EAR NOSE THROAT AND FACIAL PLASTIC SURGERY SPECIALISTS, PC

723 Fitzwatertown Road, Willow Grove, PA 19090-1332
215-659-8805 Fax 215-784-9729

Last Name:_____ First Name:_____ _____ Acct#:_____

Address: _____ City/State/Zip: _____

Please circle the best way to reach you

Home Phone: _____ ☐ OK to leave a message Cell Phone: _____ ☐ Texts OK Work Phone: _____

Date Of Birth: _____ Age: _____ Sex: ___ SS #: ___

Email _____ Pharmacy # _____

Emergency Contact Name: _____ Relationship: _____

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

Primary Care Physician: _____

Address: _____

Phone #: _____ Fax #: _____

For appointments not kept or cancelled less than 24 hours prior to your appointment date & time, the full charge of the visit, diagnositc testing, procedure, and or surgical procedure, will be charged to you

INSURANCE INFORMATION

If Insurance is held by someone other than this patient, please fill out the information below:

Name of Insured: _____

DOB: _____

(COPY OF CARD)

Address: _____

Relationship to Patient: _____

I AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO MANAGE MY CARE.
I UNDERSTAND AND AGREE THAT REGARDLESS OF MY INSURANCE STATUS, I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR ANY PROFESSIONAL SERVICE RENDERED. I HAVE COMPLETED THE ABOVE QUESTIONS AND CERTIFY THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY YOU OF ANY CHANGES IN MY INSURANCE STATUS OR ANY OF THE ABOVE INFORMATION. I AUTHORIZE THE STAFF TO PERFORM ALL NECESSARY SERVICES NEEDED DURING THE DIAGNOSIS AND TREATMENT. I ALSO AUTHORIZE THE PROVIDER TO RELEASE ALL INFORMATION REQUIRED TO PROCESS INSURANCE CLAIMS.

_____ ❒ **NONE (if none, please indicate)**

(Name of designated person)

SIGNATURE:_____ DATE:_____

EAR NOSE THROAT & FACIAL PLASTIC SURGERY SPECIALISTS PC

PATIENT FINANCIAL RESPONSIBILITY INFORMATION

DEAR Patient T. Test:

THANK YOU FOR CHOOSING US AS YOUR HEALTH CARE PROVIDER. THE FOLLOWING IS OUR FINANCIAL POLICY. OUR MAIN CONCERN IS THAT YOU RECEIVE THE PROPER AND OPTIMAL TREATMENTS NEEDED TO RESTORE YOUR HEALTH. THEREFORE, IF YOU HAVE ANY QUESTIONS OR CONCERNS ABOUT OUR PAYMENT POLICIES, PLEASE DO NOT HESITATE TO CONTACT OUR BILLING DEPARTMENT.

WE ASK THAT ALL PATIENTS READ AND SIGN OUR FINANCIAL POLICY AND HIPAA FORM AS WELL AS COMPLETE OUR PATIENT INFORMATION FORM AND CONSENT FORM PRIOR TO HAVING YOUR EXAMINATION, THERAPY, AND/OR STUDY. MEDICARE PATIENTS ARE REQUIRED TO SIGN AN ABN.

ALL INSURED PATIENTS ARE REQUIRED TO SIGN THE ASSIGNMENT OF BENEFITS FOR PAYMENT FROM THE INSURANCE COMPANY. WE WILL SUBMIT YOUR CLAIM TO THE INSURANCE COMPANY ON YOUR BEHALF BUT IF THE INSURANCE COMPANY DOES NOT PAY YOUR BALANCE IN FULL WITHIN 30 DAYS, WE ASK THAT YOU CONTACT THE CARRIER. YOU WILL BE BILLED FOR ANY NON-COVERED SERVICES, DEDUCTIBLES, CO-PAYS, AND/OR CO-INSURANCE AND FINANCE CHARGES.

IT IS THE RESPONSIBILITY OF THE PATIENT TO ENSURE ANY REFERRALS, PRECERTIFICATION, OR AUTHORIZATIONS HAVE BEEN OBTAINED PRIOR TO YOUR APPOINTMENT. IN THE EVENT YOUR PLANNED PROCEDURES ARE NOT FOLLOWED PRIOR TO YOUR APPOINTMENT, YOUR APPOINTMENT MAY BE RESCHEDULED.

DELINQUENT ACCOUNTS WILL BE TURNED OVER TO COLLECTION AGENCY WITH A 2 WEEK NOTICE UNLESS DEMOGRAPHIC INFORMATION HAS CHANGED AND RETURNED TO US BY THE UNITED STATES POSTAL SERVICE. ACCOUNTS WILL BE CONSIDERED DELINQUENT IF UNPAID AFTER 60 DAYS. IN THE EVENT YOUR ACCOUNT IS TURNED OVER TO COLLECTION, YOU WILL BE RESPONSIBLE FOR ALL REASONABLE COLLECTION AND COURT COSTS AT THE TIME THE ACCOUNT IS CONSIDERED DELINQUENT. AGAIN, THANK YOU FOR CHOOSING US AS YOUR HEALTH CARE PROVIDER. WE APPRECIATE THE OPPORTUNITY TO SERVE YOU.

