DATE:_____

Loudoun ENT Specialists
46090 Lake Center Plaza #104
Sterling, VA 20165
(703) 421-1700 phone (703) 421-5550 fax
www.entofloudoun.com

Family Hearing Services
14102 Sullyfield Circle #350c
Chantilly, VA 20151
(703) 988-6767 phone (703) 988-6768 fax
www.familyhearingva.com

Patient Name:_____Date of Birth: _____ Sex: Male○Female○

(Last) (First) (Middle) **Preferred Name**:_____

Patient Address:_____

Home Telephone #: (_____) _____ Cell #: (____) _____ Work #: (____) _____

Email:_____ Emergency Contact name and phone #_____

Preferred method of communication: (circle one) ○ Home phone ○ Cell phone ○ Work phone ○ Email

Parent or Guardian (if patient is under 18)_____

Primary Care Physician: _____ Did your primary refer you?_____

Referring Physician:_____

Whom shall we thank for referring you? (circle one) *Physician Family/Friend Insurance Internet Search Yellow Pages Website Social media Direct mail*

INSURANCE INFORMATION

Primary Insurance Company Name:_____ HMO_____ PPO _____ POS _____

Policy/ID#_____ Group #_____

Policy Holder Name:_____ Date of Birth: _____

Secondary Insurance Company Name:_____ HMO_____ PPO _____ POS _____

Policy/ID#_____ Group #_____

Policy Holder Name:_____ Date of Birth: _____

PLEASE HAVE A COPY OF YOUR INSURANCE CARD AND PHOTO ID

I certify that all the information provided on the form is accurate to the best of my knowledge. I have read and understand the Authorization to *Release Information and the Benefit Assignment to Loudoun ENT Specialists.*

_____ **x**_____

Please print patient's full name Patient's signature

PLEASE READ AND INITIAL THE FOLLOWING FOR LOUDOUN ENT SPECIALISTS:

_____**Cancellation Policy**: We reserve the right to charge a missed appointment fee of $75 for appointments cancelled or missed without 24 hours' notice.

_____**Copayment, Deductible, Coinsurance**: We collect all patient financial responsibility at the time of your visit. This information is gathered directly from insurance information provided by you.

_____**Eligibility and Benefit Verification**: We attempt to verify all insurance information prior to your arrival. We invite you to also familiarize yourself with your plan benefits and restrictions. We have no leverage with your insurance company on what procedures are paid and at what rates.

_____**Referrals**: If your insurance plan requires a referral from a primary care provider, it is **your responsibility** to obtain and provide that information to Loudoun ENT Specialists. Noncompliance may result in additional fees.

_____**Out-of-Network**: Your insurance plan may provide out-of-network coverage. We will provide you with the necessary paperwork to be reimbursed directly.

_____**Medicare**: Loudoun ENT Specialists and Dr. Betsy Vasquez offers Medicare appointments in the Chantilly location. Please phone the office for appointment availability.

_____**Divorced/Separated Parents of Minors**: The parent who consents to treatment of a minor child is responsible for payment of services rendered. Loudoun ENT Specialists will not be involved with separation or divorce issues.

AUTHORIZATION TO RELEASE INFORMATION
AND TO PAY BENEFITS TO Loudoun ENT Specialists

I hereby assign payment directly to **Loudoun ENT Specialists** for any medical/surgical procedures performed. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

I agree to be financially responsible to **Loudoun ENT Specialists** for all charges in the event that I have no insurance or my insurance is rejected, and for any balance or fee not covered by my insurance and/or determined to be my responsibility. I understand and acknowledge that if **Loudoun ENT Specialists** files my insurance claim, I will remain responsible for the account, and I will be expected to pay any amount due if my insurance does not pay the claim within 45 days.

I hereby authorize **Loudoun ENT Specialists** and its employees and agents to release my medical records documenting my examination and treatment, including AIDS related testing, psychiatric or substance abuse information, upon valid request.

I acknowledge that any amounts quoted as my "out-of-pocket costs" are only an ***estimate*** and that the exact determination of my financial responsibility will be made after my insurance company processes the claim. ***Payment is expected at the time of service***. I further acknowledge that I understand that **Dr. Betsy Vasquez schedules Medicare patients in the Chantilly location.** Phone the main number for availability

I further agree to pay all costs of collection, including reasonable attorney's fees, at the legal rate of interest on the account until paid in full, and I agree to waive all rights of exemption under the Constitution and the laws of the Commonwealth of Virginia.

I hereby request and authorize all doctors, nurses, technicians or affiliated medical personnel, hospitals and health care facilities to furnish all records and reports, including x-rays, photo copies, and abstracts or excerpts of all records, and any other information requested relating to any hospitalizations, examinations, treatments, tests or opinions concerning any condition for which I am presently being treated, including AIDS related testing, psychiatric or substance abuse information. A copy of this authorization shall be as valid as the original of this document.

