CANYON SKY ENT
Comprehensive Ear Nose & Throat Care

2151 E. Pecos Rd. • Suite 1 • Chandler, AZ 85225

www.canyonskyent.com

Today's Date:	Email:

Patient Information

Patients Last Name:	First:	Middle:

Preferred Language: ☐ English ☐ Other	Race: ☐ White ☐ Black / African American ☐ Asian ☐ Other ☐ Decline	Ethnicity: ☐ Non-Hispanic ☐ Hispanic ☐ Other

Date of Birth:	Gender: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Other

Street Address:	Home Phone #:

City:	State:	Zip Code:	Cell #:

Occupation:	Employer:	Work #:

Preferred Contact: ☐ Phone Call ☐ Text ☐ Email

Emergency Contact Person:	Relationship:	Phone #:

Physician Information

Referring Physician:	Phone #:	Address:

Primary Care Physician:	Phone #:	Address:

Pharmacy:	Cross Streets:	Phone #:

Medical Insurance

Primary Insurance:	Address to Mail Medical Claims To (back of card):

Subscriber's Name:	Date of Birth:	Policy/Member ID:	Group #:

Patient's relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other :

Secondary Insurance:	Address to Mail Medical Claims To (back of card):

Subscriber's Name:	Date of Birth:	Policy/Member ID:	Group #:

Patient's relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other :

How Did You Find Us?

☐ Referring Physician ☐ Friend/Family ☐ Internet ☐ Website ☐ Health Plan Directory ☐ Other

Guarantor Information: *(Person to be billed, if different from patient)*

Last Name:	First Name:	Middle:

Date of Birth:	Employer:

Address:	Apt #:

City:	State:	Zip:

Home Phone:	Work Phone:	Cell Phone:

AUTHORIZATION / RELEASE of MEDICAL INFORMATION

I acknowledge that I have been offered a copy (available at front desk) of the Privacy Notice from Canyon Sky ENT, and authorize the following list of people who may receive my Protected Health Information. I understand that I may revoke this authorization at any time by giving written notification to the office.

These people along with any referring, or primary care physicians listed on the patient information sheet may receive my Protected Health Information:

1. Name: _____ Date of Birth:_____ Phone #:_____

   Relationship to Patient: ☐ Spouse ☐ Child ☐ Parent ☐ Other

2. Name: _____ Date of Birth:_____ Phone #:_____

   Relationship to Patient: ☐ Spouse ☐ Child ☐ Parent ☐ Other

3. Name: _____ Date of Birth:_____ Phone #:_____

   Relationship to Patient: ☐ Spouse ☐ Child ☐ Parent ☐ Other

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

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

I have received, read and understand 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 its Notice of Privacy practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

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

X_____ _____

Signature of the patient or responsible party Date

_____

Print Name of Above

FINANCIAL AND BILLING POLICY

Welcome to Canyon Sky ENT. It is our pleasure to serve the East Valley community. We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please read the following office policies. If you have any questions, please ask a staff member for answers to your needs.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. WE WILL REQUEST TO PHOTOCOPY YOUR INSURANCE CARD(S) FOR YOUR FILE.

- REFERRALS – If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral, we may need to reschedule your appointment, or you will be personally responsible for that day's services.

- CO-PAYMENTS – By law we MUST collect your carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit. Should you not pay at the time of service and we subsequently send you a statement, an administrative fee of $20 may be added to your account.

- OUT OF NETWORK PLANS – You will be responsible for any balance your plan indicates as due on their explanation of benefits form. We will adjust the charges to coincide with your plan's UCR (Usual, Customary and Reasonable) charges. All patients will be responsible for their co-insurance and deductible. If we do not 'participate' with your plan, we will send a courtesy bill to that carrier on your behalf. However, should they not pay your claim within 45 days, you will be responsible for the full amount due. Should you receive payment from your insurance carrier, please forward it to the physician's office.
  Private Insurance Authorization for Assignment of Benefits/Information Release: I, the undersigned, authorize payment of medical benefits to Canyon Sky ENT, for any services furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize any holder of medical information about me to release to my insurance company (or their agent) information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

- SELF-PAY PATIENTS – Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.