EAR NOSE THROAT & FACIAL PLASTIC SURGERY SPECIALISTS PC

NAME_____ DATE OF BIRTH _____ DATE _____

HEIGHT _____ WEIGHT _____

It is your responsibility to provide accurate and current medical information below at your initial and subsequent visits. Any information not disclosed can result in misdiagnosis and maltreatment.

PAST MEDICAL HISTORY ☐ NONE ☐ NO CHANGE (existing patients only)

☐ anemia	☐ bronchitis	☐ emphysema	☐ heart murmur	☐ kidney disease	☐ MS
☐ arthritis	☐ cancer	☐ glaucoma	☐ hepatitis	☐ lung cancer	☐ reflux
☐ asthma	☐ cataracts	☐ hearing problem	☐ high blood pressure	☐ migraine headaches	☐ seizures
☐ bleeding disorder	☐ diabetes	☐ heart disease	☐ high cholesterol	☐ mono	☐ thyroid

Other illnesses:

_____

PAST SURGICAL HISTORY ☐ NONE ☐ NO CHANGE (EXISTING PTS ONLY)

_____

_____

_____

ALLERGIES ☐ NONE ☐ NO CHANGE (EXISTING PTS ONLY)

_____

_____

MEDICATIONS ☐ NONE ☐ NO CHANGE (EXISTING PTS ONLY)

_____

_____

_____

OCCUPATIONAL HISTORY ☐ NONE ☐ NO CHANGE (EXISTING PTS ONLY)

_____

_____

SOCIAL HISTORY ☐ NONE ☐ NO CHANGE (EXISTING PTS ONLY)

TOBACCO _____

ALCOHOL _____

ILLICIT DRUGS _____

FAMILY HISTORY ☐ NONE ☐ NO CHANGE (EXISTING PTS ONLY)

GRANDPARENTS _____

PARENTS _____

SIBLINGS _____

I am signing that I am responsible for providing all accurate and up to date medical information listed above.

PATIENT/GUARDIAN SIGNATURE:_____ Date:_____

EAR NOSE THROAT & FACIAL PLASTIC SURGERY

SPECIALISTS PC

PATIENT FINANCIAL AND MEDICAL RESPONSIBILTY INFORMATION

THE OFFICE OR DR. GOLDBERG MAY HAVE ORDERED A STUDY, TEST, CONSULTATION AND/OR FOLLOWUP APPOINTMENT FOR YOU. WE WILL ASSUME IF YOU HAVE NOT SCHEDULED THE ADVISED ORDER THAT YOU DO NOT PLAN ON HAVING THE ABOVE PERFORMED. MISSING FOLLOWUP MAY BE SUBJECT TO MISDIAGNOSIS, DELAYED DIAGNOSIS AND MALTREATMENT.

PLEASE ADVISE US IF THERE HAS BEEN A CHANGE IN YOUR ADDRESS, PHONE NUMBER, OR INSURANCE COVERAGE SINCE YOUR LAST APPOINTMENT.

IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT WITH THE DOCTOR AND DO NOT GIVE 24 HOURS NOTICE A FEE MAY BE CHARGED.

IF YOU ARE UNABLE TO KEEP YOUR PROCEDURE OR TESTING APPOINTMENT AND DO NOT GIVE 48 HOURS NOTICE A FEE MAY BE CHARGED.

PAYMENT IS EXPECTED AS SERVICES ARE RENDERED UNLESS PRIOR FINANCIAL ARRANGEMENTS HAVE BEEN MADE.

IF CO-PAY IS NOT PAID AT TIME OF VISIT, THERE WILL BE A CHARGE OF $11.50 FOR ADMINISTRATIVE COSTS.

A FEE OF $25.00 WILL BE CHARGED FOR ALL RETURNED CHECKS.

THERE WILL BE AN ADMINISTRATIVE FEE FOR THE COMPLETION OF ALL FORMS.

COMMUNICATION IS DOCUMNETED THROUGH PHONE CALLS DIRECTLY MADE TO OUR OFFICE. EMAILS, TEXTS & SOCIAL MEDIA IS NOT PART OF YOUR MEDICAL RECORD.

SIGNATURE_____DATE_____

(IF OVER 18 YEARS OF AGE)

EAR NOSE THROAT & FACIAL PLASTIC SURGERY

SPECIALISTS PC

[redacted]

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE PLEASE CONTACT OUR PRIVACY OFFICIAL AT THE OFFICE ADDRESS AND NUMBER.

[redacted]

YOU MAY CONTACT OUR PRIVACY OFFICIAL AT 723 FITZWATERTOWN ROAD, WILLOW GROVE, PA 19090, Ph: (215) 659-8805

[redacted]

NAME: _____

I ACKNOWLEDGE THAT A COPY OF THE NOTICE OF PRIVACY PRACTICES FOR EAR NOSE THROAT & FACIAL PLASTIC SURGERY SPECIALISTS PC WAS MADE AVAILABLE TO ME.