_____ **X**_____

Please print patient's full name — Patient's signature

_____ _____

Date — Witness signature

_____

Provider Signature

PLEASE READ AND INITIAL THE FOLLOWING FOR FAMILY HEARING SERVICES:

I authorize Family Hearing Services to release information requested with regard to processing my claims. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet, and certify that this information is correct to the best of my knowledge. I will notify Family Hearing Services of any changes in my health status or in the above information.

Unless otherwise instructed, **Family Hearing Services, Inc**. will assume that if you are married, we are authorized to disclose information about your care and benefits to your spouse (or parents, if you are a dependent child). If you disagree, please inform us immediately

Signature _____ Date _____

Parent Signature if Minor _____ Date _____

AUTHORIZATION TO RELEASE INFORMATION
AND TO PAY BENEFITS TO FAMILY HEARING SERVICES

Since the founding of this practice, we have always offered the best hearing care possible. In order to continue to do so, we have implemented a Patient Financial Policy which is outlined in this document.

We send monthly statements to inform our patients of any balances due, and we also remind patients of money due when they call to schedule appointments and when we call to confirm appointments. We expect that patient due balances will be paid upon receipt of our statement, or at the next office visit. In order to make it easier for our patients, we accept cash, checks, money orders, VISA, Master Card, American Express and Discover. All may be given as a payment at the front desk or sent with statements. A fee of $50.00 will be charged for all returned checks.

For Self-pay Patients: We expect payment at the time of treatment for patients who have no insurance coverage. We will do our best to give the patient an estimate of the charges the day ahead of their visit when we call to confirm their appointment. Before visits, we will expect payment of the actual charges by one of the methods listed above. On accounts which have historically proven difficult to collect and for which additional administrative cost have been associated, the patient will be expected to prepay for the office visit at the time of visit. The payment will be reconciled once the insurer settles the account balance. We will work with our patients to develop a payment plan.

For Insurance Patient: We require that patients bring their insurance card with them to each appointment in our office so that we can be sure that we have correct insurance information on file, and we will scan it into our system if necessary. As a courtesy to our patients, we will file claim with their primary and secondary plan. When primary and secondary plans have paid their portion of charge, the remainder will become the patient's balance and will be indicated on statement patient receive from our office. On accounts which have historically proven difficult to collect and for which additional administrative cost have been associated, the patient will be expected to prepay for the office visit at the time of visit. The payment will be reconciled once the insurer settles the account balance.

While our billing professionals will do all they can to help our patients in communicating and negotiating with their insurance plan, we must inform patients that any question regarding coverage, benefits, or payment for services provided, is their responsibility to resolve.

Any balance on a patient account, for any covered or non-covered service, that is 30 day old, will be considered due, and is the patient's responsibility to pay. Any balance on an account that is greater the 30 days old is considered past due. It is out policy to send two statements (at 30 and 60 days) and make one phone call to patients before taking further action on their account. In the event an account is placed with agency for collection purposes, the patient will be responsible for all collection agency fees (up to 35% of the balance placed for collection). In addition, the patient will be responsible for all court cost, filing fees, and attorney fees should this account require litigation.

For Medicare Patients: Family Hearing Services and Dr. Pinky Khatri are in-network with Medicare and patient’s need to bring in a referral for the hearing test at the time of the appointment. As a courtesy to our patients, we will file claim with their primary and secondary plan.

I have read the above financial policy. All of my question have been answered and I understand the policy.

_____ _____
Patient Signature Date

_____
Patient Name Printed

HIPAA Statement of Privacy Practices

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principal concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

Protecting Your Personal Healthcare information

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the Commonwealth of Virginia. This includes issues relating to your treatment, payment, and our health care operations. Your personal health information will never be otherwise given to anyone – even family members – without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting protected Health Information

We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of your Protected Health Information

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing purposes without your written consent.

We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards.

Patient Rights

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

We thank you for being a patient at our office. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

X _____

Patient Signature/Date

I grant access to my personal health information to the following:

_____

_____

_____

Family Hearing Services
14102 Sullyfield Circle, Suite 350c
Chantilly VA 20151

Loudoun ENT Specialists
46090 Lake Center Plaza, Suite 104
Sterling, VA 20165

Health History

TO HELP US MEET ALL YOUR HEATHCARE NEEDS, PLEASE FILL OUT THIS FORM COMPLETELY.
THIS IS A CONFIDENTIAL RECORD OF YOUR MEDICAL HISTORY AND WILL BE KEPT IN THIS OFFICE.

Date_____

Patient Name_____DOB_____Male/Female Height_____Weight_____Lbs.

