Collier Otolaryngology
1879 Veterans Park Dr. Suite 1201
Naples, Fl. 34109
Tel: (239) 592-9666
Fax: (239)592-1835

_____ New Patient

_____ Visiting Patient

_____ Updating Info.

Welcome to Our Office

Patient Demographic Information

Patient Name: _____ Date: _____

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

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

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Social Security: _____ Date of Birth: _____ Sex: M or F Marital Status: M S W D

Race: _____ Ethnicity: _____

Email Address: _____

Employer: _____ Address: _____

Family Physician: _____ Phone Number: _____

Family Physician Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Phone Number: _____

Spouse Name: _____ Date of Birth: _____ Social Security: _____

Insurance/Payment Information

Name of Policy Holder: _____ Date of Birth: _____

Policy Holder Address: _____ Social Security: _____

Method of Payment: Visa MasterCard Discover Amex Cash Check

If Patient is a Minor Please Complete the Following Information

Fathers Name: _____ Date of Birth: _____ Social Security: _____

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

Employer: _____ Phone Number: _____

Mothers Name: _____ Date of Birth: _____ Social Security: _____

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

Employer: _____ Phone Number: _____

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Confidential Medical Information

Date: _____ Referred By: _____

Patients Name: _____ Date of Birth: _____ Age: _____

Sex: Male or Female Occupation: _____

Chief Complaint: _____

_____

Pharmacy Information

Name: _____ Phone: _____

Address: _____

Past Medical History

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Cancer
  Type: _____
- ☐ Depression/Anxiety
- ☐ Diabetes Type _____
- ☐ Dizziness
- ☐ Environmental Allergies
- ☐ Food Allergies
- ☐ Gastric Reflux
- ☐ Headaches
- ☐ Hearing Loss
- ☐ Heart Disease
- ☐ Hepatitis _____
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Sleep Apnea
- ☐ Stomach Ulcer
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ TMJ Disorder
- ☐ Other:_____
  _____
  _____

Past Surgical History

- ☐ Ear Surgery _____
- ☐ Facial Surgery_____
- ☐ Nasal/Sinus Surgery
  _____
- ☐ Neck Surgery
  (ex. Thyroid) _____
- ☐ Skin Lesion/Cancer
  Surgery _____
- ☐ Tonsillectomy
  /Adenoidectomy
  _____
- ☐ Vocal Cord Surgery
- ☐ Vascular Stents
- ☐ Other: _____

Medications

List all current Medications: _____

_____

_____

_____

_____

Confidential Medical Information

Review of Systems

Constitutional:
- ☐ Fatigue
- ☐ Unexplained Fevers
- ☐ Weight Gain/Loss

Eyes:
- ☐ Blurred Vision
- ☐ Corrective lenses
- ☐ Double Vision
- ☐ Eye Drainage
- ☐ Visual Changes

Ears/Nose/Throat:
- ☐ Ear Pain
- ☐ Ear Drainage
- ☐ Difficulty Hearing
- ☐ Sinus Pain
- ☐ Nosebleeds
- ☐ Nasal Congestion
- ☐ Mouth Sore/Ulcer
- ☐ Snoring
- ☐ Hoarseness
- ☐ Sore Throat

Cardiovascular:
- ☐ Chest Pain/Tightness
- ☐ Palpitation

Respiratory:
- ☐ Chronic Cough
- ☐ Shortness of Breath
- ☐ Wheezing

Gastrointestinal:
- ☐ Loss of Appetite
- ☐ Constipation
- ☐ Abdominal Pain
- ☐ Nausea/Vomiting
- ☐ Diarrhea

Genitourinary:
- ☐ Frequent Urination
- ☐ Hesitancy
- ☐ Incontinence

Musculoskeletal:
- ☐ Joint Pain or Swelling
- ☐ Muscle/Bone Pain
- ☐ Weakness

Integumentary/Skin:
- ☐ Itching
- ☐ Rashes
- ☐ Ulcer

Neurological:
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches

Hematologic/Lymphatic:
- ☐ Excessive Bruising
- ☐ Excessive Bleeding
- ☐ Swollen Lymph nodes

Endocrine:
- ☐ Thyroid Problems
- ☐ Frequent Thirst
- ☐ Excessive Sweating
- ☐ Heat/Cold Intolerance

Allergic/Immunologic:
- ☐ Certain Foods
- ☐ Frequent Colds/Infections
- ☐ Pollens
- ☐ Dust
- ☐ Animals
- ☐ Molds
- ☐ Seasonal Allergies