IF I WISH TO ALLOW A FAMILY MEMBER OR FRIEND TO RECEIVE MY PERSONAL PROTECTED HEALTH INFORMATION, I MUST SIGN AN AUTHORIZATION FORM PROVIDED BY THE PRACTICE.

SIGNATURE: _____ DATE: _____
(if over 18 years of age)

WITNESS SIGNATURE: _____

It is your responsibility to provide accurate and current medical information below at your initial and subsequent visits. Any information not disclosed can result in misdiagnosis and maltreatment.

REVIEW OF SYSTEMS

CONSTITUTIONAL: ❑NONE ❑FEVERS ❑CHILLS/SWEATS ❑WEIGHT LOSS ❑TIRED

❑LOSS of APPETITIE ❑RECENT TRAVEL ❑BLOOD TRANSFUSION

EYES: ❑NONE ❑PAIN ❑ITCHING ❑VISION CHANGE

EAR: ❑NONE ❑PAIN ❑DRAINAGE ❑HEARING LOSS ❑RINGING ❑DIZZINESS

NOSE: ❑NONE ❑PAIN ❑DRAINAGE ❑LOSS of SMELL ❑CONGESTION ❑NOSEBLEEDS

ORAL: ❑NONE ❑PAIN ❑LUMP/LESION ❑LOSS/CHANGE TASTE ❑CAVITIES

THROAT: ❑NONE ❑PAIN ❑LUMP/LESION ❑DRAINAGE ❑HOARSENESS ❑COUGH

❑TROUBLE SWALLOWING

NECK: ❑NONE ❑PAIN ❑SWELLING ❑NUMBNESS ❑LUMP/LESION

CARDIOVASCULAR: ❑NONE ❑CHEST PAIN ❑PALPITATIONS

RESPIRATORY: ❑NONE ❑SHORTNESS BREATH ❑WHEEZING ❑COUGH

GASTROINTESTINAL: ❑NONE ❑NAUSEA ❑VOMITING ❑DIARRHEA

❑CONSTIPATION ❑PAIN ❑BLOOD IN STOOL

GENITALURINARY: ❑NONE ❑PAIN/BURNING ❑URGENCY/FREQUENCY ❑BLOOD

NEUROLOGY: ❑NONE ❑HEADACHES ❑WEAKENESS ❑NUMBNESS ❑TREMOR

ENDOCRINE: ❑NONE ❑ALWAYS HOT OR COLD ❑HAIR OR NAIL CHANGES

❑HORMONE CHANGES

HEMATOLOGY/ONCOLOGY: ❑NONE ❑CANCER ❑EASY BLEEDING/BRUISING

MUSCULOSKELETAL: ❑NONE ❑ACHES/PAINS ❑JOINT SWELLING/STIFFNESS

ALLERGIC/IMMUNE: ❑NONE ❑SNEEZING/ITCHING ❑COLDS/INFECTIONS

SKINCARE: *❑ACNE ❑ROSACEA ❑WRINKLES ❑PIGMENTATION ❑SUN DAMAGE ❑SCARS*
❑ I am interested in a complimentary skin care consult

I am signing that I am responsible for providing all accurate and up to date medical information listed above.

SIGNATURE_____DATE_____
(IF OVER 18 YEARS OF AGE)

SIGNATURE_____DATE_____
(RESPONSIBLE INDIVIDUAL)

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Phone: 215-659-8805 Fax: 215-784-9729

Office Billing Policies

To:

Welcome to the practice. We are so happy that you chose our practice to help you with your Ear Nose Throat, ENT Allergy, Facial Plastic and Hearing Aids.

It is your responsibility to know if your insurance plan requires you to have a referral at the time of your office visit. If a referral is required, it is expected that we receive it no later than the date of your visit. It is the patients responsibility to request and manage their referral.

Your co-payment is required to be collected on the day services are rendered. As a convenience, our practice accepts cash, check, and credit cards. If a check is returned by the bank for non-sufficient funds, a service charge of $25 will be incurred to cover bank fees.

If your insurance plan has a deductible in its policy, you will be required to pay for any costs deemed to be patient responsibility. If you have any questions regarding your insurance policy contact your insurance company and/or any member of our front desk staff. Finance charges will accrue on patient responsibility balances greater than 60 days.

We participate with the Medicare program. To those patients who do not have a secondary insurance please realize that you are responsible for paying the deductible and 20% of the accepted fee that Medicare allows.

You must understand that certain tests, scopes, treatments, surgeries and/or procedures are required to be paid completely if your insurance policy or insurance company does not.

Patients who DO NOT have any insurance or have an insurance plan that we do not participate; are expected to pay for the visit or procedure before leaving the office. Please ask the front desk for the costs that will be associated with your office visit. If a specimen is sent to the lab for pathology you will incur additional charges billed to you by the lab.

If it is necessary to cancel an appointment, we require that 24-hour notice be given. If 24 hour notice is not provided, $50 will be billed for missed office appointments; $300 will be billed for missed allergy skin tests; $500 will be billed for missed otologic/vestibular testing; $600 will be billed for missed surgeries and office procedures.

Patient Signature _____ Date: