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

Potomac Ear, Nose & Throat, PLLC

SECTION 1 – GENERAL INFORMATION (PLEASE PRINT)

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

IF A MINOR, NAME OF PARENT/GUARDIAN	DATE OF BIRTH OF PARENT/GUARDIAN	REFERRED BY ☐

OCCUPATION (INDICATE IF STUDENT	E-MAIL ADDRESS

EMPLOYER NAME and STREET ADDRESS	CITY	STATE	ZIP

NOTIFY IN CASE OF EMERGENCY (NAME) :	EMERGENCY PHONE NUMBER
(RELATIONSHIP TO PATIENT): ☐ SPOUSE ☐ FATHER ☐ MOTHER ☐ OTHER:	

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? ☐ I DO NOT NEED ONE ☐ YES ☐ NO	IS THIS AN HMO? ☐ YES ☐ NO	DO YOU HAVE A REFERRAL? ☐ I DO NOT NEED ONE ☐ YES ☐ NO	IS THIS AN HMO? ☐ YES ☐ NO
RELATIONSHIP TO PATIENT ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER:		RELATIONSHIP TO PATIENT ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER:	

SECTION 3 – DEMOGRAPHICS – Please check one from each category

RACE		LANGUAGE	ETHNICITY
☐ ASIAN	☐ HISPANIC	☐ ENGLISH	☐HISPANIC/LATINO
☐ NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER	☐ OTHER RACE	☐ SPANISH	☐NOT HISPANIC/LATINO
☐ WHITE/CAUCASIAN	☐ OTHER PACIFIC ISLANDER	☐ INDIAN(INCLUDES HINDI & TAMIL)	☐REFUSED TO REPORT
☐ BLACK OR AFRICAN AMERICAN	☐ REFUSED TO REPORT	☐ 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.
□ Myself □ My Spouse □ My insurance company □ 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 SIGNATURE	DATE
X	

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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.

1. **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.
2. **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.
3. **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.
4. **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.
5. **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.
6. **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.
7. **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.
8. **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.
9. **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 Signature

Update: July 31, 2012

Potomac Ear, Nose & Throat, PLLC

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Dr. Ramin Ipakchi Dr. Alidad Arabshahi

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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_____ _____

Signature of Patient, Parent or Guardian Date

Updated: July 31, 2012

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PATIENT HISTORY FORM

Patient Name	Date of Birth

Reason for Visit

_____

_____

MEDICAL HISTORY – Please identify if you or your immediate family [**You**, **M**OTHER, **F**ATHER, AND **S**IBLING] 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	_____				

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

TOBACCO USE		**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 DECRIBES 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 provided 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 out 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 authorize 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 coping 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.