Southern New England Ear, Nose, Throat
and Facial Plastic Surgery Group, LLP
(Head and Neck Surgery)
www.southernnewenglandent.com

Ronald H. Hirokawa, MD, FACS, PC
(203) 865-6391

Eaton Chen, MD, MPH, FACS, LLC
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(203) 776-1288

Samantha Almeida, MHS, PA-C
(203) 624-9465

IMPORTANT INFORMATION – PLEASE READ

To our patients:

Please take note that we are forced to change our billing policies.

We do accept insurance assignment for your visits, but many of the commercial insurance plans have a high deductible causing a large balance on your account. In order to increase our efficiency, we will require a credit card at the time of check-in, to cover those high deductibles.

The information will be held in a secure area until it is determined what your balance is. It usually takes 2-3 weeks before we receive an insurance Explanation of Benefits (EOB). Once received, we will call you for permission to use your credit card. If you are not at home we will leave a message. If we do not hear from you in two days we will bill your credit card for the balance and send you a copy of the credit card receipt and the EOB.

Payment in this manner will be an advantage to you and us. You will no longer have to mail in payment or call in your credit card information and for us it will save us from sending out a bill. We will still collect co-pays at the time of visit.

We thank you for your cooperation and understanding.

Please sign below that you agree to these terms.

Southern New England Ear Nose Throat & Facial Plastic Surgery Group, LLP

Signature ____

Print Name ____

Date ____________________

Main Office: ***One Long Wharf Drive, Suite 302, New Haven, CT 06511*** Clinical Fax (203) 776-7741 • ADM Fax (203) 777-8469

497 Main St	1157 Highland Ave	669 Boston Post Rd	299 Washington Ave	455 Lewis Ave	51 South Main St	233 Broad St
Ansonia CT 06401	Cheshire CT 06410	Guilford CT 06437	Hamden CT 06518	Meriden CT 06451	Middletown CT 06457	Milford CT 06460
(203) 734-9291	(203) 271-1444	(203) 458-6181	(203) 288-3288	(203) 639-8154	(860) 344-0055	(203) 877-6001
Fax (203) 732-4440	Fax (203) 669-9474	Fax (203) 458-6879	Fax (203) 230-0848	Fax (203)630-7084	Fax (860) 346-0199	Fax (203) 822-0986

Southern New England
Ear, Nose, Throat & Facial Plastic Surgery Group LLP

PATIENT IDENTIFICATION ☐Mr. ☐Mrs. ☐Miss ☐Ms. ☐Dr. DATE__________

Patient's Name:	Last	First	MI
Address:	Street	City	State / Zip code
Email:		DOB:	
Home Phone:	Cell Phone:	Work Phone:	

Sex: ☐ M ☐F | Race: ☐American Indian/Alaska Native ☐Asian ☐Black/Africa American ☐Native Hawaiian/other Pac Islander ☐ White

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown | Language: | SS#

Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed ☐Separated

Employer:	Your Occupation:
Spouse's Name:	DOB:
Spouse's Address:	
Spouse's Employer:	Phone:
Emergency Contact:	Name Address Phonr#
Pharmacy: Name	Address (street, city, state, zip) Phone#

IF THE PATIENT IS A MINOR, STUDENT OR ANOTHER PARTY RESPONSIBLE FOR PAYMENT

Responsible Party/Guarantor(s):	Relationship:
Address:	DOB:

Home Phone: Cell Phone: Work Phone:

INSURANCE INFORMATION

Primary: ☐Medicare ☐State Welfare ☐Other Insurance	Name of Insured:
ID# Group#	DOB:
Secondary: ☐Medicare ☐State Welfare ☐Other Insurance	Name of Insured:
ID# Group#	DOB:

Is it Worker's Compensation?

If yes, name of your company & contact person:

Referring Doctor:	Name	Address	Phone#	Fax #
Primary Care Doctor:	Name	Address	Phone#	Fax #

If we participate with your insurance company we will submit your claim to them, but we cannot be responsible for errors or delay in the filling out and/or submission of insurance forms if we do not have the proper insurance card.

Regardless of any insurance coverage I/we may not have, it is my/our responsibility to pay the entire bill. In the event that this office needs to obtain legal assistance in collection of any unpaid balance, I/we agree to pay costs and attorney fees, as allowable by law and acknowledge receipt of a photocopy of this agreement.

Signature	Signature
	Parent, Guardian or responsible party

Authorization to release my medical records for billing purposes is granted by me.

Signature	Signature
	Parent, Guardian or responsible party

*****PLEASE PRESENT INSURANCE CARD AT THE TIME OF EACH VISIT*****

Southern New England
Ear, Nose, Throat & Facial Plastic Surgery Group LLP

PATIENT HISTORY DATE__________CHART #______________

NAME____DATE OF BIRTH______________________AGE___________

ALLERGIES TO MEDICATIONS:____

MEDICATIONS:

1. ____ REFERRAL M.D.____
2. ____YOUR OCCUPATION____
3. ____SOCIAL HISTORY: Marital status: M____ S____ D____ W_____
4. ____Cigarettes (packs/day) ______________ Alcohol (drinks/day)__________
5. ____Recreational Drugs____

PRIOR SERIOUS ILLNESSES/MEDICAL CONDITIONS:

1. ____
2. ____
3. ____
4. ____

Pertinent Medical History about your Family

1. ____
2. ____
3. ____
4. ____

HOSPITALIZATIONS/SURGERY (give date and reason):

1. ______________________ 2. ______________________ 3. ______________________ 4. ______________________

REVIEW OF SYSTEMS (check all):

Yes	No	**1. Allergic / Immunologic**
		Frequent Infections
		Positive HIV test
Yes	No	**2.Cardiovascular**
		Chest pain
		Heart murmur
		High blood pressure
		Irregular heartbeats
		Leg swelling
		Low blood pressure
		Rheumatic fever
Yes	No	**3. Constitution**
		Fever / night sweats
		Weakness / fatigue
		Weight loss
Yes	No	**4. Endocrine**
		Diabetes ("sugar")
		Irregular menses
		Thyroid disorder
Yes	No	**5. Eyes**
		Blurred / double vision
		Cataracts
		Dryness / redness
		Glaucoma
		Itchy
		Macular degeneration
		Watery

Yes	No	**6. Gastrointestinal**
		Black stools
		Crohn's disease
		Heartburn / reflux
		IBS
		Jaundice / hepatitis
		Nausea / vomiting / diarrhea
		Spitting up blood
Yes	No	**7. Genitourinary**
		Bloody / cloudy urine
		Frequent urination
		Genital rash / ulcers
		Kidney disease
		Kidney stones
		Pain / burning on urination
		Penile / vaginal discharge
		Venereal disease
Yes	No	**8. Hematologic / lymphatic**
		Anemia
		Bleeding tendency
		Easy bruising
		Thalassemia
Yes	No	**9. Integumentary (skin)**
		Dryness
		Eczema
		Growths / discoloration
		Rash
		Rosacea
		Swollen glands

Yes	No	**10. Musculoskeletal**
		Muscle weakness / pain
		Joint pain / swelling
		Arthritis / gout
Yes	No	**11. Neurological**
		Bell's palsy
		Headache
		Neuralgia
		Numbness / weakness
		Off balance / dizziness
		Seizure
		Stroke
Yes	No	**12. Psychiatric**
		Anxiety
		Delusions / hallucinations
		Depression
		Medications
Yes	No	**13. Respiratory**
		Asthma
		COPD
		Cough
		Coughing of blood
		Emphysema
		Shortness of breath
		Tuberculosis
Yes	No	**14. If Child:**
		Immunizations up to date
		Feeding difficulties

The information is to the best of my knowledge accurate & complete. PATIENT SIGNATURE:______________________________

Reviewed and updated. PHYSICIAN SIGNATURE:____

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Acknowledgment of Receipt of Notice of Privacy Practices

Elizabeth Sullivan, Practice Manager 203-777-7500

Name of Patient: ______________________________

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

HIPAA Questions

As my doctor, you or your staff may:

(PLEASE CHECK APPROPRIATE BOXES)

A. ☐ Call my home/cell phone and if necessary leave a message on the answering machine/voice mail/with a family member for me to call you back to schedule an appointment or to return your call.

B. ☐ Call my home/cell phone and if necessary leave a message on the answering machine/voice mail/with a family member giving the results of a test.

C. ☐ Call my home and if necessary leave a message on the answering machine/voice mail/with a family member inquiring how I am doing.

D. ☐ Call my workplace and if necessary leave a message for me to call you back to schedule an appointment or just to return your call.

(The above instructions are valid for 12 months)

Signature: ____________________________________ Date: _____________________

Print Name: ___________________________________ Telephone: ________________

If not signed by patient, please indicate your relationship to the patient: ______________________

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To our patients:

You are responsible for knowing your medical policy. For example, you will be responsible for any charges if any of the following apply:

- Your health plan requires prior authorization or referral by a primary care physician (PCP) before receiving services at Southern New England Ear Nose Throat & Facial Plastic Surgery Group, LLP (SNEENT), and you have not obtained such an authorization or referral
- You receive services in excess of such authorization or referral
- Your health plan determines that the services you received at SNEENT are not medically necessary and/or not covered by your insurance plan
- Your health plan coverage has lapsed or expired at the time you receive services at SNEENT
- You have chosen not to use your health plan coverage.

If you are not familiar with your plan coverage, we recommend that you contact your carrier or plan provider directly.

Thank you.

Southern New England Ear Nose Throat & Facial Plastic Surgery Group, LLP

Signature ____

Print Name ____

Date ______________________

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APPOINTMENT CANCELLATION and NO SHOW POLICY AGREEMENT

Effective February 15, 2017

Southern New England Ear Nose Throat & Facial Plastic Surgery Group, LLP is committed to providing all of our patients with excellent care. When a patient cancels without giving enough notice, they prevent another patient from being seen.

If you cannot make your scheduled appointment for any reason, please call our Scheduling Department at **203-787-4951** at least **24 hours** before your scheduled appointment to cancel and/or reschedule your appointment. There will be a $25.00 charge for missing your appointment without a 24 hour notification call.

Patients who do not show up for their appointment without a call to cancel an office appointment or procedure appointment will be considered as a **NO SHOW**. Patients who No Show three (3) or more times in a 12 month period may be dismissed from the practice, and will be denied any future appointments.

We thank you for your cooperation and understanding.

Please sign below that you agree to these terms.

Southern New England Ear Nose Throat & Facial Plastic Surgery Group, LLP

Signature of patient or guardian ____

Print Name ____

Date __________________

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