Desert Ear, Nose & Throat

The offices of:

Stuart Barton, M.D., F.A.C.S.
Quinten M. VanderWerf, M.D., F.A.C.S.
Christopher M. Walz, M.D., F.A.C.S
Mark D. Wilson, M.D., F.A.A.O.A
Kari Moeller-Thomas, FNP-C

The office is located on the Eisenhower Medical Center Campus:
39000 Bob Hope Drive
Wright Building 301
Rancho Mirage, CA 92270
Telephone: (760) 340-4566
Fax: (760) 340-2481
Web Address: www.desertent.org

Office Hours:
Monday – Friday 8:30 A.M. – 5:00 P.M.

Enclosed are the new patient forms. Once you have completed all the paperwork, please bring them to your appointment along with your insurance card(s) and a list of medication you may be taking. We ask that you arrive 15 minutes prior to your scheduled appointment time so we can process your paperwork and check you in.

Thank you.
Desert Ear, Nose, & Throat

DO NOT FAX PAPERWORK, HAND CARRY TO APPOINTMENT

DESERT EAR, NOSE & THROAT
OFFICE POLICIES

Today's Date: ______________________________

OFFICE USE ONLY:

DR: ______________________

☐NEW ☐DELETE ☐UPDATE ☐ EMR

IF DELETED PATIENT:

Last seen: ______________________

By Dr: ______________________

PLEASE PRINT CLEARLY

Personal Information *(PLEASE FILL OUT ALL INFORMATION)*

Government requirement for Electronic Health Care reporting

Preferred language: ☐ English ☐ Spanish ☐ Other: ______________________

Race: ☐ White ☐ African American ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ decline

Ethnicity: ☐ Hispanic/Latino ☐ Non -Hispanic/Latino ☐ decline

Patient Name: ______________________ Birth Date ________ Age: ____ Sex: ___
(nombre) (Last) (First) (MI) fecha de nacimiento) (edad) (sexo)

Mailing & Street Address: ______________________
(domicilio)

City: ______________ State: ______________ Zip ________
(ciudad) (estado) (codigo postal)

Local Phone#: ______________ Work Phone: ______________ Cell Phone: ______________
(telefono de casa) (telefono de trabajo) (telefono de celular)

Social Security#: ______-______-______ **(we need your SS# for any testing requested by physician)**
(seguro social) (es necesario para procesar sus examenes de laboratorio o biopsias)

Emergency Contact: ______________ **Relationship:** ______________ **Phone:** ______________
(Contacto de emergencia) (relasion) (telephono)

2nd address (if applicable)

E-MAIL ADDRESS: ______________________

Employment and/or Insurance Information (If patient is a minor we need guardians information)

Employer: ______________________
(Nombre de Empleador)

Insurance: ______________ Policy Holders Name: ______________
Aseguranza (nombre del asegurado)

SSN: ______________ DOB: ______________ Relationship to Patient: ______________
(Seguro social) (fecha de nacimiento) (relacion al paciente)

DESERT EAR, NOSE & THROAT MEDICAL GROUP **NEW PATIENT HISTORY**

Date of Visit: ______________

Patient's Name: ______________ Birth Date: ______________ Age: ______

Current Primary Care Physician (**FIRST/LAST NAME**) ______________ City & State ______________

Physician Requesting Consult: ______________ City & State: ______________

[1] Reason for Your Visit: ______________

[2] SYSTEM REVIEW: (check all that apply)

Constitutional: ☐ fever ☐ unexpected weight loss
Eyes: ☐ double vision ☐ eye pain
Ears: ☐ hearing loss ☐ ear pain
Throat: ☐ throat pain ☐ hoarseness
Cardiovascular: ☐ chest pain ☐ irregular heart rate
Respiratory: ☐ bloody cough ☐ snoring/apnea
Gastrointestinal: ☐ heartburn ☐ difficulty swallowing
Genitourinary: ☐ urinary blood ☐ difficulty urinating
Musculoskeletal : ☐ joint pain ☐ muscle loss
Skin: ☐ itching ☐ skin lesions
Neurological: ☐ tremors ☐ numbness
Psychiatrics: ☐ anxiety ☐ panic attacks
Endocrine: ☐ heat /cold intolerance ☐ thyroid nodule
Hematologic: ☐ clotting disorders ☐ anemia
Allergy: ☐ sneezing ☐immune system disorders

PAST MEDICAL HISTORY (CHECK ALL THAT APPLY)

☐Diabetes ☐High blood pressure ☐Heart disease
☐Stroke ☐Asthma/Lung disease ☐Bleeding Disorder
☐Stomach/Intestinal/Ulcers ☐Kidney ☐Prostate
☐Glaucoma ☐Tuberculosis
☐Need to take antibiotic: before seeing dentist
☐Cancer **(Please Specify)** ______________
☐Other: **(Please specify)** ______________

