

WELCOME!

We would like to take this opportunity to welcome you to our clinic and thank you for choosing Ear, Nose and Throat Northwest for your health care needs. We look forward to providing you with quality care and service.

In order to be respectful of the medical needs of our patients, please be courteous and call at least 24 hours prior to your appointment if you are unable to attend. We will reallocate this time to another patient who is in need of treatment. This is how we can best serve the needs of all our patients.

Please complete the enclosed registration forms and return them to the front desk on your appointment date. Also, please remember to bring your current insurance cards and photo identification.

Copayments and deductibles are **required** at the time of service, and we will collect them prior to your appointment with our physicians. We accept cash, checks, Visa, MasterCard, Discover and American Express.

If you have managed care insurance that requires prior authorization, it is your responsibility to obtain a referral from your primary care physician.

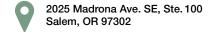
If you have any questions regarding our clinic or your scheduled appointment, please call our office at (503) 980-1950. Thank you very much.

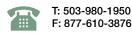
Ear, Nose and Throat Northwest, LLC		
has an appointment scheduled on	at	

Please arrive 20 minutes before your scheduled appointment time

Office Address:

2025 Madrona Ave. SE, Ste. 100 Salem, OR 97302









PATIENT INFORMATION

Patient Name: (First, MI, Las	st)					Sex: □M □F
Birth Date:	_ Age:	_SS#:	Email	l:		
Race:	_ Ethnicity:		_ Preferred La	nguage	j:	
Address:	City: _		State	:	Zip: _	
Cellphone:		Home	Phone:			
Employment Status:	☐ Full	□ Part	☐ Student		☐ Retired	□ None
Employment Name:						
		☐ Married				
Is your condition a result of	a work injury?	? □ Yes	□No	Date:		
Auto Accident?		☐ Yes	□No	Date:		
Preferred Pharmacy:						
REFERRAL INFORMATION						
			Office Phone	o:		
Referring Physician:						
Primary Care Physician:			_ Office Phone	e:		
INSURANCE INFORMATIO	N					
Primary Insurance:			_ ID #:		_ Group #:	
Policy Holder:	Policy	/ Holder DOB:		_ Relati	on:	
Secondary Insurance:			ID #:		Grou	p #:
Policy Holder:						
ALL PATIENTS, PLEASE REIN order to establish optimal payment policies, our staff payments are due at the time requires a referral, you will due at time of service. If yo below indicates that you un responsible for all charges release such medical information herein authorize payment of	al relations with is trained to in me of service a need to have u need a paynderstand and not covered bation necess	n our patients a form you of the as stated in you that in place b nent plan, plea accept this po by insurance. F ary to process	and avoid mise financial polur insurance cefore your apuse consult the licy and acknurther, your signary	underst icies of contract pointme e busine owledg gnature ce/Medi	ENT Northweent. If your insurations. If self-payers office. You e that you are authorizes the care claims (if	est. All co- ance carrier s, payment is ar signature e financially ne doctor to f any). You
Signature of Patient or Lega	al Guardian			Date		

ADULT HEALTH HISTORY

Patient Name:		Date of Birth:	Age:
Today's Date:			
How did you hear about our practice?			
Height: We	eight:		Sex: 🗆 M 🗆 F
What is the primary reason for your vis	sit with the	doctor today?	
Do you have a:			
Latex Allergy	☐ Yes	□No	
Drug Allergy	☐ Yes	□No	
If yes, please list medications a	nd reactior	าร:	
Past Medical History			
Do you have any medical problems?	☐ Yes	□No	
Please list:			
Have you ever had cancer?	☐ Yes	□No	
If so, what type?			
Past Surgical History			
Have you ever had surgery?	☐ Yes	□No	
Please list type and approximat	te date:		

Family History Any family history of the following? If yes, please list family member's relation to you: ☐ Yes ☐ No Heart Disease ☐ Yes ☐ No _____ **Arthritis** Cancer ☐ Yes ☐ No _____ Diabetes ☐ Yes ☐ No ____ ☐ Yes ☐ No _______ Bleeding tendencies Other **Habits** Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks per week? Do you currently use illicit drugs? ☐ Yes ☐ No If yes, what drugs? Have you ever used tobacco products? ☐ Yes ☐ No If yes, for how many years? If yes, how many packs per day? ☐ Yes ☐ No If yes, what date or how long ago? Have you stopped? **Review of Systems** Do you currently have any of the following symptoms? **Constitutional Symptoms** Neurological Allergic/Immunologic ☐ Yes ☐ No ☐ Yes ☐ No Dizzy spells ☐ Yes ☐ No Fever Itchy eyes/nose Chills ☐ Yes ☐ No Numbness/tingling ☐ Yes ☐ No Runny nose ☐ Yes ☐ No Lethargy ☐ Yes ☐ No Endocrine ☐ Yes ☐ No Pets in the home ☐ Yes ☐ No ☐ Yes ☐ No Weight gain/loss ☐ Yes ☐ No Excessive thirst Immune disorder ☐ Yes ☐ No Eyes Too hot/cold Head, Ear, Nose or Throat ☐ Yes ☐ No Blurred vision Hearing loss ☐ Yes ☐ No Hematological/Lymphatic Double vision ☐ Yes ☐ No Blood clotting problem ☐ Yes ☐ No Tinnitus ☐ Yes ☐ No ☐ Yes ☐ No Respiratory Easy bruising ☐ Yes ☐ No Ear pain

