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

(Head and Neck Surgery)

www.southernnewenglandent.com

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~ Welcome to Southern New England ENT & FPS Group ! ~

Thank you for choosing our practice for your ear, nose, and throat medical/surgical care. Our physicians, PA's, and staff will provide you with caring attention and professional healthcare.

***INSURANCE and CREDIT CARDS**. We accept insurance assignment for your visits, and recognize that many of the commercial insurance plans have a high deductible causing a large balance on your account. In order to increase our efficiency, we **require a credit card at the time of check-in**, to cover these high deductibles (NOT applicable to Medicare or Medicaid patients).

The information will be held in a completely secure area until it is determined what your balance is. It can take up to 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 for you to call us back. If we do not hear from you in two (2) business days, we will proceed with payment processing on your credit card, and will send you a copy of the credit card authorization and the EOB. Your signature below allows us to proceed as outlined.

Rest assured that we take every safety precaution to protect your information in a locked and secure location with NO online or computer exposure. This avoids the inconvenience of mail-in payments or calling in credit card numbers. We will still expect co-payments at the time of your visit.

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***APPOINTMENT CANCELLATION and NO SHOW POLICY AGREEMENT.** 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 or reschedule. There will be a **$25.00** charge for missing an appointment without a 24 hour notification call.

Patients that **NO SHOW** (do not provide a notification call to cancel) three (3) or more times in a 12 month period may be dismissed from the practice and will be denied any future appointments.

Thank you for your cooperation and understanding. Please sign below that you agree to these terms.

Signature: ______________________ *Printed Name/Relation:*___________________________ *Date:*__________

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	Phone#
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:____

CURRENT MEDICATIONS YOU ARE TAKING:

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

REFERRAL M.D.____

OCCUPATION____

SOCIAL HISTORY: Marital status: M____ S____ D____ W_____

Cigarettes (packs/day) _______________ Alcohol (drinks/day)__________

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 phone: 203-777-7500

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

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HIPAA Questions

(PLEASE CHECK ALL APPROPRIATE BOXES) (Instructions valid for 12 months) As my doctor, you or your staff may:

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.

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***HEALTH PLAN REQUIREMENTS**. I am responsible for knowing my medical policy and am responsible for any charges if any of the following apply:

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

**I agree with all the above terms.

*Signature:*_______________________ *Printed Name/Relation:*__________________________________ *Date:*_______