DESERT VALLEY ENT

PATIENT INFORMATION

PATIENT NAME: LAST	**FIRST:**	**MI:**	
STREET ADDRESS:	**CITY:**	**STATE**	**ZIP**
HOME PHONE:	**CELL PHONE:**	**SS#**	
EMAIL ADDRESS:	**PRIMARY LANGUAGE:**		
DATE OF BIRTH	**□ MALE** **□ FEMALE**	**MARTIAL STATUS:** **□ SINGLE □ MARRIED □ DIVORCED □ WIDOWED □ OTHER_____________**	
RACE: **□ WHITE □ ASIAN □ HISPANIC** **□ NATIVE HAWAIIAN OR PACIFIC ISLANDER** **□ BLACK OR AFRICAN AMERICAN**	**ETHNICITY:** **□ HISPANIC OR LATIN DECENT** **□ NON HISPANIC OR LATIN DECENT**		
EMPLOYER:	**OCCUPATION:**		
WORK PHONE:	**MAY WE CONTACT YOU AT WORK?** **□ YES □ NO**		

INSURANCE INFORMATION

PRIMARY INSURANCE:		**POLICY ID#**
CARD HOLDERS NAME:		**GROUP#**
SS#		**DOB:**
RELATION TO PATIENT:		
SECONDARY INSURANCE:		**POLICY ID#**
CARD HOLDERS NAME:		**GROUP#**
SS#		**DOB:**

RESPONSIBLE PARTY INFORMATION

RESPONSIBLE PARTY:	**SS#**	**DOB:**
ADDRESS:	**CITY/STATE:**	**ZIP:**
PHONE:	**WORK PHONE:**	**RELATION TO PATIENT:**

PHYSICIAN REFERRAL INFORMATION

PRIMARY/REFERRING PHYSICIAN:	**PHONE:**	**FAX:**
ADDRESS:	**CITY:**	**STATE/ZIP**

PHARMACY INFORMATION

PHARMACY NAME:	**PHONE:**
ADDRESS:	**CROSS STREETS:**

EMERGENCY CONTACT

IN CASE OF EMERCENTY NOTIFY:	**PHONE:**	**Relation:**

I herby certify the above information is true and correct to the best of my knowledge. I understand that while Desert Valley ENT, contract with many insurance companies, it is MY responsibility to verify with my plan that the physician is a participating provider. It is also my responsibility to find out what coverage options are with my insurance plan. I further understand that Desert Valley ENT will assist me in obtaining authorization from my primary care physician or insurance company if necessary. If however; authorization is not obtained, I am financially responsible for services rendered. I herby authorize Desert Valley ENT to submit insurance claim forms along with medical records necessary to obtain payment from my insurance company. I understand that I am responsible for all charges regardless of insurance overage. I acknowledge that photo id's are taken are used to assist in patient recognition per HIPPA guidelines.

PATIENT/RESPONSIBLE PARTY SIGNATURE:	**DATE:**

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES AND INFORMATION RELEASE

I, ____acknowledge that I have received a copy of Desert Valley ENT's "Notice of Privacy Practices". This notice describes how Desert Valley ENT may use and disclose my protected health information, certain restrictions on the use of disclosure of my healthcare information, and rights I may have regarding my protected health information. I herby authorize Desert Valley ENT to give the following people my health information.

Name:	Phone:	Relationship:
Name:	Phone:	Relationship:
Name	Phone:	Relationship:

May we leave medical information on your answering machine at home? □ Yes □ No On your cell phone? □ Yes □ No

Patient Signature:	Date:

ADVANCE DIRECTIVE/POWER OF ATTORNEY

Do you have an advance Directive? □ Yes □ No	Do you have a living will? □ Yes □ No	Do you have a health care proxy or power of attorney? □ Yes □ No

Please make sure if you have any of these documents we have a copy on file. Signature:	Date:

PATIENT SELF ASSESMENT

MEDICATIONS: Please list ALL medications you are now taking. Include over the counter and herbal vitamins.

Medication Name:	Dosage	Amount taking daily

If additional space is needed please submit on a separate sheet of paper.