Wheezing

Frequent cough

Abdominal pain

Nausea/vomiting

Indigestion/heartburn

Gastrointestinal

Shortness of breath

☐ Yes ☐ No

Swollen nodes

transfusion

HIV/AIDS

History of a blood

History of hepatitis

☐ Yes ☐ No

☐ Yes ☐ No

☐ Yes ☐ No

☐ Yes ☐ No

Nose bleeds

Voice change

Throat pain

Snoring

Nasal obstruction

Swallowing problems

☐ Yes ☐ No

APPOINTMENT CANCELLATION/NO-SHOW POLICY FOR ENT NORTHWEST

ENT Northwest is privileged to provide medical and surgical treatment for our patients. We work diligently to maintain our high level of personalized service and strive to accommodate our patients' needs for office visits in a timely manner. This requires careful planning and coordination among many individuals in our office.

We understand that emergencies arise from time to time for our patients, just as they do for us. However, when a patient cancels an appointment without adequate notice or simply fails to keep an appointment, we cannot use that time to serve the needs of our other patients. Therefore, we have developed this policy regarding failure to keep appointments or canceling appointments without adequate notice. We respectfully request your understanding and agreement to our policy as it is stated below.

CLINIC APPOINTMENT CANCELLATION POLICY

Any patient who fails to keep an appointment or who cancels or reschedules an appointment less than 24 hours in advance of their appointment may be subject to a \$25 fee.

We understand that delays can happen; however, in fairness to other patients, if you arrive more than 15 minutes after your scheduled appointment, we may have to reschedule your appointment to another day.

If an established patient fails to keep three appointments or fails to give adequate notice on three occasions, the practice will have the right to dismiss the patient.

SURGERY CANCELLATION/NO-SHOW POLICY

Please consider your surgical date carefully before scheduling. Your surgery requires the coordination of several providers, including the surgeon, anesthesiologist, facility and possibly a pathologist. Therefore, any surgery that is canceled less than seven days prior to the surgery will be subject to a \$75 fee. Patients who fail to check-in for surgery or give less than 24-hour notice of cancellation will be subject to a \$150 fee.

FEES

All fees charged by ENT Northwest pursuant to this no-show/cancellation policy <u>are not payable by your insurance company.</u>

Your physician may waive your "no-show" fee for good cause shown. To request that we waive this fee, you must email a written request and explanation to the following address: info@entnorthwest.com.

Thank you for your consideration and understanding of our policy.

Patient Name (Please Print)	Date of Birth
Signature of Patient/Guardian	 Date



PATIENT POLICIES

Thank you for choosing us as your health care provider. At Ear, Nose and Throat Northwest, we are committed to building a successful provider-patient relationship with you and your family. Your clear understanding of our patient-related policies is an integral part of our professional relationship. We ask that you read and sign this document prior to any treatment. Please let us know if you have any questions.

FINANCIAL POLICY

We will verify your insurance coverage at every visit. It is the patient's responsibility to provide updated insurance information, current address and contact information. Failure to do so may result in denial of your claim and may lead to any visit balances being the patient's responsibility. We expect payment for the estimated portion of the patient's financial responsibility, including co-pays and deductibles, at the time we provide services.

As a courtesy to our patients, we will bill all major insurance companies, including Medicare and Medicaid. However, our health insurance coverage is a contract between the patient and an insurance company, and it is the patient's responsibility to know the details of coverage under their insurance plan. Some insurance companies require referrals and authorization; however, it is ultimately the patient's responsibility to acquire these. Failure to do so may result in any visit balance being the patient's responsibility.

We accept cash, checks, Visa, MasterCard, Discover and American Express. We will charge a \$25 fee for any returned checks.

The adult accompanying a minor to a visit and the legal parents/guardians are responsible for full payment. We do not get involved in negotiating between parents in a custody dispute.

As a courtesy, we bill any automobile accident insurance/workers' compensation when requested. Due to the nature of the drawn-out litigation, we reserve the right to bill you after a year of no response from your insurance.

I acknowledge that I have been offered or have received the Notice of Privacy Practices for Ear, Nose

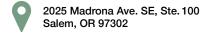
Initials

NOTICE OF PRIVACY PRACTICES

and Throat Northwest

Signature of Patient or Responsible Party

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RELEASE OF	MEDICAL INFORMATION		
I authorize the	following means of communication:		
□ Yes □ No	Leave a message on my home/cell voicemail.		
□ Yes □ No	Speak to or discuss your medical condition wi	th anyone else in your household:	
If yes, whom: _	Relationship:	Phone:	





T: 503-980-1950

F: 877-610-3876





Date