ENTNORTHWEST
EAR | NOSE | THROAT

Jared C. Hiebert, MD

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.** If the patient is a child under 18 years old, please bring photo identification of the parent or legal guardian. If the child is less than 18 years old, a parent or guardian **must** accompany them at the first visit.

Co-payments or 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, Last) _____ Sex: ☐ M ☐ F

Birth Date: _____ Age: _____ SS#: _____ Email: _____

Race: _____ Ethnicity: _____ Preferred Language: _____

Address: _____ City: _____ State: _____ Zip: _____

Cellphone: _____ Home Phone: _____

Preferred Pharmacy: _____ Auto Accident? ☐ Yes ☐ No Date: _____

REFERRAL INFORMATION

Referring Physician: _____ Office Phone: _____

Primary Care Physician: _____ Office Phone: _____

INSURANCE INFORMATION

Primary insurance: _____ ID #: _____ Group #: _____

Policy Holder: _____ Policy Holder DOB: _____ Relation: _____

Secondary insurance: _____ ID #: _____ Group #: _____

Policy Holder: _____ Policy Holder DOB: _____ Relation: _____

ALL PATIENTS, PLEASE READ AND SIGN THE STATEMENT BELOW

In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial policies of ENT Northwest. All co-payments are due at the time of service as stated in your insurance contract. If your insurance carrier requires a referral, you will need to have that in place before your appointment. If self-pay, payment is due at time of service. If you need a payment plan, please consult the business office. Your signature below indicates that you understand and accept this policy and acknowledge that you are financially responsible for all charges not covered by insurance. Further, your signature authorizes the doctor to release such medical information necessary to process your insurance/ Medicare claims (if any). You herein authorize payment of medical benefits to the doctor when we file the assigned claim.

_____ _____

Signature of Patient or Legal Guardian Date

IF THE PATIENT IS UNDER 18 YEARS OF AGE, PLEASE COMPLETE THIS SECTION:

Legal Guardian/Parent Name: _____

Relationship to Patient: _____

Legal Guardian Birth Date: _____

Address if Different than Patient's: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Email Address: _____

PARENT, CONTINUE IF THE PATIENT IS NOT 15 YEARS OF AGE OR OLDER. IF PATIENT IS 15 YEARS OF AGE OR OLDER, THEY WILL COMPLETE THE FOLLOWING:

Does Ear, Nose and Throat Northwest have your permission to:

- Leave a message on your voicemail/answering machine?
  ☐ Yes ☐ No
- Discuss your medical condition with other members of your household?
  ☐ Yes ☐ No

If yes, please give the name of that person: _____

What is that person's relationship to you? _____ Phone Number: _____

_____ _____

Signature of Patient (if 15 years of age or older) Date

PEDIATRIC HEALTH HISTORY

Patient Name: _____ Date of Birth: _____ Age: _____

Today's Date: Doctor you are seeing today: _____

How did you hear about our practice? _____

Height: _____ Weight: _____ Sex: ☐ M ☐ F

What is the primary reason for your visit with the doctor today? _____

_____

DOES YOUR CHILD HAVE A:

Latex Allergy: ☐ Yes ☐ No

Drug Allergy: ☐ Yes ☐ No

If yes, please list medications and reactions: _____

_____

MEDICATIONS

Please list any medications that your child takes on a regular basis. Include medication name, dose and frequency.

_____

_____

PAST MEDICAL HISTORY

Does your child have any medical problems? ☐ Yes ☐ No

Please list: _____

_____

_____

_____

Has your child ever had cancer? ☐ Yes ☐ No

If so, what type? _____

PAST SURGICAL HISTORY

Has your child ever had surgery? ☐ Yes ☐ No

Please list type and approximate date: _____

_____

_____

SOCIAL HISTORY FOR CHILDREN

Who is your child's primary caregiver (mother, father, grandparent, etc.)?

_____

Does your child attend daycare? ☐ Yes ☐ No

Does anyone smoke around your child? ☐ Yes ☐ No

Have immunizations been updated? ☐ Yes ☐ No

When? _____

Does your child have siblings? ☐ Yes ☐ No

Age(s) _____

Health problems of siblings: _____

_____

_____

FAMILY HISTORY

Any family history of the following? If yes, please list their relation to the child:

Heart Disease ☐ Yes ☐ No _____

Arthritis ☐ Yes ☐ No _____

Cancer ☐ Yes ☐ No _____

Diabetes ☐ Yes ☐ No _____

Bleeding tendencies ☐ Yes ☐ No _____

Other _____ _____

REVIEW OF SYSTEMS

Does the child currently have any of the following symptoms?

Constitutional Symptoms

Fever ☐ Yes ☐ No

Chills ☐ Yes ☐ No

Lethargy ☐ Yes ☐ No

Weight gain/loss ☐ Yes ☐ No

Eyes

Blurred vision ☐ Yes ☐ No

Double vision ☐ Yes ☐ No

Respiratory

Wheezing ☐ Yes ☐ No

Frequent cough ☐ Yes ☐ No

Shortness of breath ☐ Yes ☐ No

Gastrointestinal

Abdominal pain ☐ Yes ☐ No

Nausea/vomiting ☐ Yes ☐ No

Indigestion/heartburn ☐ Yes ☐ No

Neurological

Dizzy spells ☐ Yes ☐ No

Numbness/tingling ☐ Yes ☐ No

Endocrine

Excessive thirst ☐ Yes ☐ No

Too hot/cold ☐ Yes ☐ No

Hematological/Lymphatic

Blood clotting problem ☐ Yes ☐ No

Easy bruising ☐ Yes ☐ No

Swollen nodes ☐ Yes ☐ No

History of a blood transfusion ☐ Yes ☐ No

History of hepatitis ☐ Yes ☐ No

Allergic/Immunologic

Itchy eyes/nose ☐ Yes ☐ No

Runny nose ☐ Yes ☐ No

Pets in the home ☐ Yes ☐ No

Immune disorder ☐ Yes ☐ No

DOES YOUR CHILD HAVE:

Trouble sleeping ☐ Yes ☐ No

Frequent awaking ☐ Yes ☐ No

Snoring ☐ Yes ☐ No

Mouth breathing ☐ Yes ☐ No

Restless legs ☐ Yes ☐ No

Sleepwalking ☐ Yes ☐ No

Sleep talking ☐ Yes ☐ No

Wetting the bed ☐ Yes ☐ No

Trouble eating ☐ Yes ☐ No

Finicky eating habits ☐ Yes ☐ No

Sinus infections ☐ Yes ☐ No

How many per year?

Tonsil infections ☐ Yes ☐ No

How many per year? _____

Ear infections ☐ Yes ☐ No

How many per year? _____

Trouble hearing ☐ Yes ☐ No

How long? _____

Speech difficulty ☐ Yes ☐ No

Reflux ☐ Yes ☐ No

Large tonsils ☐ Yes ☐ No

Finicky eating habits ☐ Yes ☐ No

Failure to thrive ☐ 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 are not payable by your insurance company.

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

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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.

_____ Initials

NOTICE OF PRIVACY PRACTICES

_____ Initials I acknowledge that I have been offered or have received the Notice of Privacy Practices for Ear, Nose and Throat Northwest.

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 with anyone else in your household:

If yes, whom: _____ Relationship: _____ Phone: _____

_____ _____

Signature of Patient or Responsible Party Date

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info@entnorthwest.com

www.entnorthwest.com