Co-Payments and Deductibles:** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
- Non-Covered services:** Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or medically necessary by Medicare/Medicaid or other insurers. Non-covered services are required to be paid in full at the time of service.
- Proof of Insurance:** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
- Claims submission:** We will submit your claims and assist you in any way we reasonable can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. **Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.** Your insurance benefit is a contract between **you and your insurance company**; we are not a party to that contract.
- Coverage 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. If your insurance company does not pay your claim in 90 days, the balance will automatically be billed to you.
- Non-payment:** If your account is over 90 days past due, you will receive a letter stating that you have 10 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you 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.
- Missed Appointments:** Our policy is to charge \$50.00 for missed appointments (excluding surgery and VNG) cancelled less than 24 hours in advance. **Surgery and VNG appointments must be cancelled 1 week in advance otherwise there will be a charge of \$150.00.** These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly schedule appointment.
- Returned Check Fee:** There is a \$35.00 fee for checks that are returned due to insufficient funds.

Our practice is committed to providing you with quality patient care. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

Patient Name (Please Print)

Date

Patient/Guardian Signature

Update: July 31, 2012



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Receipt of Practice Privacy Notice Written Acknowledgement Form

I, _____, have received a copy of Potomac Ear, Nose & Throat PLLC's privacy notice in accordance with mandated HIPAA privacy laws.

If you have any questions or comments about this Notice please contact:

Potomac Ear, Nose & Throat, PLLC
2070 Old Bridge Rd. Suite 103
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Patient/Guardian Signature

Date



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PATIENT HISTORY FORM

| | |
|------------------|---------------|
| Patient Name | Date of Birth |
| Reason for Visit | |
| <hr/> <hr/> | |

MEDICAL HISTORY – Please identify if you or your immediate family [You, MOTHER, FATHER, AND SIBLING] have the following:

| Please Circle | Illness: | Please Circle | |
|----------------------------|-----------|----------------------|-----------|
| Allergies | You M F S | Kidney Problems | You M F S |
| Asthma | You M F S | Liver Problems | You M F S |
| Back Problems | You M F S | Low Blood Pressure | You M F S |
| Bleeding Problems | You M F S | Low Blood Sugar | You M F S |
| Bronchitis | You M F S | Meningitis | You M F S |
| Cancer: | You M F S | Mononucleosis | You M F S |
| Type(s) of Cancer: | | Nervous Breakdown | You M F S |
| Chest Pain/Angina | You M F S | Paralysis | You M F S |
| Epilepsy | You M F S | Peptic Ulcer Disease | You M F S |
| Diabetes | You M F S | Pneumonia | You M F S |
| Emphysema | You M F S | Polio Paralysis | You M F S |
| Fibromyalgia | You M F S | Pregnant (currently) | You |
| Gallbladder Disease | You M F S | Reflux Disease | You M F S |
| Glaucoma | You M F S | Rheumatic Fever | You M F S |
| Hay Fever/Seasonal Allergy | You M F S | Sickle Cell Trait | You M F S |
| Hearing Loss | You M F S | Stroke | You M F S |
| Heart Attack | You M F S | Thyroid Disease | You M F S |
| Heart Murmur | You M F S | Tuberculosis | You M F S |
| Hepatitis | You M F S | Other illnesses | You M F S |
| Hiatal Hernia | You M F S | MRSA | You M F S |
| High Blood Pressure | You M F S | | You M F S |
| Irregular Heartbeat | You M F S | | You M F S |
| Jaundice | You M F S | | You M F S |

HOSPITALIZATIONS & SURGERIES – Please indicate the following:

Have you ever been hospitalized before? Yes No If so, when and for what?

