ASSOCIATED EAR, NOSE & THROAT SPECIALISTS, LLC

Todd A. Zachs, M.D.
Sarah Sanford, APRN
Hannah Vollinger, Au.D., CCC-A

PLEASE NOTE: ALL FORMS ARE DOUBLE SIDED AND MUST BE COMPLETED FULLY PRIOR TO BEING SEEN BY OUR PROVIDERS

Name: ______________________________ Date of Birth: ____________________
Last *First*

If patient is a minor, parent's name: ____________________ *Date of Birth:* ________________

Address: ______________________________________ Apt: ____________

Town: ____________________ State: ______ Zip Code: __________ Male ☐ Female ☐

Phone: ______________ Work: ________________ Cell: ________________

Occupation: ________________ Employer: ______________________________

Email Address: ____________________________ Student: Full Time / Part Time

Primary Care Physician: ________________________ Town: ______________

Referring Physician: ________________________ Town: ______________

Emergency Contact: ________________________ Phone Number: ______________
Last *First*

Relationship to Patient: ____________________

Primary Insurance: ______________________ ID: ____________________

Primary Cardholder: ______________________ Birthdate: ________________

Secondary Insurance: ______________________ ID: ____________________

Primary Cardholder: ______________________ Birthdate: ________________

Marital Status: Single / Married / Divorced / Widowed / Other / DECLINED
Other: ____________________

Employment Status: Employed / Unemployed / Retired / Student (full or part time) / DECLINED
Other: ____________________

Language: English / Spanish / Russian / French / Italian / Polish / DECLINED
Other: ____________________

Race: White / Black / Hispanic / Asian / African-American / DECLINED
Other: ____________________

Ethnicity: Caucasian / African-American / Italian / Spanish / Russian / DECLINED
Other: ____________________

Preferred local pharmacy: ____________________

Pharmacy address: ________________________________

- IF YOUR INSURANCE REQUIRES REFERRALS, IT IS IMPERATIVE THAT YOU HAVE A WRITTEN OR ELECTRONIC REFERRAL IN PLACE WITH YOUR INSURANCE COMPANY PRIOR TO YOUR VISIT (DEPENDING ON WHICH TYPE IS REQUIRED BY YOUR INDIVIDUAL INSURANCE PLAN) OR YOUR APPOINTMENT WILL BE CANCELLED OR RESCHEDULED UNTIL A REFERRAL IS OBTAINED.
- I UNDERSTAND THAT IF I DO NOT HAVE A VALID REFERRAL FROM MY PRIMARY DOCTOR, THAT MY INSURANCE COMPANY COULD REFUSE TO PAY FOR MY VISIT. IF MY INSURANCE REQUIRES REFERRALS AND I FAIL TO OBTAIN A VALID REFERRAL, I AGREE TO ASSUME FULL RESPONSIBILITY FOR PAYMENT OF SERVICES.
- I UNDERSTAND THAT INSURANCE CO-PAYS ARE DUE AT THE TIME OF MY VISIT.
- I UNDERSTAND THAT THE DOCTORS UTILIZE SCRIBES IN THE EXAM ROOMS AND I GIVE PERMISSION FOR A SCRIBE TO BE PRESENT DURING MY EXAMINATION.
- I UNDERSTAND THAT 24-HOUR NOTICE IS REQUIRED TO CANCEL MY APPOINTMENT(S) AND THAT I WILL BE CHARGED FOR A "NO SHOW VISIT' IF I FAIL TO CALL WITHIN 24 HOURS OF MY SCHEDULED VISIT. THIS IS A $48 CHARGE THAT IS NOT BILLED TO OR COVERED BY INSURANCE AND IS MY RESPONSIBILITY.
- I HEREBY GIVE ASSOC. EAR, NOSE & THROAT SPECIALISTS PERMISSION TO RELEASE MY RECORDS TO MY PRIMARY CARE PHYSICIAN LISTED ABOVE, AND TO MY INSURANCE COMPANY, INCLUDING PSYCHIATRIC, SUBSTANCE ABUSE AND AIDS-RELATED INFORMATION.
- I UNDERSTAND THAT IF I WANT ANY OR ALL OF MY RECORDS SENT TO ANOTHER PROVIDER THAT IS NOT LISTED AS MY PRIMARY CARE PHYSICAN, I MUST FILL OUT A RELEASE OF INFORMATION FORM OR PROVIDE IN WRITING, WITH SIGNATURE, AUTHORIZATION TO FORWARD MY PRIVATE MEDICAL INFORMATION TO THE DOCTOR I PROVIDE.
- I UNDERSTAND THAT THERE IS A $25 CHARGE TO HAVE FMLA, DISABILITY FORMS, OR ANY OTHER FORMS FILLED OUT BY AENTS PROVIDERS. I ALSO UNDERSTAND THAT THIS MUST BE PAID PRIOR TO THE FORMS BEING COMPLETED AND IT IS ALSO NOT A CHARGE THAT IS COVERED BY ANY INSURANCE.
- I HEREBY ACKNOWLEDGE THAT I HAVE BEEN GIVEN ACCESS TO A COPY OF THE NOTICE OF PRIVACY PRACTICES AND UNDERSTAND THAT I MAY CONTACT THE OFFICE MANAGER IF I HAVE FURTHER QUESTIONS OR COMPLAINTS; I ALSO UNDERSTAND THAT I AM ENTITLED TO RECEIVE UPDATES UPON REQUEST, IF THE NOTICE OF PRIVACY PRACTICES IS AMENDED OR CHANGED.

