ADVANCED SINUS AND ALLERGY CENTER

Patient Demographics

Patient Name: _____Date of Birth: _____

Social Security Number: _____ Marital Status: _____

Email: _____Race/Ethnicity: _____

Address: _____City, State, Zip: _____

Home Ph: _____Work Ph: _____ Cell Ph: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone: _____

Primary Care Physician: _____

Primary Care Physician Address: _____

Primary Care Physician Phone: _____

How were you Referred to Our Practice? _____

Primary Insurance: _____

Id Number: _____Group #_____

Policy Holders Name: _____

Policy Holder Date of Birth: _____

Secondary Insurance: _____

Id Number: _____Group #_____

Policy Holders Name: _____

ADVANCED SINUS AND ALLERGY CENTER

Consent for Treatment

I hereby consent to examination and treatment as rendered appropriate by the physician. I hereby authorize the release of information and the records of any treatments or examinations rendered, to other physicians who may be involved in my care, to my insurance company or companies to facilitate billing and directing reimbursement to the physician those insurance benefits to which I am entitled under the terms of my policy, and for quality assurance assessments and physician's certification. I consent to have my medication history accessed. This information is protected under the federal HIPAA regulations and its release is subject to my approval. I understand that this organization may change its Notice of Privacy Practices at any time and that I may request a copy of this policy.

HIPAA Consent

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

Electronic Prescription Consent

Our electronic medical record program accesses your prescription/medication history for us to safely prescribe your medication. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years. By signing this, you authorize us to do so.

Patient Portal

Advanced Sinus and Allergy, SC and offers secure viewing and communication as a service to patients who wish to view parts of their records and communicate with our staff and physicians. Secure messaging can be a valuable communications tool but has certain risks. In order to manage these risks, we need to impose some conditions of participation. This form is intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation.

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

Patient/Guardian Signature Date

ADVANCED SINUS AND ALLERGY CENTER

Office Billing Policy

Thank you for choosing Advanced Sinus and Allergy Center, SC! We are committed to the success of your treatment and care, and that often requires testing or procedures that are not offered by primary care physicians. These additional measures, in conjunction with Dr. Caballero's' training and experience, allow us to identify and treat your problems.

Self-Pay
Patients without medical insurance are required to pay at the time of service. A 15% discount will be honored for all services that are paid in full at the time of service.

Managed Care/Traditional Insurance
Advanced Sinus and Allergy Center will submit insurance claims for all services provided to patients with insurance coverage in a managed care plan (PPO, HMO, and POS) as well as traditional/indemnity plans. A copy of your insurance card must be presented to our office. Patients without an insurance card must pay at the time of service. If you participate in an HMO or POS plan that requires authorization from your primary care physician, we require a referral or authorization number at the time of service in order to submit your insurance claim for payment. Without a referral or authorization from your primary care physician, your benefits may be reduced or denied entirely. HMO patients without referrals will be required to pay at the time of service

Co-Pay & Deductible Statement
All charges for services rendered will be sent to your insurance company for reimbursement to our office, but you may have an out-of-pocket expense if your deductible is not met or if a co-insurance payment is required by your policy. **Please note we do collect co-pays and deductibles that have not been met at the time of service, if you are unable to pay the full amount the day of service our staff will help you to set-up payment arrangements.** You will receive a statement if a balance remains due after your insurance company has correctly processed your claim(s).

CT Imaging
A CT scan may be obtained to assess the success of various treatments, to determine the extent of sinus disease or nasal obstruction, to map the sinuses in preparation for surgery or to assess nasal and facial fractures. We bill insurance $1039 for this procedure.

Nasal Endoscopy
To see deep inside the nose and to examine the structures of the nasal passages, a small rigid telescope is used. This helps identify abnormalities of the nasal septum, locate polyps, and determine whether infection is present. Insurance categorizes this procedure as surgical procedure, due to entering the orifices of the nasal passages, the insurance is billed $443 for this procedure.

Allergy Testing & Treatment
Allergy skin or blood testing may be performed to determine the sensitivities that may be contributing to your symptoms.

The Center for Medicaid and Medicare Services (CMMS) and the insurance companies have developed standardized procedure (CPT) codes for these services. Insurance companies do not differentiate between these services when they are provided in the office and when they are provided in the hospital or operating room, so surgery or procedure codes may appear on your insurance billing statement for the services listed above.

