BOULDER VALLEY
Hearing Associates

BOULDER VALLEY
Ear, Nose & Throat

Provider: JDW/DDM/ACG/DAM
MBB/JTL/MEG/ALLERGY

AU.D.: SD/GM/KG/SW/NN

NEW UPDATE

PATIENT INFORMATION- Please read and complete this form as fully as possible. Please read and initial the back page.

_____ _____ _____ _____

FIRST NAME ***M.*** ***LAST NAME*** ***PREFERRED NAME***

Sex: M F **D.O.B.** _____ **AGE:** _____ **MARITAL STATUS:** S M D W

_____ _____ _____ _____ _____

HOME ADDRESS ***APT#*** ***CITY*** ***STATE*** ***ZIP***

HM PH# _____ **WK PH#** _____ **CELL#** _____

WHICH NUMBER SHOULD WE CONTACT TO LEAVE A MESSAGE? **HOME** **WORK** **CELL**

EMPLOYER _____ **EMAIL** _____

REFERRING DOCTOR _____ **CLINIC NAME** _____

PRIMARY DOCTOR _____ **CLINIC NAME** _____

PRIMARY INSURANCE COMPANY _____

POLICY HOLDER NAME_____ **RELATIONSHIP TO PATIENT** _____

D.O.B. _____ **EMPLOYER**_____**POLICY HOLDER PH #** _____
MM/DD/YYYY

SECONDARY INSURANCE COMPANY _____

POLICY HOLDER NAME _____ **RELATIONSHIP TO PATIENT**_____

D.O.B. _____ **EMPLOYER** _____**POLICY HOLDER PH#** _____
MM/DD/YYYY

IN CASE OF EMERGENCY, WHO SHOULD WE CONTACT?

CONTACT NAME: _____ **RELATIONSHIP TO PATIENT:** _____

_____ _____ _____ _____ _____

HOME ADDRESS ***APT#*** ***CITY*** ***STATE*** ***ZIP***

D.O.B _____ **HM #**_____ **CELL #** _____

BY SIGNING BELOW, I AM ACKNOWLEDGING THAT THE ABOVE INFORMATION IS CORRECT AND THAT I HAVE READ **AND UNDERSTOOD THE** INFORMATION ON THE REVERSE SIDE OF THIS FORM. I AM ALSO AUTHORIZING THE BILLING OF THE ABOVE-MENTIONED INSURANCE COMPANIES. **Note:** It is very important that you take a moment and read the back of this document for information regarding billing and a HIPAA notification.

_____ _____

Patient or Guarantor Signature ***Today's Date***

FINANCIAL POLICY

Please Note: Complete insurance and personal information is required at the time of your visit in order for our office to file a claim with your insurance. If this information is not provided at the time of your visit, we require payment in full. In lieu of payment in full, we will hold a current credit card copy for 5 business days as a courtesy to you. If at the end of 5 days we have not received the missing information, your card will be charged any balance due at that time. *****Questions regarding your insurance coverage and benefits are best directed to, and answered by your insurance company.

Contracted Insurance Plans **Patient Initials _____**

Boulder Valley Ear, Nose & Throat (BVENT) is contracted with most major PPO commercial insurance companies. The patient is responsible for calling their insurance company to ensure we are in-network with their specific policy and inquire if a referral is required.

Non-Contracted Commercial Insurance, Travel Insurance, Out of Country Insurance

In the absence of a contract, BVENT is unable to financially hold your insurance responsible for your visit. As a result, you will be responsible for paying any charges in full at the time of your visit.

Medicare

We will file Medicare claims on your behalf. Please provide any supplemental insurance information to the front desk at the time of your service. Clearly indicate whether a plan is a replacement or a supplemental plan.

Copays/Co-Insurance/Deductibles **Patient Initials _____**

Copays specified by your plan (usually indicated on your insurance card), must be collected when you arrive for your appointment. Please be aware that insurance companies instruct medical offices to reschedule appointments in the event a copay is not provided. Co-Insurance/Deductible: Should your plan include co-insurance or detectible, BVENT reserves the right to collect resulting balances at the time of your service or prior to surgeries.

Charges **Patient Initials _____**

Multiple and separate charges may be incurred during the course of your visit. Your provider may utilize various diagnostic instruments, order tests, or perform in-office surgical procedures in order to render appropriate medical care. This may result in extra out of pocket costs such as deductible, co-pay, co-insurance. Insurance companies define charges for a procedure involving the usage of diagnostic instruments as surgical. This will be reflected on the "Explanation of Benefits" you receive from your insurance company. ***If you have questions or concerns regarding a possible procedure and associated costs, please ask to speak with a representative in our billing department.***

Injury Related Claims (Worker's Comp, Auto, and Personal Injury)

We will file the above-mentioned claims on your behalf. YOU MUST PROVIDE A WORKERS COMP/AUTO CLAIM NUMBER, claim address, phone number and case manager's name. Should the required information be unavailable, payment will be due at the time of your visit. Alternately, you may reschedule your appointment. We are unable to provide treatment on a lien basis.

