

**EAR NOSE THROAT AND FACIAL PLASTIC SURGERY SPECIALISTS, PC**

723 Fitzwatertown Road, Willow Grove, PA 19090-1332

215-659-8805 Fax 215-784-9729

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Acct#: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

*Please circle the best way to reach you*

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 OK to leave a message  Texts OK

Date Of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ SS #: \_\_\_\_\_

Email \_\_\_\_\_ Pharmacy # \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

**For appointments not kept or cancelled less than 24 hours prior to your appointment date & time, the full charge of the visit, diagnostic testing, procedure, and or surgical procedure, will be charged to you**

**INSURANCE INFORMATION**

If Insurance is held by someone other than this patient, please fill out the information below:

Name of Insured: \_\_\_\_\_

DOB: \_\_\_\_\_

Address: \_\_\_\_\_

**(COPY OF CARD)**

Relationship to Patient: \_\_\_\_\_

I AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO MANAGE MY CARE.  
I UNDERSTAND AND AGREE THAT REGARDLESS OF MY INSURANCE STATUS, I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR ANY PROFESSIONAL SERVICE RENDERED. I HAVE COMPLETED THE ABOVE QUESTIONS AND CERTIFY THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY YOU OF ANY CHANGES IN MY INSURANCE STATUS OR ANY OF THE ABOVE INFORMATION. I AUTHORIZE THE STAFF TO PERFORM ALL NECESSARY SERVICES NEEDED DURING THE DIAGNOSIS AND TREATMENT. I ALSO AUTHORIZE THE PROVIDER TO RELEASE ALL INFORMATION REQUIRED TO PROCESS INSURANCE CLAIMS.

\_\_\_\_\_  
(Name of designated person)

NONE (if none, please indicate)

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

# **EAR NOSE THROAT & FACIAL PLASTIC SURGERY**

## **SPECIALISTS PC**

### **PATIENT FINANCIAL RESPONSIBILITY INFORMATION**

**DEAR**

**THANK YOU FOR CHOOSING US AS YOUR HEALTH CARE PROVIDER. THE FOLLOWING IS OUR FINANCIAL POLICY. OUR MAIN CONCERN IS THAT YOU RECEIVE THE PROPER AND OPTIMAL TREATMENTS NEEDED TO RESTORE YOUR HEALTH. THEREFORE, IF YOU HAVE ANY QUESTIONS OR CONCERNS ABOUT OUR PAYMENT POLICIES, PLEASE DO NOT HESITATE TO CONTACT OUR BILLING DEPARTMENT.**

**WE ASK THAT ALL PATIENTS READ AND SIGN OUR FINANCIAL POLICY AND HIPAA FORM AS WELL AS COMPLETE OUR PATIENT INFORMATION FORM AND CONSENT FORM PRIOR TO HAVING YOUR EXAMINATION, THERAPY, AND/OR STUDY. MEDICARE PATIENTS ARE REQUIRED TO SIGN AN ABN.**

**ALL INSURED PATIENTS ARE REQUIRED TO SIGN THE ASSIGNMENT OF BENEFITS FOR PAYMENT FROM THE INSURANCE COMPANY. WE WILL SUBMIT YOUR CLAIM TO THE INSURANCE COMPANY ON YOUR BEHALF BUT IF THE INSURANCE COMPANY DOES NOT PAY YOUR BALANCE IN FULL WITHIN 30 DAYS, WE ASK THAT YOU CONTACT THE CARRIER. YOU WILL BE BILLED FOR ANY NON-COVERED SERVICES, DEDUCTIBLES, CO-PAYS, AND/OR CO-INSURANCE AND FINANCE CHARGES.**

**IT IS THE RESPONSIBILITY OF THE PATIENT TO ENSURE ANY REFERRALS, PRECERTIFICATION, OR AUTHORIZATIONS HAVE BEEN OBTAINED PRIOR TO YOUR APPOINTMENT. IN THE EVENT YOUR PLANNED PROCEDURES ARE NOT FOLLOWED PRIOR TO YOUR APPOINTMENT, YOUR APPOINTMENT MAY BE RESCHEDULED.**

**DELINQUENT ACCOUNTS WILL BE TURNED OVER TO COLLECTION AGENCY WITH A 2 WEEK NOTICE UNLESS DEMOGRAPHIC INFORMATION HAS CHANGED AND RETURNED TO US BY THE UNITED STATES POSTAL SERVICE. ACCOUNTS WILL BE CONSIDERED DELINQUENT IF UNPAID AFTER 60 DAYS. IN THE EVENT YOUR ACCOUNT IS TURNED OVER TO COLLECTION, YOU WILL BE RESPONSIBLE FOR ALL REASONABLE COLLECTION AND COURT COSTS AT THE TIME THE ACCOUNT IS CONSIDERED DELINQUENT. AGAIN, THANK YOU FOR CHOOSING US AS YOUR HEALTH CARE PROVIDER. WE APPRECIATE THE OPPORTUNITY TO SERVE YOU.**

# **EAR NOSE THROAT & FACIAL PLASTIC SURGERY**

## **SPECIALISTS PC**

### **PATIENT FINANCIAL AND MEDICAL RESPONSIBILITY INFORMATION**

THE OFFICE OR DR. GOLDBERG MAY HAVE ORDERED A STUDY, TEST, CONSULTATION AND/OR FOLLOWUP APPOINTMENT FOR YOU. WE WILL ASSUME IF YOU HAVE NOT SCHEDULED THE ADVISED ORDER THAT YOU DO NOT PLAN ON HAVING THE ABOVE PERFORMED. MISSING FOLLOWUP MAY BE SUBJECT TO MISDIAGNOSIS, DELAYED DIAGNOSIS AND MALTREATMENT.