I authorize benefits to be paid directly to the Physician and I understand that I am responsible for any unpaid balance under the terms of my insurance policy. *I have read and fully understand the statements above and my questions have been adequately addressed.*

_____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

ADVANCED SINUS AND ALLERGY CENTER

Endoscopy

Dear Patient,

Please be advised that at Advanced Sinus and Allergy Center endoscopies are employed as part of your evaluation to ensure an accurate and thorough exam. Performing endoscopies is the standard of care for providing complete and comprehensive Otolaryngology services in an office setting.

A **Nasal Endoscopy** is a routine in-office procedure performed to examine the deeper parts of your nose that cannot be seen with a nasal speculum and a headlight. This procedure helps identify redness, swelling, polyps, crusting, mucous, and/or pus deep in the nasal cavity. Nasal endoscopy is performed by introducing a camera (called a scope) with a bright light into the dark cavities of your nose. A nasal endoscopy can be performed with a rigid scope or a flexible scope. Sometimes, the flexible endoscope may be introduced deeper to look at the back of your tongue and your voice box. This is called a **Flexible Nasopharyngoscopy**. In some instances, the doctor may capture an image of your evaluation in digital format to follow your progress. This is called Photo-Endoscopy. In some cases, the scope may be used to clean your sinuses after surgery or to remove a polyp or nasal mass. This is called an **Endoscopic Debridement.**

Endoscopies are very safe but may cause temporary nasal tenderness and some nasal bleeding. A small number of patients may feel lightheaded from anxiety. If any nasal bleeding occurs, your doctor may need to control it using topical medications and silver nitrate cautery.

Insurance companies will consider all of these procedures "surgical". We do not have control over how endoscopies are interpreted by insurance companies. Diagnostic endoscopies are always considered "surgical" despite the fact that surgical instruments are not used. We would like to make you aware of this issue in advance, so you are not surprised when you receive an explanation of benefits from your insurance company that states a "surgical service" was provided. Also, please note that these procedures may be reimbursed at a different rate than an office visit. If you have any concerns or questions regarding endoscopy fees or your insurance coverage, please contact our office.

Sincerely,

Advanced Sinus and Allergy Center, S.C.

By signing below, I acknowledge that I have read and understand the above information regarding the nasal endoscopy that may be performed during my office visit(s). I agree to be financially responsible for any co-insurance or deductible balances that may remain after my insurance has processed the claim.

_____ _____

Patient Signature Date

ADVANCED SINUS AND ALLERGY CENTER

Patient Name _____ **Date of Birth** _____

Medications: Please list **ALL** prescriptions **AND** any over the counter drugs and supplements that you are **currently** taking:

_____

_____

Do you have any allergies to medications? (Circle Yes or No.)……No/Yes I**f yes, please list:** _____

Do you currently have or have you ever had any of the following? (Circle Yes or No.)

Heart Disease……..Yes/No	Kidney Disease……..…Yes/No	Stroke……..…Yes/No	Head/Neck trauma……..…Yes/No
Atrial fibrillation (Afib)….Yes/No	Liver/Gallbladder……..…Yes/No	Migraine……..……Yes/No	HIV……..……Yes/No
High Blood Pressure..…Yes/No	Thyroid Problems……..…Yes/No	Seizure……..……Yes/No	Arthritis……..……Yes/No
Asthma……..……Yes/No	GERD/acid reflux……..Yes/No	Anxiety……..……Yes/No	Glaucoma……..……Yes/No
COPD……..…..Yes/No	Crohn's/Ulcerative Colitis…Yes/No	Depression…..……Yes/No	Macular degeneration…….Yes/No
Diabetes……..…Yes/No	Cancer……Yes/No	If yes, what type _____	

List any other medical history not noted above: _____

Have you ever had surgery? (Circle Yes or No.)……..No/Yes **If yes, please list below:**

_____

_____

Social History:

Do you drink caffeine……..Yes/No	Do you drink alcohol?……..Yes/No	Do you use recreational drugs……..……Yes/No
Do you currently smoke/chew tobacco?……Yes/No	Have you ever smoked/chewed tobacco?……Yes/No	If yes, please list: _____

Family History - Has any blood relative had any of the following? (Circle Yes or No.)

