Desert Ear Nose & Throat
The offices of:

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

The office is located on the Eisenhower Health Campus
(Formally known as Eisenhower Medical Center)
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 through 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 with you to your appointment along with your insurance card(s) and a list of medications 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
Medical & Surgical Care of the Senses

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.
Mark J. Maslan, M.D.
Mark Dome, M.M.S., P.A.
Kari Moeller, M.S., FNP-BC

Welcome!

Thank you for choosing *Desert Ear, Nose & Throat Medical Group*. We realize that you have a choice in medical providers and are pleased that you have chosen to seek care with us. The staff at *Desert Ear, Nose & Throat Medical Group* are here to assist you and we strive to exceed expectations in care and service. Our office have implemented policies below that enable us to make your experience as efficient as possible.

New Patient Paperwork:

Please fill out your paperwork PRIOR to your appointment with our practice. We understand that there may be questions that you do not understand and may need assistance and our staff are here to help. However, please fill out as much as possible to the best of your ability. If it is not completed, you may be asked to reschedule your appointment as you may be preventing another patient from being seen at their scheduled appointment time.

- ***Reminder: Please bring your photo ID, Insurance card and if applicable, a list of your current medications.***

Arbitration Agreement:
Our Doctors have an Arbitration Agreement that require the patient or a guardian's signature. If you do not wish to sign the Arbitration Agreement you will need to seek care from another physician or practice. Please do not question the front office staff or ask for exceptions; they are carrying out the protocols and policies of this office which have been in place for many years.

Harassment of Staff:
At Desert Ear Nose and Throat Medical Group we strive to do our best to assist patients with any questions or needs that may arise. Please be courteous to the staff who are trying to assist you. Our office does not tolerate harassment of any sort i.e., bullying, profanity and/or shouting. Patients who harass the staff will be asked to leave the premises immediately and will not be seen in the future.

Wait time:
Here at Desert Ear, Nose & Throat Medical Group, we understand your time is valuable and we do our best to keep your appointment as timely as possible. However, there will be times that your physician will be behind due to unforeseeable circumstances. Please be patient and our office staff will keep you appraised if your physician is running behind. If you need to re-schedule due to time constraints please notify our office staff and they will assist you.

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure Section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services _____
Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____
Patient's or Patient Representative's Signature Date

By: _____ _____
Physician's or Authorized Representative's Signature Date

Print Patient's Name

DESERT EAR, NOSE & THROAT
39000 Bob Hope Dr., W-301 • Rancho Mirage, CA 92270
Print or Stamp Name of Physician,
Medical Group, or Association Name

_____
(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.

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:** _____

Primary Care Physician (FIRST/LAST NAME)_____City/State/ Phone:_____

Cardiologist (if any): _____ City/State/phone: _____

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: _____

OFFICE POLICIES

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.

Please read our office policies as they are strictly enforced

- 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

- *Know your insurance plan and what your benefits are*. 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. ***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:*** _____.
  (Initial)
  If you ***DO NOT*** 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:

DESERT EAR NOSE & THROAT
Medical & Surgical Care of the Senses

Stuart Barton, M.D., F.A.C.S.
Quinten M. Vanderwerf, M.D., F.A.C.S.
Christopher Walz, M.D., F.A.C.S.
Mark D. Wilson, M.D., F.A.A.O.A.
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

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.