Date: _____ For: _____

Date: _____ For: _____

Date: _____ For: _____

Have you ever had surgery before? Yes No

| Date of Surgery | Name of Surgery | Date of Surgery | Name of Surgery |
|-----------------|-----------------|-----------------|-----------------|
| 1. _____ | _____ | 4. _____ | _____ |
| 2. _____ | _____ | 5. _____ | _____ |
| 3. _____ | _____ | 6. _____ | _____ |

REVIEW OF SYSTEMS – Please indicate current problems only

| | | |
|-------------------|------------------------------|---------------------------|
| Fever | Weakness of arm/leg | Joint Pain |
| Weight loss | Tingling/numbness hands/feet | Skin Problems |
| Weight gain | Slurred Speech | Difficulty with Urination |
| Hearing changes | Headaches | Easy Bruising |
| Nasal obstruction | Difficulty sleeping | Abnormal Bleeding |
| Voice changes | Cold intolerance | Lymph node enlargement |
| Lump in neck | Heat intolerance | Rash/Hives |
| Vision loss | Shortness of Breath | Itchy Eyes/Nose |
| Double vision | Wheezing | Depression |
| Chest pain | Nausea | Mood Changes |
| Palpitations | Vomiting | Cosmetic Issues |

| | | ALCOHOL USE | | RECREATIONAL DRUGS | |
|---------------------------------|-------|------------------------------|-------|--------------------------------|-----|
| Have you ever smoked? | Y / N | Have you ever drank alcohol? | Y / N | Do you use recreational drugs? | Y/N |
| Do you smoke now? | Y / N | Do you drink beer? | Y / N | Have you ever used them? | Y/N |
| # of years smoked | _____ | Frequency/week | Y / N | | |
| # of packs per day? | _____ | Do you drink wine/liquor? | Y / N | | |
| Do you chew tobacco | Y / N | Frequency/week | Y / N | | |
| Other tobacco products? | Y / N | | | | |
| Is there a smoker in the house? | Y/N | | | | |

Have you had a reaction to anesthesia? YES NO

If yes, was it difficult breathing difficulty waking from surgery other _____

MEDICATIONS – Please list all medications you are CURRENTLY taking:

Not on any medications

| Name of Medication | Dose of Medication | Frequency |
|--------------------|--------------------|-----------|
| | | |
| | | |
| | | |
| | | |

Pharmacy name and telephone number currently using _____

ALLERGIES TO MEDICATIONS – Please list all allergies to medications

No allergies to medications

| Name of Medication | Allergic Reaction |
|--------------------|-------------------|
| | |
| | |
| | |



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Practice Privacy Notice – HIPAA Mandated

Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW YOUR PROTECTED HEALTH INFORMATION (PHI) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

You may opt out of this agreement at any time by presenting this office with written notice of your wishes. We may change the terms of this Privacy Notice at any time. The new notice will be effective for all PHI that we maintain at that time. A copy of this notice will be posted in our office at all times.

What Information Does this Notice Cover?

In accordance with the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)*, we are providing you with this Privacy Notice. Protected Health Information is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health and related health care services. This notice covers all information in our written or electronic records which concerns you, your health care, and payment for your health care. It also covers information we may have shared with other organizations to help us provide your care, get paid for providing care, or manage some of our administrative operations.

When Can We Use or Disclose Information About You?

Treatment

We may use or disclose information about you for treatment purposes to doctors, nurses, technicians, medical students, interns or other individuals who work in our practice who are involved in providing you with health care. We may also disclose information about you to organizations and individuals involved in your health care who are outside of our practice, such as consulting physicians, laboratories, social workers, etc. However, your written consent will be required before sending Protected Health Information to another office or facility that is outside of our practice.

Payment

We may use or disclose information about you such as diagnoses and treatment modalities for payment purposes. We may also disclose such information to your health insurance company or other party financially responsible for your health care.

Health Care Operations

We may use or disclose information about you for operations in connection with our practice. These activities might include practice quality improvement, business planning and administration of our practice. Such information may also be used to determine what additional services we can or should offer to improve the effectiveness of our treatment procedures. Or, we may audit our management practice so we can become more efficient.