High Blood Pressure……Yes/No	Asthma……Yes/No	Thyroid Disease……Yes/No	Easy bruising/ bleeding……..Yes/No	Other……Please list _____
Heart Disease……Yes/No	Diabetes…..Yes/No	Migraines…….Yes/No	Blood clots……Yes/No	Cancer….Please list _____

Review of Systems: Do you experience any of the following? Please circle Yes or No

Unexpected weight loss……..Yes/No	Congestion/ stuffy nose……Yes/No	Hoarseness or voice change……Yes/No	Anemia/low blood count……Yes/No	Headaches….Yes/No
Fevers/sweats/ chills……Yes/No	Difficulty swallowing……Yes/No	Neck masses……Yes/No	Blood clotting problem……Yes/No	Numbness on face/ legs/arms……Yes/No
Double vision/ Blurry vision……..Yes/No	Post-nasal drip…….Yes/No	Cough……Yes/No	Heartburn……..…Yes/No	Depression….Yes/No
Light sensitivity….Yes/No	Loss of smell/ taste……..Yes/No	Wheezing……..Yes/No	Indigestion ..……Yes/No	Anxiety…….Yes/No
Palpitations……Yes/No	Frequent nose bleeds……Yes/No	Sneezing fits……Yes/No	Rashes……..…Yes/No	Excessive thirst……Yes/No
Chest pain…….Yes/No	Frequents sore throat……Yes/No	Itchy nose/eyes……Yes/No	Skin lesions;;……Yes/No	Heat/cold intolerance….Yes/No

Please complete back side

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What is the MAIN REASON for your visit today? Please list ONLY ONE _____

What is the main location of your symptoms? (Circle one): Nose Throat Face Mouth Ears Eyes

How long ago did the symptoms start? (Circle one): Hours Days Weeks Months Years

How would you describe your symptoms (Circle one): Mild Moderate Severe

Rate the intensity of your symptoms: (Circle one number): 1 2 3 4 5 6 7 8 9 10

Have your symptoms changed since they began? Yes/No **If yes, circle one:** Gotten worse/Gotten better

Are your symptoms always present? (Circle one) Yes, symptoms are constant No, symptoms come and go (intermittent)

On average, how long do your symptoms last? (Circle one)

Seconds Minutes Hours Days Months Years

Which of the following do you experience IN ADDITION to the main reason you are here today? (Check all that apply).

- ❑ Need to blow nose
- ❑ Nasal blockage
- ❑ Sneezing
- ❑ Runny nose
- ❑ Cough
- ❑ Postnasal drainage
- ❑ Thick nasal drainage
- ❑ Ear fullness
- ❑ Ear pain
- ❑ Facial pain and pressure
- ❑ Decreased sense of smell and or taste
- ❑ Difficulty falling asleep
- ❑ Waking up at night
- ❑ Lack of a good night sleep
- ❑ Waking up tired
- ❑ Fatigue
- ❑ Reduced productivity
- ❑ Reduced concentration
- ❑ Feeling frustrated/restless/ irritable
- ❑ Sadness
- ❑ Feeling embarrassed

Which one of the following helps alleviate your symptoms? (Check all that apply)

- ❑ Antibiotics
- ❑ Oral steroids like Prednisone or Medrol
- ❑ Steroid sprays like Flonase, Rhinocort, Nasacort
- ❑ Allergy tablets like Benadryl, Claritin, Zyrtec, Allegra
- ❑ Breathe-Right strips
- ❑ Saline sprays like Ayr or Ocean Saline
- ❑ Humidity
- ❑ Sinus rinses using a Neti Pot or Neil Med bottle
- ❑ Nasal decongestants like Afrin spray
- ❑ Oral decongestants like Sudafed
- ❑ Anti-inflammatory tablets like Ibuprofen or Aleve
- ❑ Migraine medications like Excedrin
- ❑ Caffeine
- ❑ Acid reflux medications like Pepcid, Zantac
- ❑ Acid reflux medications like Prilosec or Nexium
- ❑ Inhalers like Albuterol
- ❑ Pulling nose by stretching your cheek with fingers
- ❑ Nothing
- ❑ Other (Please list)_____

Which one of the following worsens your symptoms? (Check all that apply)

- ❑ Frequent air travel
- ❑ Exposure to sick contact like toddler or co-Worker
- ❑ Changes in barometric pressure (weather changes)
- ❑ Bright lights (photophobia)
- ❑ Bright sounds (phonophobia)
- ❑ Sitting at a desk all day
- ❑ Looking at the computer
- ❑ Stress
- ❑ Sleeping on your back
- ❑ Lying on your side
- ❑ Eating late at night
- ❑ Eating spicy foods
- ❑ Lying down shortly after eating
- ❑ Being outdoors in the Spring
- ❑ Being outdoors in the Summer
- ❑ Being outdoors in the Fall
- ❑ Being indoors with the air-conditioning on
- ❑ Being indoors with the heat on
- ❑ Exposure to pets
- ❑ Dry air
- ❑ Cold air
- ❑ Exercise
- ❑ Can't tell
- ❑ Other (Please list)_____

Please complete back side