MEDICAL HISTORY: Please check if you have or had any of the following:

□ ASTHMA	□ KIDNEY DISEASE	□ HAY FEVER
□ HEART DISORDER	□ TUBERCULOSIS	□ DIABETES
□ BLEEDING DISORDER	□ NERVOUS DISORDER	□ BRUISE EASILY
□ EYE DISEASE	□ HIGH BLOOD PRESSURE	□ LIVER TROUBLE
□ ULCERS	□ ECZEMA	□ CANCER TYPE___________
□ THYROID DISEASE	□ HIGH CHOLESTEROL	□ STROKE
□ OTHER ______________________	□ OTHER _________________________	□ OTHER ______________________

ALLERGIES

Do you have any known allergies to medication? □ Yes □ No If yes, please list medication below:

Medication Name:	Reaction:

Do you have any know seasonal allergies or hay fever? □ Yes □ No If yes, please list allergies below:

SURGERY AND HOSPTILIZATIONS

PLEASE LIST ALL SURGERIES AND HOSPITAL ADMISSIONS

SURGERY/ILLNESS	DATE (MO/YR)

FAMILY HISTORY

Please check all that apply and indicate which family member has history of disease checked.

□ ASTHMA ____________________	□ HEARING LOSS ________________	□ BLEEDING DISORDER ________________
□ SINUSITIS ___________________	□ THYROID DISEASE _________________	□ CANCER TYPE______________
□ OTHER __________________	□ OTHER ___________________	□ OTHER ___________________

SOCIAL HISTORY

Please check which describes you best

Tobacco:

□ I have never smoked	□ I am a former smoker	□ I currently smoke
	I smoked for _________ years.	I smoke _____________ a day.
	I stopped smoking ________ years ago.	I have been smoking for ________ years.

Street Drugs:

I use street drugs □ No □ Yes	If yes which street drug do you use:	How Often do you use the street drug:
□ Never, I have never used street drugs		

Alcohol Use:

□ Never, I never use alcohol	□ I drink 1-2 drinks a day	□ I drink 3 or more drinks a day
How many years have you used alcohol?	□ 1-2 years	□ 3 or more years

Marital Status:

□ Married	□ Divorced	□ Single	□ Widowed	□ Other
How many children do you have?	□ None	□ 1 □ 2 □ 3	□ 4 □ 5 or more	

OFFICE FINANCIAL BILLING POLICIES

MISSED APPOINTMENTS

We reserve the right to charge a 25.00 fee for missed appointments that are not cancelled or rescheduled with an advance week notice. We value your time, so please value ours.

SURGERY CANCELATION POLICY

We reserve the right to charge a 15% service fee for surgeries not cancelled or rescheduled with a 1 week advance notice. It takes a great deal of time to call insurance companies and obtain authorizations, so please at least 1 week prior to your surgery if you are canceling.

PLEASE BE ADVISED

- Co-pays are due at the time services are rendered. If co-pay is not paid at the time of service a 15% service fee will be asses to your visit.
- A $35.00 administration fee will be charged for the completion of FMLA or Disability forms.
- A $50.00 fee will be charged for all returned check.

Please know all information is kept confidential and for office use only.

Credit Card#_______________________________________ EXP _____________________________ CVV_____________________

Signature: ____Date: ____

DISCHARGE OF PATIENTS

Please be advised, Desert Valley ENT reserves the right to discharge patients who:

- are uncooperative
- do not follow medical advice
- do not keep appointments
- do not pay their bill
- Are disruptive and/or unpleasant and/or verbally abusive to the staff.

By signing below I am agreeing to the policies explained above of Desert Valley ENT and agree to follow them and accept the terms if otherwise.

Patient Signature:	Date:

MEDICAL SERVICE AGREEMENT

THIS AGREEMENT DESCRIBES OUR PHYSICIAN - PATIENT RELATIONSHIP: *PLEASE* REVIEW IT CAREFULLY.

In consideration of the agreement of James Reidy DO, and his employees, directors, shareholders, officers, agents or successors, herein called the "Physician", to render certain medical and surgical services for hereinafter named "Patient", Physician and Patient hereby agree as follows:

(A) DEFINITIONS: (1) The terms "we", "parties", or "us" means you (the Patient), and the Physician, his clinic, partners, affiliates, employees, and agents. (2) The term "service" means any exam, medical treatment, or intervention, medical or surgical procedure, therapy, pharmaceutical or nutritional intervention, and/or the application of or use of any product, device, or treatment to produce or anticipated to produce a medical intervention or surgical effect or that is provided by or under the direct or indirect supervision of a licensed Physician. (3) The term "Agreement" means collectively the following consents, notices, attachments, and clauses as adopted and incorporated herein which shall set forth the terms and conditions under which all medical services and interrelated care shall be provided and governed.