Occupation_____Pharmacy Name_____Pharmacy Number_____

Please tell us the Main Reason for Today's ENT/Audiology Consultation and List your Current Symptoms and/or treatment:
(e.g. ears, nose, throat, sleep disorder, voice, etc.) (e.g. hearing loss, pain/ pressure, discharge)

_____

_____

Who Referred you to us? Doctor _____Friend_____ Google ☐ Other_____

Medications: (please include aspirin, vitamins, over-the-counter or herbal medications)

Medication Name	Dose	How often taken

Medication/Drug Allergies: ○ NONE

Medication Name	Type of Reaction

Environmental Allergies ☐ yes ○ no	Please list:
Food Allergies ○ yes ○ no	Please list:
Latex Allergy ☐ yes ○ no	Please list:
Other Allergies ○ yes ○ no	Please list:

Surgical History:

ENT Specific Surgery	Date	Physician and Location
○ Ear Tubes	_____	_____
○ Ear Surgery (other)_____	_____	_____
○ Nasal Surgery _____	_____	_____
○ Sinus Surgery _____	_____	_____
○ Tonsil and/or Adenoids (circle one or both)	_____	_____
○ Other ENT Surgery_____	_____	_____
Other Surgery Not ENT Related		
☐ _____	_____	_____
☐ _____	_____	_____
☐ _____	_____	_____

Social History:

Do you smoke Cigarettes?
○ Never ○ Former Smoker (Quit _____ago) ○ Active/Every day Smoker (Packs per day _____) ○ Exposed to second-hand smoke
Do you drink Alcohol?
○ Never ○ Social ○ Yes/Regularly (Amount per wk. _____)
Do you consume caffeine regularly?
○ Never ○Occasional ○ Yes □Amount _____per day
Do you use recreational drugs? If so, what type and how often? _____

Patient Name_____

Past Medical History: (*check all that apply* also *check the © if problems currently active*)

To the best of my knowledge, none of these listed applies:

_____
Patient Initials

Ear/Nose/Throat
- o © Adenoiditis (Chronic)
- o © Cholesteatoma of Middle Ear
- o © Cough (chronic) /Bronchitis
- o © Cyst/Abscess location _____
- o © Decreased Smell or taste
- o © Deviated Nasal Septum
- o © Difficulty Swallowing
- o © Ear Infections (Chronic/Recurrent)
- o © Dizziness
- o © Hearing Loss/Decreased Hearing
- o © Laryngitis (Chronic)
- o © Meniere's Disease
- o © Nasal Bone Fracture
- o © Nasal Obstruction
- o © Nasal Polyps
- o © Nose Bleeds (Frequent)
- o © Obstructive Sleep Apnea
- o © Pharyngitis (Chronic)
- o © Rhinitis (Chronic)
- o © Sialadenitis
- o © Sinusitis (Chronic)
- o © Snoring
- o © Sore Throat (Chronic)
- o © Strep Throat (Chronic/Recurrent)
- o © Tinnitus (Ringing in Ear(s)
- o © TMJ
- o © Tonsillitis (Chronic)
- o © Vocal Cord Nodule
- o © Voice Disturbance/Hoarseness

Cardiovascular
- o © Cardiovascular Disease
- o © Elevated Cholesterol (Hyperlipidemia)
- o © High Blood Pressure (Hypertension)
- o © History of Heart Attack
- o © Heart Murmur
- o © Palpitations
- o © Stroke
- o © Pacemaker

Pulmonary/Respiratory
- ○ © Asthma
- ● © COPD/Emphysema
- ○ © Pneumonia
- ○ © Shortness of Breath
- ○ © Tuberculosis
- ○ © Wheezing

Musculoskeletal
- ○ © Eustachian Tube Dysfunction
- ○ © Fibromyalgia
- ○ © Osteoporosis
- ○ © Arthritis

Digestive
- ○ © Gastrosophageal Reflux/Heartburn
- ○ © Colitis
- ○ © Celiac Disease
- ○ © Crohn's Disease
- ○ © Persistent Nausea

Endocrine/Metabolic & Hematology
- o © Anemia
- o © Autoimmune Disorder (e.g. lupus)Type_____
- o © Chronic Fatigue Syndrome
- o © Diabetes □Type I □Type II
- o © Herpes □Simplex □Zoster
- o © Hepatitis
- o © HIV/AIDS
- o © Thyroid Deficiency (Hypothyroidism)
- o © Thyroid Excess (Hyperthyroidism)
- o © Renal Failure
- o © Vitamin Deficiency Type_____
- o © Sexually Transmitted Diseases Type_____

Neurologic & Psychiatric
- ○ © Anxiety
- ○ © Depression
- ○ © Headache/Migraine (Chronic/Frequent)
- ○ © Memory Loss
- ○ © Nervousness
- ○ © Tremors
- ○ © Other Mental Illness Type_____