- MEDICAL INSURANCE – We participate with many insurance companies, and we will bill them as a service to you. As the responsible party, you are responsible if your insurance company declines to pay for any reason. If you are unsure if we are contracted with your Insurance Company please ask the Front Office before being seen. If you have medical insurance, we are pleased to help you receive your maximum allowance benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy. You will be asked to update your demographic and insurance information periodically, including providing our office with copies of your insurance card(s). We are required to obtain your signature for permission to release information to your insurance carrier annually.

- RETURNED/STOPPED/BOUNCED CHECKS – There will be a $35.00 charge and the original balance due will also be applied.

- PENALTIES & OFFICE BILLING FEES – Once your Insurance companies have settled your claim, you may receive a bill for any balance, which is considered "Patient Responsibility". This may include deductibles, co-payments, co-insurances not paid at the time of service. Please pay your bill promptly. If not paid within ninety (90) days, it may be forwarded to an outside agency. If you need to make any payment arrangements, please do it with the Office Manager.

- MISSED APPOINTMENT & SAME DAY CANCELLATION FEE – Our office will charge a fee of $50.00 for established patients and $100.00 for new patients that does not call 24 hours prior to their appointment to cancel, re-schedule, or they miss their appointment.

- PAYMENT – Cash, Check, MasterCard, Visa, Discover and American Express card are recognized forms of payment.

You are responsible for the timely payment of your account. Should it become necessary for us to use an outside agency to collect payment from you, you will be additionally responsible for whatever charges we incur as a result of this.

X_____ _____

Signature of the patient or responsible party Date

_____

Print Name of Above

PAYMENT POLICY IN-OFFICE PROCEDURES

In addition to an office visit, consultation and examination, your care may also involve office procedures that routinely performed in the evaluation and treatment of Ear, Nose, and Throat conditions. As per customary practice with medical insurance carriers, these office procedures are billed as a distinct procedure from the office visit. Your health plan may categorize these procedures as surgical and apply the fees for these services to you as a copay, co-insurance, deductible, and/or out-of-pocket charge. This is based on your contract with your insurance carrier.

These procedures include, but are not limited to the following:

Nasal Endoscopy *(cpt 31231)*:
This procedure uses the flexible or rigid scope attached to a light source to view areas of the nasal cavities that cannot be viewed by the physician using the standard nasal speculum and head mirror.

Nasal Endoscopy with Debridement or Biopsy *(cpt 31237):*
This is the same procedure as above with removal of crusting or tissue.

Flexible Laryngoscopy *(cpt 31575):*
This procedure involves passing a long thin flexible fiber-optic scope through the nasal cavity and into the throat. The fiber-optic scope enables the physician to visualize areas of the throat not readily seen using laryngeal mirrors.

Flexible Nasopharyngoscopy *(cpt 92511):*
This involves examining both the tissues of the nasal passages AND the pharynx and larynx.

Cerumen Removal *(cpt 69210):*
This involves removal of impacted ear wax from the ear canal.

Microscope Exam *(cpt 92504):*
The use of a microscope is sometimes used in assisting the physician to clean out the ears or in instances when they need to look deeper into the ear due to infection or a foreign body.

*Hearing exams, even though considered diagnostic testing, will sometimes get applied to a patient's deductible. CPT codes for Hearing Exams: 92557 & 92567.

By signing this form, you acknowledge that you are aware of this policy and understand that you are responsible for any of the associated fees.

Patient Name (Print)_____

X_____ _____

Signature of the patient or responsible party Date

Patient Clinical Information

Last Name: First Name: Middle: Date of Birth:

Reason for Visit:

Social History:

Do you smoke?	☐ No, never	☐ No, quit	☐ Yes Packs per day _____x_____years
Do you drink alcohol?	☐ No, never	☐ No, but used to	☐ Yes How many drinks? _____day/week
Illicit drug use?	☐ No, never	☐ No, but used to	☐ Yes Which drug?