(B) TREATMENT CONSENT: On behalf of the patient, consent is hereby given to the Physician and any designee to provide health care Services to Patient and to administer physician orders for the benefit of the patient, for this visit and any subsequent visits. It is agreed that: (1) The practice of medicine is an art and not an exact science, therefore no warranty, promise, or guarantee of any result or anticipated outcome of any service has been or can be given, written, or implied in regard to utility, appropriateness, or anticipated outcome of any service provided by the Physician and received by the Patient. (2) It is not possible for physician, nurse, pharmacist, pharmaceutical company, product manufacturer, or other entity to assure the individual that any service is free from risk even with the currently approved, accepted, or the investigational use of such service. The Physician will explain the common service risks so that the Patient can make an informed decision before receiving a service, but cannot identify every potential risk of the service to the Patient. It is understood that with any health care service there is an inherent risk or potential of substantial and serious harm, unforeseen side effects or complications, including death, including the possibility that the service may have no complications or produce no effect what so ever. (3) Patient agrees and understands that all medical decisions recommendations, and Services are based upon medical evaluation as well as the current medical history provided, and therefore concur that each answer or response to the Physician must be truthful and accurate, and Patient grant the Physician unchallenged immunity for both intentional and unintentional errors and omissions of this nature.

(C) MEDICAL RECORD REQUEST CONSENT: You consent and authorize the Physician to request and receive your medical records from other entities and allow the Physician to consult with other healthcare providers or related entities regarding your healthcare or service to coordinate and facilitate physician orders for receipt of, payment of, reporting of, and coordination of such service.

(D) MEDICATION MANAGEMENT AGREEMENT: Only one Physician at a time will prescribe a medication listed as a controlled substance by the State of Arizona. This means that Patient will not request or receive the Medication from any other medical professional without notifying the Physician. No prescriptions will be refilled early, and no prescriptions shall be refilled if they are lost, destroyed, or stolen. For a chronic condition, the Patient must be seen in the office during normal clinic hours on at least a monthly basis for a physician evaluation to assess the efficacy of the treatment medication upon the condition, to review any investigative reports, and for authorization of any prescription refills.

(E) FINANCIAL RESPONSIBILITY: Patient and the undersigned, if other than the patient, each jointly and severally agree to pay for all the health care services received by the patient. (1) Charges for Service shall be by written quote or published fee-for-service schedule, which may be updated from time to time. Payment is considered due and payable at the time the service is rendered unless other arrangements have been made. Service or product deposits are not refundable. (2) Your signature will serve as your authorization for us to bill your credit or debit card, or any other related account that we may have on file, for our services, products, and treatments for this and any other single or recurring charges you my flair as part of the service you receive. We reserve the right to charge up to 2% per month on all outstanding and pending account balances, and charge for any costs associated with the cost of collecting delinquent accounts, including but not limited to attorney fees. (3) We are not obligated to bill Medicare, Medicaid, or your medical insurance carrier for our Service, or submit any claims for reimbursement on your behalf. Any insurance reimbursement for our professional Service is determined by your benefit plan agreement, and if not legally prohibited from doing so, we can provide you with an itemized service bill that you can submit to your insurance carrier for reimbursement according to your health plan benefit agreement, or utilize as a tax deduction. The fact that Medicare, Medicaid, or your medical insurance may not provide coverage for a particular medical service or that the Physician does not directly participate as a provider with your medical insurance company does not mean that you should not receive the Service. Medical decisions and recommendations are based upon sound medical judgment, which may or may not be reflected in the financial arrangement you may have with your medical insurance carrier or your defined benefit package. (4) Check with your tax advisor about the deductibility of your health care expenses.

(F) NOTICE OF PRIVACY PRACTICE: The federal government published regulations (HIPPA) designed to protect the privacy of your health information. (1) We protect the privacy of your health information. For some actives, we must have your written authorization to use or disclose your health information. However, the law permits us to use or disclose your health information for the following purposes without your authorization: for treatment, for payment, for health care operations, as required by law, business associates who provide services at our request, to avert a serious threat to health or safety, for public health risks, for heath oversight activities, judicial and administrative procedures, for specific government functions, for research and organ donation, for coroner and funeral directors, for communications with care givers and relatives. (2) Except as described, we will not use or disclose your health information without your written authorization. If you do authorize us to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time. If Arizona State Law provides additional restrictions upon any of the foregoing uses and disclosures, we will follow the state law. (3) You have the following rights with respect to your health information: You have the right to request restrictions on certain uses and disclosures of your health information, but we are required to agree to a restriction that you request and cannot agree to limit the uses or disclosures of information that are required by law; You have the right to inspect and copy your health information as long as we maintain the health Information, but we may charge you a fee for the costs of retrieving, copying, mailing or other supplies that are necessary to grant your request and we may deny your request in certain circumstances; You have the right to request that we amend your health information that is incorrect or incomplete, but we are not required to amend health information that is accurate and complete and we will provide you with information about the procedure for addressing any disagreement with a denial; You have a right to receive an accounting of the disclosures of your health information, which may not be longer