Signature: ______________________________ **Date:** ____________________

Permission to Discuss Patient's Records

I, ____, give Dr. Todd Zachs,
(print name)
permission to discuss my medical condition and any pertinent medical information with the following people:

1. ______________________________ ______________________________
Name Relationship

2. ______________________________ ______________________________
Name Relationship

Signature: ______________________________ **Date:** ____________________

Name: ______________________ Birth date: ______________________

Reason for todays visit: ____

Please answer the following questions regarding your medical status and history:

Do you currently have any of the following?	**If NO, please put an X / If YES, please Circle or Explain:**
Chronic fever, unexpected weight loss/gain, fatigue	No ____ Yes ______________________
Eye (e.g. glaucoma, cataracts, retinal disease)	No ____ Yes ______________________
Heart (e.g. chest pain, irregular heartbeat, high blood pressure)	No ____ Yes ______________________
Respiratory (e.g. shortness of breath, wheezing)	No ____ Yes ______________________
Gastrointestinal (e.g. heartburn, abd pain, diarrhea)	No ____ Yes ______________________
Urinary (e.g. pain or discomfort, blood in urine)	No ____ Yes ______________________
Skin (e.g. skin cancer, rashes, excessive dryness)	No ____ Yes ______________________
Musculoskeletal (e.g. arthritis, swollen joints)	No ____ Yes ______________________
Neurological (e.g. numbness, weakness, headaches)	No ____ Yes ______________________
Psychiatric (e.g. depression, anxiety)	No ____ Yes ______________________
Endocrine (e.g. diabetes, hypothyroid)	No ____ Yes ______________________
Blood/Lymph (e.g. anemia, cholesterol problems)	No ____ Yes ______________________
Allergic/Immunologic (e.g. hay fever, lupus)	No ____ Yes ______________________
Hearing loss	No ____ Yes ______________________
Snoring, nosebleeds, runny nose	No ____ Yes ______________________
Sinus problems, sore throat, recurrent infections	No ____ Yes ______________________
Mouth sores, dryness, blisters	No ____ Yes ______________________
Cancer (e.g. head/neck cancer)	No ____ Yes ______________________

Have you ever had any surgery? [ ] Yes [ ] No ***If yes, please list:**

____

____

Family History:

Do any medical issues or diseases run in your immediate family (parents, siblings, etc)? [ ] Yes [ ] No

If yes, please list if anyone has or had: heart disease, ear problems, hearing loss, sleep apnea, diabetes, high blood pressure, cancer, kidney disease, stroke, bleeding/immune disorder?

Mother ______________________ **Father** ______________________

Sister ______________________ **Brother** ______________________

Mat Grandmother ______________________ **Mat Grandfather** ______________________

Pat Grandmother ______________________ **Pat Grandfather** ______________________

Name: ______________________________ Birth date: ____________________

Height: ________ **ft** ____________ **Inches** **Weight:** ______________ **lbs**

<u>(Circle and Fill In)</u>

Do you smoke tobacco or use E-Cigs/Vape/CBD? Yes or No

(If yes) how much?

- How many ________________
- Daily / Weekly / Monthly / Socially

(If no) have you smoked in the past?

- When did you quit? Date: __________________ or Number years ago? ____________________

Do you drink alcohol? Yes or No

(*If yes*) how much?

- How many _______
- Daily / Weekly / Monthly / Socially

Name: ______________________________ Birth date: ____________________

Medications

Allergies to Medications: ____________________ ____________________ ____________________

Current Medications including vitamins, over-the-counter medications and supplements

Medication Name:	Dosage:	Frequency:

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Advance Beneficiary Notice of Noncoverage (ABN)

Patient Name: ________________________ **Date of Birth:** ______________________

Patient Responsibility - Insurance Disclaimer

Insurance Disclaimer: "A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service."

Insurance Liability for Payment: Your health insurance company will only pay for services that it determines to be "reasonable and necessary." Every effort will be made by this office to have all services and procedures preauthorized by your health insurance company, when applicable. If your health insurance company determines that a particular service is not reasonable and necessary, or that a particular service is not covered under the plan, your insurer will deny payment for that service. We suggest to all patients that they contact their insurance to confirm that these services are covered.

Under this arrangement, you are responsible for paying your co-pay, any non-covered portions, and any deductible you have yet to cover. In addition, if your insurance company including MEDICAID does not pay for our services, you agree to pay for the services provided in our office.

Beneficiary Agreement: I understand that my health insurance company including MEDICAID may deny payment for the services identified above, for the reasons stated. If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies.

I, ________________________________, acknowledge that I have read the information above and understand that I will be fully responsible for any account balance resulting from both covered (deductible, co-pays and co-insurance) and non-covered services.

____   ________________________

Patient signature or person acting on behalf of patient   Date

Relationship to patient

____

Acknowledgement Form

Dr. Todd Zachs feels that patients presenting to our office with sinus, allergy, hearing, throat or voice complaints require a thorough examination of that specific area. In some cases, this can only be accomplished through an endoscopy, laryngoscope, cerumen removal (wax removal), etc. These examinations are a separate charge to insurance. These are essentially painless and, in many cases, can be completed quickly. If we participate with your insurance company, you will be only obligated to pay any deductibles, co insurance or co-payments that apply to this claim.

Please note some insurance companies may list these diagnostic procedures as "surgery" on the insurance remittance form you will receive.

These procedures have almost no risk and provide your physician with an excellent view of the areas involved. You also reserve the right to refuse any of these tests/services at any time prior to them being performed.

Please sign below to acknowledge that you have read and understood the above.

________________________________ ________________________

Patient Name-Printed DOB

________________________________ ________________________

Patient Signature Date

**The above named patient was unable to physically complete these intake forms and needed assistance by one of our staff members. These forms were completed by:* __________________________

Patient Initials: __________________________ Date: ______________________