PAST SURGICAL HISTORY: (check all that apply)

☐ Ear Surgery Please specify: ______________
☐ Tonsils/Adenoid Surgery
☐ Appendectomy
☐ Gallbladder Surgery
☐ Hernia Repair
☐ Hysterectomy
☐ Thyroidectomy
☐ Pacemaker Placement
☐ Eye Surgery. **Please specify**: ______________
☐ Cosmetic Surgery **Please specify**: ______________
☐ Sinus **Please Specify**: ______________
☐ Other: ______________

PLEASE PROVIDE CURRENT MEDICATION LIST (include dose & frequency):

☐Aspirin ☐Coumadin ☐ Plavix ☐ Xarelto ☐ Eliquis

DRUG ALLERGIES &REACTIONS ______________

Have you had your flu vaccine? ☐ **Yes** ☐ **No**
If yes, when: ______________

Preferred Pharmacy and Location (Cross Street & Zip Code)

____

Do you authorize our practice to access your prescription history through your insurance company? ☐ **Yes** ☐ **No**

[4] SOCIAL HISTORY:

Marital Status: ☐ **Single** ☐ **Married** ☐ **Domestic Partner** ☐ **Divorced** ☐ **Widowed**
Type of work: ______________
How much do you smoke daily? ______________
If you smoked in the past, when did you quit? ______________
History of heavy alcohol use? ☐ YES ☐ NO
How much alcohol do you drink daily? ______________
Street Drugs? ______________

FAMILY HISTORY: Do any of your relative have:

☐ Bleeding Disorder ☐ Early Hearing Loss ☐ Vertigo
☐ Thyroid Cancer
If "YES", **specify which relative**: ☐ Mother ☐Father ☐Sister ☐Brother ☐Grandmother ☐Grandfather
☐other: ______________

DESERT EAR, NOSE AND THROAT OFFICE POLICIES

Desert Ear Nose and throat has taken steps to optimize our administrative operations in order to spend more time on patient care. We are deeply committed to the highest quality of patient care and are here to make your experience as pleasant as possible. In order to be successful, we will require your help and cooperation.

<u>Please read our office policies as they are strictly enforced</u>

- Due to increasing changes with Insurance payers; we have implemented a *credit card policy* in which we will require a credit card to be on file. You will sign a separate sheet.
- In order to serve our patients better, we have instituted a *cancellation policy.* If you cannot make it to your appointment please contact us 24 hours in advance to cancel your appointment. If you do not cancel 24 hours in advance you will be charged a no-show fee of $30.00
- *<u>Know your insurance plan and what your benefits are</u>.* If we are not a contracted provider with your insurance we will ask for payment at time services are rendered, however, as a courtesy, we will bill your insurances company. You will be responsible for any remaining balance your insurance company did not cover.
- Co-payments and deductibles are due at the time of service.
- There will be a $36.00 fee for all returned checks (NSF)
- Refill requests should be made through your pharmacy. Please allow 24 - 48 hours for all refill requests to be processed, *excluding weekends and holidays.*
- If your physician has ordered tests, *it is your responsibility to call our office for results.* Do not assume that your tests are negative because your physician has not called you. Please allow three business days for turnaround time for your results.
- You must update our practice with any new insurance and/or demographic information as soon as possible.
- There is a 48 - 72 hour turnaround time for medical records. There will be up to a $25.00 fee that due at the time the request is made. If the records are in storage the fee is $8.00 in addition to the record copy fee.
- There will be a fee up to $25.00 charge for the first disability; social security forms $15.00 thereafter for any additional form(s).
- If you call and leave a message for your physician, we ask that you be patient. All phone calls are returned by the end of the business day. *IF YOU ARE NOT AVAILABLE, THE PHYSICIANS/STAFF MAY LEAVE A MESSAGE ON A MACHINE REGARDING YOUR REQUESTS, RESULTS, OR HEALTH INFORMATION (unless you decline, see below)*
- *Authorization for release of medical information.* I hereby authorize Desert Ear, Nose and Throat to release any and all medical records to my insurance company in order to process this or any future medical claims with this office.
- *Financial Policy*: I understand that I am financially responsible for payment due at the time services are rendered by Desert Ear, Nose & Throat. This includes payment in full or any deductibles, co-payment and co-insurance amounts which apply at the time of services.
- The physicians/staff at Desert Ear Nose & Throat are given the authority, by the patient/guardian, to leave a message on a machine in the event you are not available, The message, may pertain to results, health information, appointments and/or any other information that you may have discussed with your physician. ***<u>IF YOU AUTHORIZE FOR DESERT EAR NOSE AND THROAT TO LEAVE A MESSAGE ON A MACHINE OR TO SPEAK WITH ANYONE OTHER THAN YOURSELF, INITIAL HERE</u>:*** ______________________.