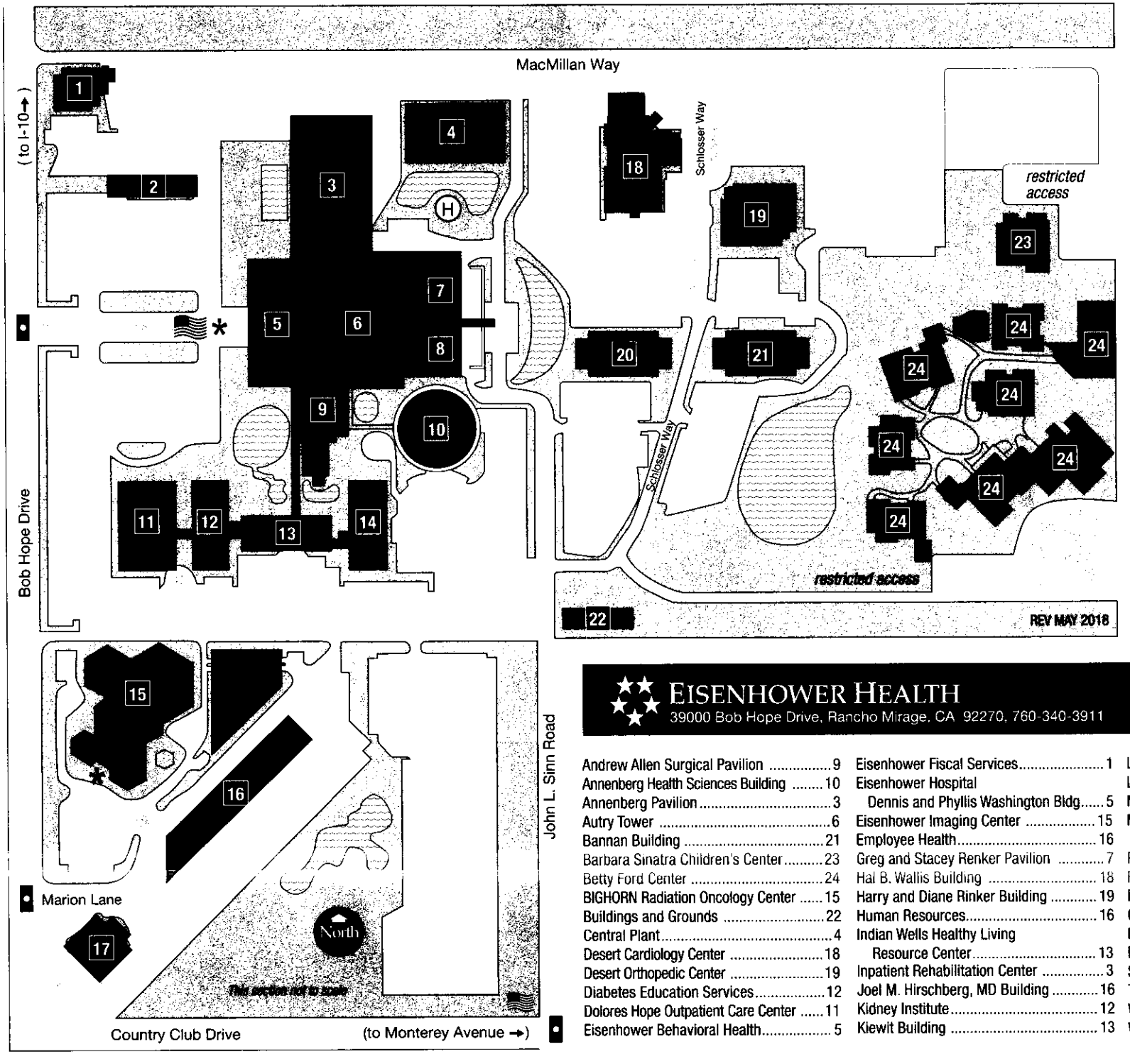
Co-insurance and deductibles are based upon the charge determination of the Medicare carrier.

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

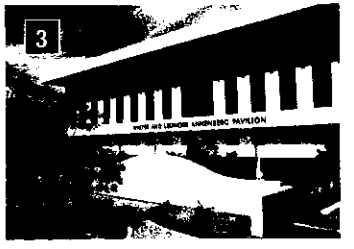
_____ _____

(Signature) **(Date)**



The Annenberg Pavilion vs. the Annenberg Health Sciences Building

The Annenberg Pavilion refers to the hospital wing attached to the north side of the original hospital. Access is through the main lobby of the hospital.



The Annenberg Health Sciences Building, the round building located at the rear of the hospital, hosts community events and lectures and houses Graduate Medical Education.

EISENHOWER HEALTH

39000 Bob Hope Drive, Rancho Mirage, CA 92270, 760-340-3911

- Andrew Allen Surgical Pavilion 9
- Annenberg Health Sciences Building 10
- Annenberg Pavilion 3
- Autry Tower 6
- Bannan Building 21
- Barbara Sinatra Children's Center 23
- Betty Ford Center 24
- BIGHORN Radiation Oncology Center 15
- Buildings and Grounds 22
- Central Plant 4
- Desert Cardiology Center 18
- Desert Orthopedic Center 19
- Diabetes Education Services 12
- Dolores Hope Outpatient Care Center 11
- Eisenhower Behavioral Health 5
- Eisenhower Fiscal Services 1
- Eisenhower Hospital
  - Dennis and Phyllis Washington Bldg 5
- Eisenhower Imaging Center 15
- Employee Health 16
- Greg and Stacey Renker Pavilion 7
- Hal B. Wallis Building 18
- Harry and Diane Rinker Building 19
- Human Resources 16
- Indian Wells Healthy Living
  - Resource Center 13
- Inpatient Rehabilitation Center 3
- Joel M. Hirschberg, MD Building 16
- Kidney Institute 12
- Kiewit Building 13
- Labtechniques 11
- Lucy Curci Cancer Center 15
- Materials Management/Purchasing 17
- Mike and Jan Salta Health Center at Uihlein 20
- Peri Building 17
- Probst Building 12
- Prostate Program 15
- Quality Department 2
- Rehabilitation Services 11
- Renker Wellness Center 18
- Schnitzer/Novack Breast Center 15
- Tennity Emergency Department 8
- Wound Care Center 21
- Wright Building 14

* *Valet Parking*