

OCEAN OTOLARYNGOLOGY ASSOCIATES

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NOTICE OF PRIVACY ACTS

This is to certify that I _____ allow my medical information only be released to:

Family members (include relation): _____

Medical Doctors : _____

OR

I do not wish to have any of my health related information released to anyone other than myself.

PLEASE CHOOSE ONE:

I give permission to leave a message in regards to blood work results, outside testing, appointments, etc. either on my answering machine or with a family member who answers my home telephone.

OR

If I am unable to be reached by phone, no messages pertaining to myself are to be left on my home answering machine or with a family member except for appointment reminders.

*Any changes of patient release information must be given in writing,
verbal requests for changes will not be honored.*

Signature: _____

Date: _____

Print Name: _____

PATIENT FOLLOW-UP PLEDGE

I, _____ (print name), hereby acknowledge and understand that even with the best training, skill and experience, a medically trained professional is not always capable of solving my medical problems. Therefore, I understand it is important that any and all recommendations by doctors are followed completely in order to increase the likelihood of a positive and healthy treatment/outcome.

I understand that it is solely my responsibility to follow any of the medical advice given by any medical person in this office and any bad health outcome from my failure to follow the advice of the doctors should be expected.

Signature: _____

Date: _____

Print Name: _____

OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. The following is a statement about our Financial Policy which we request you read and sign prior to any treatment.

REGARDING INSURANCE:

All copayments are due at time of service. If we are a participating provider with your insurance company, we will be happy to submit your claim. We accept usual and customary rates from the insurance companies; however you will be responsible for any co-pays, co-insurance, or deductibles due to us. If your insurance plan requires you to obtain a referral from your Primary Care Doctor, and if that referral is not given to the office at the time of service, you may be financially responsible for that office visit. In the event that your insurance coverage changes to a plan where we are not participating providers, you will be responsible for the balance at the time of your visit. Regarding Medicare, we do accept assignment. However, if you do not have a supplemental insurance, the 20% co-insurance is your responsibility and due at the time of service. We do not accept Cobra, Workman's Comp., or Auto/Accident Insurance. **As an ears, nose, and throat specialty office, it may be required for the physician to use diagnostic instruments to achieve a treatment plan. You're insurance company may categorize this as a surgical procedure. Based on your insurance and the type of plan you have, this may require us to bill you for this procedure.**

FINANCIAL INTEREST DISCLOSURE

Public law/rule of the State of New Jersey/Board of Medical Examiners mandates that a physician, podiatrist and all other licensees of the Board of Medical Examiners inform patients of any significant financial interest held in a health care service. Accordingly, take notice that practitioners in this office do have a financial interest in the following health care services to which patients are referred:

BEY LEA AMBULATORY SURGICAL CENTER

You may, of course, seek treatment at a health care service provider of your own choice. A listing of alternative health care service providers can be found in the classified section of your telephone directory under the appropriate heading.

CANCELLATION POLICY

We reserve the right to charge a patient **\$25.00** if they do not show for their scheduled appointment, or if a patient cancels less than 24 hours prior to their appointment. We will not charge you this amount in the case of an emergency or work/school related issue. However, after 3 no shows/cancellations, patient will be billed the cancellation fee.

ASSIGNMENT OF BENEFITS:

I hereby authorize assignment and payment of all my medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans, directly to Ocean Otolaryngology Associates. I have read the Financial Policy. I understand that I am financially responsible for all charges whether or not paid by said insurance.

Signature of Responsible Party: _____ Date: _____

Patient Name (print): _____

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54 Bey Lea Road

61 Lacey Road

1673 Route 88

Toms River, NJ 08753

Whiting, NJ 08759

Brick, NJ 08724

PATIENT DEMOGRAPHIC FORM

Date: _____

First Name: _____ Last Name: _____ M.I. _____

Date of Birth: _____ Sex: _____ SSN: _____ Marital Status: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____ x _____

E-mail address: _____ Do not wish to share e-mail Do not have e-mail

Employment Status: _____ Student Status: _____

Race: American Indian or Alaska Native Asian Native Hawaiian or Other Pacific Islander

Black or African American Caucasian/White Hispanic Other _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino Language: _____

Responsible Party: Self Other: _____

Are you a former patient? Yes No Year _____ Office Hospital

Drug Allergies: _____

Emergency Contact: _____ Relation: _____

Phone: _____ Address: _____

Primary Care Physician: _____ Referring Physician: _____

Address: _____ Address: _____

Pharmacy: _____ Address: _____ Phone: _____

How did you hear about us? Primary Care Physician Other Healthcare Physician Family/Friend

Office Website Newspaper/Ocean County Women Facebook Internet Emergency Dept.