Past or Current Medical Illnesses: *check all that apply*

Hypertension (High Blood Pressure) ☐	Acid Reflux ☐	HIV ☐	DVT (deep vein thrombosis) ☐
Atrial fibrillation ☐	Heart Disease ☐	Bleeding Disorder ☐	Elevated Cholesterol ☐
Lung Disease (COPD, Asthma) ☐	Stroke ☐	Thyroid Disease ☐	Coronary Artery Disease ☐
Sleep Apnea ☐	Diabetes ☐	Kidney Failure ☐	Hepatitis B or C ☐

Cancer (*Please List*):

Other Medical Problems not listed:

Do you have a Pacemaker? Yes ☐ No ☐ | Any problems with hearing? ☐ Yes ☐ No

Past Surgeries (Operations): *check all that apply*

Ear Tubes ☐	Year:	Adenoidectomy ☐	Year:	Other Surgeries (*please list*):	
Tympanoplasty ☐	Year:	Thyroidectomy ☐	Year:		Year:
Mastoidectomy ☐	Year:	Cardiac Stents ☐	Year:		Year:
Sinus Surgery ☐	Year:	Cardiac Bypass ☐	Year:		Year:
Septoplasty ☐	Year:	Gastric Bypass or Banding ☐	Year:		Year:
Rhinoplasty ☐	Year:	Skin Cancer ☐	Year:		Year:
Tonsillectomy ☐	Year:	Kidney Transplant ☐	Year:		Year:

Family History: *check all that apply, and relationship if applicable*

Asthma ☐		Thyroid Goiter ☐		Heart Attack before 60 ☐	
Sinusitis ☐		Thyroid Cancer ☐		Stroke before 60 ☐	
Hearing Loss ☐		Anesthesia Problems ☐		Bleeding Disorder ☐	
Meniere's Disease ☐		Cancer (type):		Other:	

Medications: *(include over the counter and supplements)*

CURRENT MEDICATIONS: **Are you taking ANY kind of Medication(s) now? ☐ No ☐ Yes**

Medication Name	Dosage	How Often Taken

Allergies:

Are you allergic to any Medications? ☐ No ☐ Yes *(if yes, please list below)*

Medication:	Type of Reaction: (rash, swelling, etc.)

Patient Name:	DOB:	Date:

Do you currently have any of the following problems?

Ear/Nose/Throat		**Neurologic**		**Cardiovascular**	
Hearing Loss	❑ Yes ❑ No	Headaches	❑ Yes ❑ No	Chest pain	❑ Yes ❑ No
Ringing in the ears	❑ Yes ❑ No	Numbness	❑ Yes ❑ No	Palpitations	❑ Yes ❑ No
Room spinning, dizziness	❑ Yes ❑ No	Weakness	❑ Yes ❑ No	**Gastrointestinal**	
Ear pain	❑ Yes ❑ No	Blurred vision	❑ Yes ❑ No	Nausea	❑ Yes ❑ No
Ear discharge	❑ Yes ❑ No	Double vision	❑ Yes ❑ No	Diarrhea	❑ Yes ❑ No
Runny nose	❑ Yes ❑ No	**Respiratory**		Blood in stool	❑ Yes ❑ No
Hard to breathe through nose	❑ Yes ❑ No	Cough	❑ Yes ❑ No	**Psychiatric**	
Itchy nose	❑ Yes ❑ No	Shortness of breath	❑ Yes ❑ No	Sadness	❑ Yes ❑ No
Lump in neck	❑ Yes ❑ No	Wheezing	❑ Yes ❑ No	Abnormal mood	❑ Yes ❑ No
Facial pain	❑ Yes ❑ No	**Genitourinary**		Insomnia	❑ Yes ❑ No
Loss of smell	❑ Yes ❑ No	Frequent urination	❑ Yes ❑ No	Anxiety	❑ Yes ❑ No
Postnasal drip	❑ Yes ❑ No	Nocturnal urination	❑ Yes ❑ No	**Constitutional**	
Snoring	❑ Yes ❑ No	Painful urination	❑ Yes ❑ No	Fever	❑ Yes ❑ No
Difficulty swallowing	❑ Yes ❑ No	**Musculoskeletal**		Weight loss/gain	❑ Yes ❑ No
Pain w/ swallowing	❑ Yes ❑ No	Joint pain	❑ Yes ❑ No	Night sweats	❑ Yes ❑ No
Hoarseness	❑ Yes ❑ No	Joint swelling	❑ Yes ❑ No	Anorexia	❑ Yes ❑ No
Nose bleeds	❑ Yes ❑ No	Limited mobility	❑ Yes ❑ No	Fatigue	❑ Yes ❑ No