Appointment Reminders

We may contact you for information to support your health care, including appointment reminders, information about alternative treatments, and health-related services, which may be of interest to you. We will routinely contact patients via telephone or e-mail at home and/or work and, unless otherwise requested, may leave messages on the appropriate voice mail or answering service regarding appointments. **Please advise us if you do not wish to receive such communications, and we will not use or disclose your information for such purposes. If you wish not to receive this kind of communication, you must advise us in writing at our contact address given above.**

However, there are situations in which we are required to release your protected health information without your written consent such as:

- Situations in which we are required by law to provide treatment and we are unable to obtain your consent.
- To a public health agency, for purposes such as controlling disease.
- In case of suspected child abuse, to the appropriate governmental agencies.
- In which we reasonably believe you are a victim of abuse, neglect, or domestic violence to a governmental agency authorized to receive abuse, neglect or domestic violence reports.
- Certain legal proceedings in response to a court or administrative order.
- To coroners, medical examiners, and funeral directors.
- Health care oversight activities such as audits, investigations, or licensing purposes.
- Certain public health activities such as reporting births, deaths, communicable diseases, ect.
- Certain legal enforcement purposes in response to a subpoena, warrant, or summons, subject to all applicable legal requirements.
- If you are in the United States military, national security or intelligence, Foreign Service, to your authorized superiors or other authorized federal officials.
- When required by State, Federal or Local law.
- For workers' compensation; in such cases that your treatment is a result of an injury on the job, we may release your information to the appropriate carrier/employer.

We may not use or disclose information about you for any other purpose without your written authorization

What Legal Rights Do You Have In Connection With Your Protected Health Information?

The Law entitles you to:

- Ask us to further restrict our use and disclosure of your protected health information. We are not required to grant such a request, but if we do we must make sure the restrictions are implemented.
- You may, and are encouraged, to review your entire health care record maintained in this office by making an appointment with our administrator. Please feel free to discuss and put in writing any discrepancies you feel may be present so that we can resolve any issues or questions of care and service.
- Receive confidential information from us, at an alternative address you provide to us.
- Obtain a copy of all or any part of our records of your information. You will be charged a copying charge for your records. There is a \$10 administrative fee, then \$0.50 per page.
- Obtain an accounting of all persons to which we have disclosed information about you, for any purpose except your treatment, payment for your treatment, or our health care operations.
- If you believe we have violated your privacy rights, you may forward us a written complaint to our contact address given above. You may also file a complaint with the Secretary of the United States Department of Health and Human Services. If you do file a complaint we are legally prohibited from retaliating against you.



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Acknowledgement of CoPays for Office Procedures and Tests

During your ear, nose, and throat evaluation, additional office procedures and tests may be recommended to assist with diagnosis and treatment of your medical condition. These procedures and tests will be billed to your insurance company. However, if the insurance company requires a separate Co-Pay from the office visit, you will be billed the amount of the Co-Pay for the procedure. Your insurance company may require that you pay additional amounts if you have not met your yearly deductible.

Please be aware, that some of these office procedures and tests may show on your explanation of benefits as “surgical procedures.”

You may call your insurance company to determine what Co-Pay may be required for the associated procedures and tests and their respective Procedural Code (CPT) for the **diagnostic tests** below. However, you will then have to make another appointment for another visit so that the procedure or test may be done.

Diagnostic tests:

- 31231** - **Nasal endoscopy**
- 31575** - **Flexible laryngoscopy** (endoscopy of the throat and voice box)
- 31579** - **Videostroboscopy** (evaluation of vocal cord vibration)
- 92557** - **Audiogram** (Hearing Test)
- 92567** - **Tympanometry** (Evaluation of Ear Drum compliance)
- 10021** - **Fine Needle Aspiration** (Needle Biopsy)

Other office procedures recommended for **treatment** may also require separate Co-Pay. List of procedures the physicians perform in office are too exhaustive to list. Please ask your physician for the name of the procedure and CPT code should you wish to check with your insurance company prior to the procedure.

By signing below, you acknowledge that you will be responsible for paying any additional Co-Pays that your insurance company may require for any office procedure recommended by your physician. Your insurance company may require that you pay additional amounts if you have not met your yearly deductible.

Signature of Patient, Parent or Guardian

Date