Insurance Company Other: _____

Insurance Information:

1) _____ Subscriber Dependent

ID #: _____ Grp # _____ Copay: _____

2) _____ Subscriber Dependent

ID #: _____ Grp # _____ Copay: _____

If Dependent:

Insured's Name: _____ Relationship to subscriber: _____

Address (including city, state, zip): _____

Date of Birth: _____ Phone: _____

I authorize the release of any information related to claims on behalf of myself. I acknowledge that my signature authorizes this office to submit claims for services rendered, and serves as an assignment of benefits to my physician. I further understand that even though the physician's office will submit to my insurance company, the bill is ultimately my responsibility, and I agree to payment in a timely manner. For participating insurance companies, the proper referral or precertification must be presented for complete coverage. **FAILURE TO OBTAIN A REFERRAL OR PREAUTHORIZATION PRIOR TO THE VISIT WILL RESULT IN ME BEING FINANCIALLY RESPONSIBLE FOR THE VISIT.**

Signature: _____

Date: _____

Name _____

Age: _____

Date _____

Past Medical History:

Do you suffer from any of the following?

Review of Systems:

Do you suffer from any of the following?

Diabetes (Problems w/ blood sugar)	<input type="checkbox"/>	Change in appetite /	<input type="checkbox"/>
Congestive Heart Failure	<input type="checkbox"/>	Weight Loss	
Angina (chest pain)	<input type="checkbox"/>	Fatigue/Lethargy	<input type="checkbox"/>
Previous heart attack	<input type="checkbox"/>	Headaches	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	Dizziness/Lightheadedness/	
Coronary artery disease	<input type="checkbox"/>	Fainting	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	Blurred Vision	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	Tingling/Numbness	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	Pain	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	Decreased hearing	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	Decreased sense of smell	<input type="checkbox"/>
Bleeding disorders/Anemia	<input type="checkbox"/>	Difficulty swallowing	<input type="checkbox"/>
Thyroid disorders	<input type="checkbox"/>	Sore throat	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Swollen glands	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	Cough	<input type="checkbox"/>
Migraine headaches	<input type="checkbox"/>	Hemoptysis	<input type="checkbox"/>
Kidney disorders	<input type="checkbox"/>	Shortness of breath	
Gastrointestinal disorders	<input type="checkbox"/>	At Rest	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	With Exertion	<input type="checkbox"/>
Sleep apnea	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>
Rheumatoid arthritis/Osteoarthritis	<input type="checkbox"/>	Cold intolerance	<input type="checkbox"/>
Back or neck problems	<input type="checkbox"/>	Heat intolerance	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	Excessive thirst	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	Chest pain	
Cataracts	<input type="checkbox"/>	At Rest	<input type="checkbox"/>
Sarcoidosis	<input type="checkbox"/>	With Exertion	<input type="checkbox"/>
Hepatitis, cirrhosis, or liver disease	<input type="checkbox"/>	Irregular heart beat	<input type="checkbox"/>
Depression	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>
Prostate problems	<input type="checkbox"/>	Nausea/Vomiting	<input type="checkbox"/>
Difficulty w/ anesthesia	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>
Lupus	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	Difficulty urinating	<input type="checkbox"/>
		Frequent urinating	<input type="checkbox"/>
		Painful joints	<input type="checkbox"/>
		Dry skin	<input type="checkbox"/>
		Itchy skin	<input type="checkbox"/>
		Rashes	<input type="checkbox"/>

OTHER: _____

Past Surgical History:

Please check the box below if you've had:

- Tonsillectomy/Adenoidectomy
- Heart bypass surgery
- Carotid surgery
- Appendectomy
- Gall bladder surgery
- Ear surgery

Other: _____

(If you have a mediation list, please provide a copy)

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____
- 8. _____
- 9. _____
- 10. _____

Do you currently take:

- Garlic
- Gingko Biloba
- Vitamin E
- Aspirin
- Motrin/Ibuprofen/Advil
- Other herbal preparations: _____

Allergies:

- Do you have allergies to medications?
- Please Specify: _____
- Do you have allergies to X-ray contrast?
- Do you have allergies to:
 - Hay fever
 - Pollen
 - Dust
 - Mold
 - Pets
 - Latex

Social History

- Do you now, or have you ever smoked?
- If so, how much do you smoke per day? _____
- If you no longer smoke, when did you quit? _____
- Do you drink alcohol?
- If so, how much daily or weekly? _____
- Do you drink:
 - Coffee How much per day? _____
 - Tea How much per day? _____
 - Soda w/ caffeine How much per day? _____

Family History

Has anyone in your family ever suffered from any of the following?

- Heart disease Who? _____
- Cancer Who? _____
- Thyroid disorders Who? _____
- Early onset hearing loss Who? _____
- Diabetes Who? _____
- Bleeding problems Who? _____
- Other: _____

For Office Use Only:	
ROS Reviewed	<input type="checkbox"/>

History Reviewed: _____