than six years, made after January 5, 2005 for purposes other than disclosures made for treatment, for payment or health care operations, or based upon on your authorization, and for certain government functions; You may request confidential communication of your health

information, but must submit a written request to the clinic stating how or when you would like to be contacted, and we will accommodate all reasonable requests. If you are a minor who has lawfully provided consent for treatment and you wish for the clinic to treat you as an adult for purposes of access to and disclosure of records related to such treatment, you must notify the clinic in writing. (4) We reserve the right ft change this Notice of Privacy Practice and such changes would be effective for health information we already have about you as well as any information we receive in the future. Any revisions to this Notice of Privacy Practice will be posted in the Clinic, and a copy will be available to you upon request. (5) If you have a question, would like additional information, or would like to exercise one or more of your Notice rights, you may submit written HIPPA Privacy Request to your physician at 2680 S Val Vista Dr. Ste 175 Gilbert, AZ 85295. If you believe your privacy rights have been violated, you can file a written addressed to our HIPPA compliance Officer, or by contacting the Secretary of Health and human services. There will be no retaliation.

(G) ALTERNATIVE DISPUTE RESOLUTION: In consideration of the agreement of the Physician to render certain medical and surgical service for hereinafter named patient, physician and patient hereby agree as follows: (1) It is understood that any claim, demand, controversy, civil action or disputed, including but not limited to personal injury, malpractice, or any tort, whether brought in tort, contract or otherwise by patient, their dependants, whether or not minors unborn child or children, heirs at law, or person representatives against physician as to whether any medical service rendered under this contract were unnecessary or unauthorized or were improperly negligent]y or incompetently rendered, will be determined by submission to arbitration and not by lawsuit or resort to court processes THE SOLE METHOD FOR RESOLVING SUCH DISPUTE SHALL BE BY BINDING ARBITRATIONS ADMINISTERED IN ACCORDANCE WITH THE CODE OF PROCEDURE OF THE NATIONAL ARBITRATION FORUM THEN IN EFFECT. Both parties to this contract give up their right to have any such dispute decided in a court of law before a judge or jury, accept the use of arbitration, and agree to submit their controversy to a sole arbitrator who is a medical doctor and a member of the American Academy of Cosmetic Surgery who shall then decide the controversy based on the evidence presented. The arbitrator shall be agreed upon by mutual consent of the parties. It is agreed that any relevant parties to the dispute may be interviewed or joined. Any award of the arbitrator may be entered as a judgment in any court having jurisdiction, and any such award, including any non-economic and economic damages (including any and all costs of arbitration and reasonable attorney fees in processing and defending the claim) cannot in part or totality exceed a common claim as defined in the code of procedure. This agreement to arbitrate may be revoked within three days of signature by personal presentation of such written and properly notarized notice directly to the physician. (2) Either party seeking arbitration shall have the right to proceed despite the refusal of the opposing pasty, or arbitration may only be avoided by a valid court order. Any party initiating arbitration under this agreement shall file with the petition a bond or cash surety in the amount of one thousand dollars, which shall provide security for attorney fees and costs in the event that the moving party should not prevail. The prevailing party in any arbitration pursuant to this agreement shall be rewarded all cost, including reasonable attorney and arbitrator fees, in processing or defending the claim in arbitration, but not to exceed two thousand dollars in amount. Furthermore, if any action is initiated or undertaken to set aside or otherwise attack this arbitration agreement or award or to compel arbitration, the prevailing party shall be entitled to all costs of such action, including reasonable attorney fees as may be fixed by the court. (3) In the event a court having jurisdiction finds any portion of this agreement unenforceable, that portion shall not be effective and the remainder of the agreement shall remain effective, (4) This agreement shall not limit the ability of the physician, who may not be covered by malpractice insurance, in the exercise of his professional judgment, refer to the patient to another physician or decline further medical attention to the patient. (5) Code of procedure information may be obtained at any office of the National Arbitration Forum, or by mail at P.O. Box 50191, Minneapolis, MN 55405. This arbitration agreement shall be governed and interpreted under the Federal Arbitration Act. 9 U.S.C. Sections 1-16.

(H) DELAY IN ENFORCEMENT: Either party's failure to at any time to insist upon the performance of any provision of this agreement will not operate as a waiver of any right or remedy either party has under this agreement. A waiver of one provision of this agreement will not operate as a waiver of any other.