PLEASE ADVISE US IF THERE HAS BEEN A CHANGE IN YOUR ADDRESS, PHONE NUMBER, OR INSURANCE COVERAGE SINCE YOUR LAST APPOINTMENT.

IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT WITH THE DOCTOR AND DO NOT GIVE 24 HOURS NOTICE A FEE MAY BE CHARGED.

IF YOU ARE UNABLE TO KEEP YOUR PROCEDURE OR TESTING APPOINTMENT AND DO NOT GIVE 48 HOURS NOTICE A FEE MAY BE CHARGED.

PAYMENT IS EXPECTED AS SERVICES ARE RENDERED UNLESS PRIOR FINANCIAL ARRANGEMENTS HAVE BEEN MADE.

IF CO-PAY IS NOT PAID AT TIME OF VISIT, THERE WILL BE A CHARGE OF \$11.50 FOR ADMINISTRATIVE COSTS.

A FEE OF \$25.00 WILL BE CHARGED FOR ALL RETURNED CHECKS.

THERE WILL BE AN ADMINISTRATIVE FEE FOR THE COMPLETION OF ALL FORMS.

COMMUNICATION IS DOCUMENTED THROUGH PHONE CALLS DIRECTLY MADE TO OUR OFFICE. EMAILS, TEXTS & SOCIAL MEDIA IS NOT PART OF YOUR MEDICAL RECORD.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
(IF OVER 18 YEARS OF AGE)

# EAR NOSE THROAT & FACIAL PLASTIC SURGERY SPECIALISTS PC

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ DATE \_\_\_\_\_

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

It is your responsibility to provide accurate and current medical information below at your initial and subsequent visits. Any information not disclosed can result in misdiagnosis and maltreatment.

**PAST MEDICAL HISTORY**

- |  |                                     |   |   |
|--|-------------------------------------|---|---|
| <input type="checkbox"/> anemia            | <input type="checkbox"/> bronchitis | <input type="checkbox"/> NONE             | <input type="checkbox"/> NO CHANGE (existing patients only) |
| <input type="checkbox"/> arthritis         | <input type="checkbox"/> cancer     | <input type="checkbox"/> emphysema        | <input type="checkbox"/> heart murmur                       |
| <input type="checkbox"/> asthma            | <input type="checkbox"/> cataracts  | <input type="checkbox"/> glaucoma         | <input type="checkbox"/> kidney disease                     |
|  |                                     | <input type="checkbox"/> hearing problem  | <input type="checkbox"/> lung cancer                        |
| <input type="checkbox"/> bleeding disorder | <input type="checkbox"/> diabetes   | <input type="checkbox"/> heart disease    | <input type="checkbox"/> high blood pressure                |
| Other illnesses:                           |                                     | <input type="checkbox"/> high cholesterol | <input type="checkbox"/> headaches                          |
|  |                                     |   | <input type="checkbox"/> mono                               |
|  |                                     |   | <input type="checkbox"/> MS                                 |
|  |                                     |   | <input type="checkbox"/> reflux                             |
|  |                                     |   | <input type="checkbox"/> seizures                           |
|  |                                     |   | <input type="checkbox"/> thyroid                            |

PAST SURGICAL HISTORY                       NONE                       NO CHANGE (EXISTING PTS ONLY)

ALLERGIES                                       NONE                                       NO CHANGE (EXISTING PTS ONLY)

MEDICATIONS                                       NONE                                       NO CHANGE (EXISTING PTS ONLY)

OCCUPATIONAL HISTORY                       NONE                                       NO CHANGE (EXISTING PTS ONLY)

SOCIAL HISTORY                                       NONE                                       NO CHANGE (EXISTING PTS ONLY)

TOBACCO \_\_\_\_\_

ALCOHOL \_\_\_\_\_

ILLCIT DRUGS \_\_\_\_\_

FAMILY HISTORY                                       NONE                                       NO CHANGE (EXISTING PTS ONLY)

GRANDPARENTS \_\_\_\_\_

PARENTS \_\_\_\_\_

SIBLINGS \_\_\_\_\_

I am signing that I am responsible for providing all accurate and up to date medical information listed above.

PATIENT/GUARDIAN SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

It is your responsibility to provide accurate and current medical information below at your initial and subsequent visits. Any information not disclosed can result in misdiagnosis and maltreatment.