Account Balance **Patient Initials _____**

Patient statements are mailed out at the beginning of each month. Account balances are due within 30 days of receipt. Short term payment plans may be considered in special cases (call 303.443.2771 to speak with a representative). We participate with the patient payment program Care Credit (to apply go to www.carecredit.com) and Key Bank. Please ask the front desk for additional information. Abandoned or delinquent accounts will be forwarded to a collection agency. There is a $45 fee for NSF checks per incident.

HIPAA (Health Information Privacy Act) **Patient Initials _____**

Boulder Valley Ear, Nose & Throat Assoc., P.C., Adhere to the patient privacy guidelines stated in the Boulder Valley Privacy Practices document. A copy of this document is available to you upon request. You may also view a digital copy on our website.

MISSED APPOINTMENTS **Patient Initials _____**

KINDLY GIVE A MINIMUM OF 24 HOURS NOTICE TO RESCHEDULE OR CANCEL YOUR APPOINTMENT. FAILURE TO GIVE NOTICE WILL INCUR A $50 FEE FOR REGULAR APPOINTMENTS OR A $100 FEE FOR MISSED SURGERIES.

Medical History Form

Patient Name: _____ M/F DOB: _____

DRUG ALLERGIES/REACTIONS: _____

MEDICATIONS CURRENTLY TAKING: _____

_____

PHARMACY NAME: _____ **CROSS STREETS/LOCATION:** _____

Patient Medical History

☐ **No significant Medical History**

Yes	☐	Acute Myocardial Infarction (Heart Attack)	Yes	☐	Hearing Loss
Yes	☐	Allergic rhinitis	Yes	☐	Hypercholesterolemia (High Cholesterol)
Yes	☐	Alzheimer's Dementia	Yes	☐	HIV
Yes	☐	Anemia	Yes	☐	Hypertension (High Blood Pressure)
Yes	☐	Arthritis	Yes	☐	Migraine Headache
Yes	☐	Cataract	Yes	☐	Osteoporosis
Yes	☐	**Cancer**	Yes	☐	Psychiatric Disorders
Yes	☐	Breast Cancer	Yes	☐	**Respiratory Disorders**
Yes	☐	Lung Cancer	Yes	☐	Asthma
Yes	☐	Prostate Cancer	Yes	☐	Tuberculosis
Yes	☐	Thyroid Cancer	Yes	☐	COPD
Yes	☐	Coronary Artery Disease	Yes	☐	Seizure Disorder
Yes	☐	Diabetes Mellitus	Yes	☐	Sleep Apnea
Yes	☐	GERD	Yes	☐	Stroke
Yes	☐	Glaucoma	Yes	☐	Thyroid Disorders
Yes	☐	Gout	Other:		
Yes	☐	**Hepatic Disorder**			
Yes	☐	Hepatitis A			
Yes	☐	Hepatitis B			
Yes	☐	Hepatitis C			

***** Please have your medication list ready for the medical staff. Thank you!**

Boulder Valley Ear Nose and Throt Assoc., P.C.

EMR Entered _____

Surgical History

☐ No Surgical History

Yes ☐ Adverse reaction to Anesthesia

Yes ☐ Easy Bruising Tendency

Yes ☐ Easy Bleeding

ENT Surgeries

Yes ☐ Tonsillectomy

Yes ☐ Adenoidectomy

Yes ☐ Thyroid Surgery

Yes ☐ Tubes

Yes ☐ Mastoidectomy

Yes ☐ Tympanoplasty

Yes ☐ Sinus Surgery

Yes ☐ Septoplasty

Yes ☐ Turbinate Reduction

Yes ☐ Polypectomy

Yes ☐ UPPP

Other _____

OTHER Surgeries

Yes ☐ Appendectomy (Appendix Surgery)

Yes ☐ Breast Surgery

Yes ☐ Cardiovascular Surgery (Heart Surgery)

Yes ☐ C-section Delivery

Yes ☐ Cholecystectomy (Gall Bladder Surgery)

Yes ☐ Hernia Repair

Yes ☐ Hysterectomy

Yes ☐ Lung Surgery

Yes ☐ Oral Surgery

Yes ☐ Orthopedic Surgery

Yes ☐ Renal Surgery (Kidney Surgery)

Other _____

Family Medical History

☐ No significant Family Medical History

Yes ☐ Anesthesia Reaction

Yes ☐ Bleeding Problems

Yes ☐ Cancer

Yes ☐ Hearing Loss

Yes ☐ Migraine Headache

Yes ☐ Thyroid Disorder

Social History

Yes ☐ Alcohol use: # __drinks p/Week
_____p/Day

Yes ☐ Tobacco use: #____ packs a day

Yes ☐ History of smoking ___ years, year quit _____

Yes ☐ Drug use

Yes ☐ Marijuana

_____ _____

Patient Signature ***Date***

Boulder Valley Ear Nose and Throt Assoc., P.C.

EMR Entered _____