Psychiatric:
- ☐ Anxiety
- ☐ Depression
- ☐ Situational Stress
- ☐ Mood Swings

Drug Allergy History

☐ No Known Drug Allergies

List all known Allergies_____

_____

Social History

☐ Tobacco Use _____ # of packs/day for _____ # of years **Quit Smoking in the year _____**

☐ Alcohol Use How often? _____

☐ Drug Use _____

Family Medical History

- ☐ Allergies
- ☐ Bleeding Disorders
- ☐ Cancer
  Type: _____
- ☐ Diabetes
- ☐ Headaches
- ☐ Hearing Loss
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Family History Unknown
- ☐ Other: _____
  _____
  _____

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Acknowledgement of Receipt
HIPAA Omnibus Rule Consent Form

Our notice of privacy practices provides information about how we may use and disclose "Protected Health Information" or "PHI" about you. You have the right to review our Notice before signing. The terms of our notice may change. If we change our notice, you may obtain a revised copy.

By signing this form you consent to our use and disclosure of protected health information. You have the right to revoke the consent, in writing, and signed by you. However, such a revocation shall not affect any disclosure we may already have made in reliance on your prior consent. Our Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996. (HIPAA)

Patient Name: _____ **Date of Birth**: _____

The office and personnel are authorized to contact the party listed below to discuss and handle my medical care in the event of an emergency or to receive message information on my appointments and test results:

Name: _____ Relation: _____ Phone Number: _____

Name: _____ Relation: _____ Phone Number: _____

Name: _____ Relation: _____ Phone Number: _____

May we call you or leave a detailed message on your home answering machine? **Yes** **or** **No**
(Ex. Automated confirmation calls, normal test results, etc.)
May we call you at work and leave you a message to call our office? **Yes** **or** **No**

- You may revoke this consent at any time in writing.
- You may refuse to sign this acknowledgement and authorization, in doing so we will not be allowed to process your insurance claims.

In signing this HIPAA Patient Acknowledgment Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under the current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Patient/Parent Signature: _____ **Date**: _____

(If patient is a minor) Please Print Parent Name: _____

FOR OFFICE USE ONLY

_____

_____

_____

Office Rep. Signature: _____ Date: _____

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Financial Policy

WE ARE DEDICATED TO PROVIDING THE BEST POSSIBLE CARE AND SERVICE TO YOU AND REGARD YOUR COMPLETE UNDERSTANDING OF YOUR FINANCIAL RESPONSIBILITIES AS AN ESSENTIAL ELEMENT OF YOUR CARE AND TREATMENT.

HOWEVER, IN ORDER TO REDUCE CONFUSION AND MISUNDERSTANDING BETWEEN OUR PATIENTS AND THIS PRACTICE, WE HAVE ADOPTED THE FOLLOWING FINANCIAL POLICY:

Insurance Claims Filing:

It is our policy to collect co-payments and deductibles at the time of service. Regardless of your insurance company's guidelines, all unpaid balances will become your responsibility **45** days after your visit. In the event your health plan determines a service is non-covered you will be responsible for the complete charge. Should you dispute the way your insurance company handled your claim, it will be the patients' responsibility to follow-up with any appeals. It is your responsibility to present us with your correct insurance information otherwise you will be responsible in full for any charges.

Medicare Claims:

We file the claim to Medicare on your behalf, as well as any claims to your secondary insurance. However you will be responsible for any non-covered services.

Collections:

If payment is not received within 60 days you will be subject to referral to an outside collection agency and assessed with a 35% service fee.

Surcharge of Missed Appointments:

You will be subject to a **$50.00** fee if cancellation is not received at least 24 hours before the time of the appointment.

Please Be Aware:

We perform tests/procedures in the office and they may be considered as part of your deductible in addition to your office co-pay. It is the patients' responsibility to know what your insurance may or may not cover or if prior authorization is required before providing services for these procedures. You need to let us know if an authorization or precertification is required for any office or surgical procedures.

If you have a plan that we DO NOT have a prior agreement with, you will need to pay in full at the time of service. We will be happy to submit the claim for you upon payment and with the proper claims address.

Assignment and Release:

Patient hereby authorizes and assigns insurance benefits to be paid directly to the physician. Patient is responsible for any non-covered services regardless of how your insurance processes the claim.

Name: _____ **Date:** _____
I hereby accept by my endorsement that I have read, understand, and had all my questions answered to my satisfaction.