### REVIEW OF SYSTEMS

CONSTITUTIONAL: NONE FEVERS CHILLS/SWEATS WEIGHT LOSS TIRED

LOSS of APPETITIE RECENT TRAVEL BLOOD TRANSFUSION

EYES: NONE PAIN ITCHING VISION CHANGE

EAR: NONE PAIN DRAINAGE HEARING LOSS RINGING DIZZINESS

NOSE: NONE PAIN DRAINAGE LOSS of SMELL CONGESTION NOSEBLEEDS

ORAL: NONE PAIN LUMP/LESION LOSS/CHANGE TASTE CAVITIES

THROAT: NONE PAIN LUMP/LESION DRAINAGE HOARSENESS COUGH

TROUBLE SWALLOWING

NECK: NONE PAIN SWELLING NUMBNESS LUMP/LESION

CARDIOVASCULAR: NONE CHEST PAIN PALPITATIONS

RESPIRATORY: NONE SHORTNESS BREATH WHEEZING COUGH

GASTROINTESTINAL: NONE NAUSEA VOMITING DIARRHEA

CONSTIPATION PAIN BLOOD IN STOOL

GENITALURINARY: NONE PAIN/BURNING URGENCY/FREQUENCY BLOOD

NEUROLOGY: NONE HEADACHES WEAKENESS NUMBNESS TREMOR

ENDOCRINE: NONE ALWAYS HOT OR COLD HAIR OR NAIL CHANGES

HORMONE CHANGES

HEMATOLOGY/ONCOLOGY: NONE CANCER EASY BLEEDING/BRUISING

MUSCULOSKELETAL: NONE ACHES/PAINS JOINT SWELLING/STIFFNESS

ALLERGIC/IMMUNE: NONE SNEEZING/ITCHING COLDS/INFECTIONS

I am signing that I am responsible for providing all accurate and up to date medical information listed above.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
(IF OVER 18 YEARS OF AGE)

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
(RESPONSIBLE INDIVIDUAL)

# EAR NOSE THROAT & FACIAL PLASTIC SURGERY

## SPECIALISTS PC

### V QUESTIONS

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE PLEASE CONTACT OUR PRIVACY OFFICIAL AT THE OFFICE ADDRESS AND NUMBER.

### VI PRIVACY OFFICIAL

YOU MAY CONTACT OUR PRIVACY OFFICIAL AT 723 FITZWATERTOWN ROAD, WILLOW GROVE, PA 19090, Ph: (215) 659-8805

### HIPAA ACKNOWLEDGMENT

NAME: \_\_\_\_\_

I ACKNOWLEDGE THAT A COPY OF THE NOTICE OF PRIVACY PRACTICES FOR EAR NOSE THROAT & FACIAL PLASTIC SURGERY SPECIALISTS PC WAS MADE AVAILABLE TO ME.

IF I WISH TO ALLOW A FAMILY MEMBER OR FRIEND TO RECEIVE MY PERSONAL PROTECTED HEALTH INFORMATION, I MUST SIGN AN AUTHORIZATION FORM PROVIDED BY THE PRACTICE.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
(if over 18 years of age)

WITNESS SIGNATURE: \_\_\_\_\_

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**Office Billing Policies**

To:

Welcome to the practice. We are so happy that you chose our practice to help you with your Ear Nose Throat, ENT Allergy, Facial Plastic and Hearing Aids.

It is your responsibility to know if your insurance plan requires you to have a referral at the time of your office visit. If a referral is required, it is expected that we receive it no later than the date of your visit. It is the patients responsibility to request and manage their referral.

Your co-payment is required to be collected on the day services are rendered. As a convenience, our practice accepts cash, check, and credit cards. If a check is returned by the bank for non-sufficient funds, a service charge of \$25 will be incurred to cover bank fees.

If your insurance plan has a deductible in its policy, you will be required to pay for any costs deemed to be patient responsibility. If you have any questions regarding your insurance policy contact your insurance company and/or any member of our front desk staff. Finance charges will accrue on patient responsibility balances greater than 60 days.

We participate with the Medicare program. To those patients who do not have a secondary insurance please realize that you are responsible for paying the deductible and 20% of the accepted fee that Medicare allows.

You must understand that certain tests, scopes, treatments, surgeries and/or procedures are required to be paid completely if your insurance policy or insurance company does not.

Patients who DO NOT have any insurance or have an insurance plan that we do not participate; are expected to pay for the visit or procedure before leaving the office. Please ask the front desk for the costs that will be associated with your office visit. If a specimen is sent to the lab for pathology you will incur additional charges billed to you by the lab.

If it is necessary to cancel an appointment, we require that 24-hour notice be given. If 24 hour notice is not provided, \$50 will be billed for missed office appointments; \$300 will be billed for missed allergy skin tests; \$500 will be billed for missed otologic/vestibular testing; \$600 will be billed for missed surgeries and office procedures.

Patient Signature \_\_\_\_\_

Date: 07/22/2020