Cancer □Yes □No
Type/Location_____

Family History: □ None/Unknown

	Relationship	Type/Additional Information
o Alcoholism/Substance Abuse	_____	_____
o Asthma	_____	_____
o Diabetes	_____	_____
o Hepatitis	_____	_____
o High Blood Pressure	_____	_____
o High Cholesterol	_____	_____
o Hearing Loss	_____	_____
o Heart Disease	_____	_____
o Migraines	_____	_____
o Thyroid Disease	_____	_____
o Cancer	_____	_____
o Other_____	_____	_____

Patient Name _____

Review of Systems: (Please check any of the following symptoms you **currently have** or **had within the past 6 months**)

To the best of my knowledge, none of these listed applies:

_____
Patient Initials

Constitutional □ **No Complaints**
O Fever
O Chills
O Weight loss
O Weight gain
O Loss of appetite
O Possible Pregnancy
O Other and/or Additional Comments_____

Eyes □ **No Complaints**
O Discharge from eye(s)
O Discomfort or Pain (circle one or both)
O Redness
O Dry and/or itchy (circle or both)
O Changes in vision (explain) _____
O Excessive tearing
O Other and/or Additional Comments_____

Head/ENT □ **No Complaints**
O Headaches
O Vertigo
O Dizziness/lightheaded
O Sinus pain/pressure
O Nasal congestion
O Nasal discharge
O Nosebleeds
O Decreased sense of taste and/or smell (circle one or both)
O Nasal obstruction
O Deviated Septum
O Post nasal drip
O Frequent throat clearing
O Hoarseness and/or Change in voice (circle one or both)
O Ear Pain
O Ear pressure/fullness
O Ear discharge and/or bleeding (circle one or both)
O Itching in ear
O Hearing loss
O Ringing and/or roaring sound in ears (circle one or both)
O Noise exposure
O Swollen glands
O Enlarged tonsils and/or adenoids (circle one or both)
O Lump sensation-throat and/or Difficulty Swallowing (circle one or both)
O Dental problems
O Recent head/ENT injury (explain)_____
O Mass/Abscess /New lesion (location and duration)_____
_____
O Sore throat

Cardiovascular/Respiratory □ **No Complaints**
O Chest pain
O Rapid and/or irregular heart beat (circle one or both)
O Shortness of breath
O Cough
O Other and/or Additional Comments_____

Gastrointestinal □ **No Complaints**
O Nausea
O Vomiting
O Diarrhea
O Constipation
O Jaundice
O Other and/or Additional Comments_____

Integument &Endocrine □ **No Complaints**
O Rash
O Itching
O New lesion/lumps(explain)_____
O Hair loss
O Intolerance to heat and/or cold(circle one or both)
O Other and/or Additional Comments_____

Neurologic & Psychiatric □ **No Complaints**
O Loss of balance
O Tingling or numbness
O Tremors
O Seizures
O Memory and/or concentration (circle one or both)
O Anxiety
O Depression
O Difficulty Sleeping
O Suicidal ideation
O Other and/or Additional Comments_____

Musculoskeletal □ **No Complaints**
O Joint pain and/or swelling (circle one or both)
O Muscle pain and/or weakness (circle one or both)
O Other and/or Additional Comments_____

Heme-Lymph □ **No Complaints**
O Enlarged/swollen lymph nodes
O Easy Bruising
O Easy bleeding
O Lightheadedness
O Other and/or Additional Comments_____
_____

Patient Name _____

Hearing history

To the best of my knowledge, none of these listed applies

_____
Patient Initials

Rate the following situations based on hearing/understanding difficulty in order of importance:

__Watching TV	__ Restaurants	__Telephone
__ Parties	__ Conferences/Lectures	__Meetings
__Telephone	__Movies	__Worship Service

__other _____

Which ear do you use on the telephone? □ Right □ Left
Are you left or right handed? □Right □ Left

Hearing aid history

Are you currently using hearing aids? Yes ☐ No ☐

If yes, how long have you had a hearing aid? _____

On which ear do you use the hearing aid? □Right □ Left □ Both

Do you wear it regularly? Yes ☐ No ☐

Do you feel you benefit from it? Yes ☐ No ☐

List any problems you are having with the hearing aid: _____

_____

What would you improve with your current hearing aid? _____

_____

Is there any other information related to your hearing you feel might be important for the Audiologist to know?

_____

Whom should we thank for referring you to Family Hearing Services?

_____

Speech and Language Development (FOR PATIENTS UNDER AGE OF 18)

How do you feel your child's speech, language and basic communication skills are developing?

_____

Is your child currently in speech, occupational or physical therapy?_____

When did he/she speak their first words?_____

Does your child understand what you say to him/her? Yes ☐ No ☐

Do you have any additional concerns or questions about your child's hearing, communication skills or overall development?

_____

_____

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RESET FORM PRINT FORM EMAIL FORM