  (Initial)

  If you ***<u>DO NOT</u>*** wish for Desert Ear Nose and throat to leave a message on a machine or to speak with anyone other than yourself initial here: ____________________.

  (Initial)

______________________	______________________	____________
Patient Name (please print)	**Patient and/or Guardian Signature**	**Date:**

FINANCIAL INTEREST DISCLOSURE

Please be advised that certain physician employees of Desert ear, Nose & Throat Medical Group, Inc., a California Medical Corporation, are also owners and have a financial interest in the following facilities:

Hearing Institute of the Desert 39000 Bob Hope Drive, Wright Building, Suite 301A Rancho Mirage California 92270	Rancho Mirage Surgery Center 35800 Bob Hope Drive Suite 100 Rancho Mirage, CA 92270
Eisenhower Balance Institute 39000 Bob Hope Drive, Wright Building, Suite 309 Rancho Mirage, CA 92270	X-Ray Computed Tomography (CT SCAN) at Desert Ear, Nose & Throat 39000 Bob Hope Drive, Wright Building, Suite 307 Rancho Mirage, CA 92270

You may be referred to the Hearing Institute of the Desert, Rancho Mirage Surgery Center, Eisenhower Balance Institute or the X-Ray Computed Tomography to obtain medical services and/or equipment that each of these facilities offers. You have absolutely no obligation to obtain medical services and/or equipment from these facilities. There are medical practitioners and competing businesses other than these facilities that can provide you the same type of services and/or equipment.

______________________________ ______________________________ ____________

(Name of patient – PLEASE PRINT) **(Patient or legal guardian signature)** **(Date)**

MEDICARE & MEDICARE/MEDI-CAL ASSIGNMENT OF BENEFITS

Name: ______________________________ Medicare#: ______________________________

I request that payment of authorized Medicare Benefits be made either to me or on my behalf to Desert Ear, Nose & Throat Medical Group, Inc., Dr. Stuart Barton, Dr. Quinten VanderWerf , Dr. Christopher Walz , Dr. Mark D. Wilson and Kari Moeller, FNP for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents and information needed to determine these benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance coverage is indicated in item 9 of the HCFA-1500 claim form or elsewhere on other approved claim information to the insurer or agency shown. In Medicare assigned cases the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and non-covered services.

Co-insurance and deductibles are based upon the charge determination of the Medicare carrier.

IMPORTANT INFORMATION, PLEASE READ

Eisenhower Balance Institute, (this location), is not a Medi-cal provider. You will be responsible for your co-insurance/deductibles after Medicare's payment for services done at this location, all co-pays/co-insuance are due at the time of service

______________________________ ______________________________

(Signature) **(Date)**

Stuart Barton, M.D., F.A.C.S.
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Kari Moeller, FNP

PRIVACY PRACTICES ACKNOWLEDGMENT NOTICE

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used along the following guidelines:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physical certifications.

I have received, read and understood your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it's Notice of Privacy Practices from time to time and that I may contact this organization and any time at: Desert Ear, Nose & Throat 39000 Bob Hope Drive, W301, Rancho Mirage, CA 92270 to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private health information is used or disclosed to carry out treatment, payment and or healthcare operations. I also understand you are not required to agree with my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

____

Patient Name (please print)

____

Relationship to patient:

____

Signature of patient/guardian

____

Date

Credit/Debit Card Pre-Authorization Form

I, ______________________________, hereby authorize Desert Ear, Nose & Throat Medical Group ("DENT") to charge my credit/debit card for the balance owing on my account for services rendered by DENT that remains unpaid more than sixty (60) days after my insurance carrier has issued an Explanation of Benefits (EOB) for such services. This will allow you to receive 1 or 2 billing statements, giving you time to pay on the account before your credit/debit card is charged.

In conjunction with HIPAA regulations, all credit/debit card information shall be confidentially kept within your medical chart in our office. Only authorized staff will be able to access this information.

Should you choose not to leave a credit card on file our office will call your Insurance carrier to verify any deductible, co-pay and coinsurance that can be collected at the time of service. You will then be required to pay that amount upon checkout.

X__________________________________ X______________________________

Patient/Guarantor Signature Date Staff Signature Date

Billing Address____

______________________________________ Zip Code______________

Type of Credit/Debit Card (please circle one) VISA MasterCard Discover American Express

Card Number _________-_________-_________-_________ Exp date ____ / ____

Security Code ___________

Card holder's name (please print) _________________________________

******Please be prepared to show card to our front desk receptionist******