(I) ALTERATION: The physician may amend or modify this agreement at any time as necessary or as required by law upon thirty days notice to patient. Whether or not the patient has signed an amended or acknowledgement of the new or amended terms of this agreement, receipt of healthcare and interrelated care or service by patient after or doting such thirty-day notice constitutes acceptance of the modified amended terms and conditions as if set forth herein.

(J) TERMINATION: Except as otherwise specified or provided herein, either party may terminate this agreement upon written notice to the other with thirty days written notice. Unless specifically terminated this agreement shall automatically renew each year upon anniversary of the date of execution of this agreement. Termination of this agreement shall not release either pasty from any obligation incurred prior to termination of this agreement (including, without limitation the obligations of paragraph E and G).

(K) SUCCESSORS & ASSIGNS: The physician may assign this agreement at any time with written notice to patient. Patient may not assign this agreement.

(L) GOVERNING LAW: Except as otherwise specified or provided herein, the laws of the State of Arizona shall govern this agreement, without giving effect to the conflict of law's provisions thereof.

(M) SEVERABILTIY: If any part of this agreement is held to be invalid or unenforceable, the remaining provisions will remain in full force and will not be affected by the invalidity of any other provision.

(N) NOTICES: Except as otherwise specified or provided herein, whenever notice shall be required, written notice shall be deemed to have been given (I) three days after having been mailed, postage prepaid, to the other party at the address of record or (2) upon transmission of fax with confirmation of complete transmission, or (3) upon personal presentation to the other patty.

(O) COMPLETE AGREEMENT: This agreement together with any attachments, constitutes the entire agreement between the parties concerning the subject matter hereof, and incorporates all representations, promises and statements, oral or written, made in connection with the negotiation of the *same* which shall apply for any and all service rendered including any service prior to the date this agreement was signed, and shall super cede and replace any and all prior agreements between the parties.

THIS IS A BINDING LEGAL DOCUMENT. CONSULT YOUR ATTORNEY ON ANY QUESTIONS YOU MAY HAVE.

I, ____ of lawful age, being first duly sworn, upon oath, state that l am the patient named, or the patients representative or agent authorized to execute this document and accept and agree to its terms on behalf of the patient; my signature acknowledges that I have read the foregoing MEDICAL SERVICES AGREEMENT; that l am familiar with the contents thereof and understand the same; that I have had the opportunity to ask any questions; that any questions have been answered to my satisfaction; that I understand the alternative dispute resolution process; that I have been afforded the opportunity for legal counsel prior to signing thereof; and that I indicate my understanding to what I am agreeing to by signing my name below.

PATIENT /RESPONSIBLE PARTY SIGNATURE:	DATE:

NOTICE OF PROCEDURES IN OFFICE

Please be advised certain procedures performed in our office are NOT included in the standard office visit. Such procedures will be billed separately and in addition to the office visit charges. We are aware of some insurance carriers classifying these procedures as “surgery” procedures and apply the charges to your calendar year deductible or coinsurance, resulting in the insurance paying for the office visit but NOT a procedure. In these cases, payment for the procedure will be due from the patient. Be assured that we are following acceptable billing and coding guidelines.

The physicians of Desert Valley ENT only perform these procedures when deemed medically necessary to best diagnose and treat our patients. If you are presenting with a sinus or throat/voice complaint, there is a good chance the surgeon will need to perform one of these procedures during your office visit. If you do not wish to have any of these procedures done you may kindly decline to the physician and you will not be billed in addition to the office visit.

Examples of in-office procedures include:

• CPT-31575 Flexible Laryngoscopy
This procedure involves passing a long thin flexible fiber-optic scope through the nasal cavity and into the throat. The fiber-optic scope enables the physician to visualize areas of the throat not readily seen using laryngeal mirrors.

• CPT-31231 Nasal Endoscopy
This procedure uses the flexible or rigid scope attached to a light source to view areas of the nasal cavities that cannot be viewed by the physician using the standard nasal speculum and head mirror.

• CPT-31237 Nasal Endoscopy with Debridement or Biopsy.
This is the same procedure as above with removal of crusting or tissue.

● CPT-30901 Control of Nasal Hemorrage- Usually done with patients with nose bleeds. This a procedure involves silver nitrate applied to the source of the bleeding in the nasal cavity in order to stop the nose

bleed.

If you have any questions please speak with the front desk if you would like to know what your carrier allows for these procedures prior to their completion.

Patient Name (please print):

____ Date: __________________