ROCKY MOUNTAIN ENT ASSOCIATES

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Phone (303)783.2670 Fax (303)290-6317

Dear _____

Thank you for choosing Rocky Mountain ENT Associates for your care. We have 4 physicians, 4 audiologists and three practice locations. We ask you to complete your paperwork ahead of time. The paperwork takes approximately 20 minutes to complete. If you are an established patient and have completed our paperwork in the past we may ask you to update it if it has been over one year. Below are some quick FAQs for you to help make your visit the best experience it can be:

°Arrive 10 minutes early with your completed paperwork

°Bring a photo ID and your Insurance Card

°Make sure your insurance company does not require a referral to be processed through your insurance company prior to your visit

°If your Insurance is Medicaid make sure it is not Denver Health, University or Kaiser as we do not accept those plans.

°If your insurance has a co-pay we will collect the co-pay at the time of visit.

°If your insurance has co-insurance we will collect $20.00 that will be applied to your co-insurance

°If you see a physician and an audiologist on the same day it is possible your insurance will charge you two co-pays. We will only collect one at the time of service.

After your visit you will receive an email asking you to complete a survey. The survey takes about 3 minutes. It is important to us to hear how we did. If your experience was not excellent please call Christy, our Practice Manager at 720-475-8714 or ask for her before you leave so we can make sure your visit meets your expectations.

We have a web portal for your convenience. You will receive the credentials at check in. If you do not, please ask. The web portal allows you to access your medical records any time. In order for you to access the portal we do need your social security number as it is a unique identifier.

If you need to cancel your appointment, please do so as soon as possible. We look forward to seeing you soon.

Your appointment is at the following location:_____and on _____ at _____

Sincerely,

Rocky Mountain ENT Associates

ROCKY MOUNTAIN ENT ASSOCIATES

Adult New Patient/Update

Name:_____ Date:_____

Date of Birth:_____ Age:_____

Who referred you to us?_____ **Did you find us on the internet?**_____

Please list your current medical providers:

Primary care provider:_____ Phone:_____

Other provider:_____ Phone:_____

*Preferred Pharmacy/Location:*_____

What is the reason for your visit today? How long have you had symptoms?

_____

_____

_____

What makes you better?_____

What makes you worse?_____

What treatments have you tried?_____

What tests have been done?_____

Have you had allergy testing and when?_____ Your pain level (0-10)?_____

Have you had: pneumococcal vaccine? yes/no When?_____ Flu shot? yes/no When?_____

Medical History

List prescribed/over-the-counter medicines/supplements:

☐ ***I am currently not taking medications***

Name	Strength	# Taken	How Often	Start Date	End Date

Please list all allergies: ☐ *No known drug allergies*

Medication/Substance	Reaction	Medication/Substance	Reaction

Have you ever smoked? ☐ yes/☐ no (____packs/day for____years). Do you smoke now? ☐ yes/☐ no

Do you drink alcohol? ☐ yes/☐ no (____drinks per ☐ day/☐ week/☐ month)

Who lives with you at home?_____ What is your occupation?_____

Recreational drug use? ☐ yes/☐ no Type(s):_____

Do you have an Advanced Care Plan? ☐ yes/☐ no Who is the surrogate decision maker?_____

Office use only: ☐ New ☐ Update Last seen: _____

Date:_____ Name:_____ DOB:_____

Have you had any of the following health problems? Check all that apply

☐ Heart Attack	☐ Tuberculosis	☐ Back problems	☐ Kidney infections	☐ Arthritis/ Joint Pain
☐ Heart Disease	☐ Pneumonia	☐ Diabetes	☐ AIDS/HIV+	☐ Cystic Fibrosis
☐ Heart Murmur	☐ Stroke	☐ Hypoglycemia	☐ Thyroid problems	☐ Down's syndrome
☐ Chest Pain	☐ Seizures	☐ Hepatitis	☐ Sinus Disease	☐ Cancer, Type: ☐
☐ High Blood Pressure	☐ Head Injury	☐ Jaundice	☐ Hearing Loss	
☐ Asthma	☐ Migraines	☐ Bleeding Disorder	☐ Reflux Disease	
☐ Emphysema	☐ Meningitis	☐ Anemia	☐ Ulcers	☐ None of these listed

☐ Other problems not listed_____

Please list prior surgeries:

Surgery	Date	Surgery	Date

Please check if you are having any of the following symptoms:

✓		✓		✓		✓		✓	
☐	**General: No Problems**	☐	**Nose: No problems**	☐	**Cardiovascular: No Problems**	☐	**Neuro/Psych: No problems**	☐	**Skin: No problems**
☐	Fever	☐	Obstruction/congestion	☐	Chest pain	☐	Numbness	☐	Skin lesions/rashes
☐	Weight Loss	☐	Postnasal drip	☐	Shortness of breath	☐	Weakness	☐	Pigmentation changes
☐	Weight gain	☐	Drainage/pus	☐	Swollen legs/ ankles	☐	Tingling	☐	Allergy: No problems
☐	Night sweats	☐	Loss of smell	☐	Dizziness or fainting	☐	Convulsions	☐	Inhalant allergy
☐	Loss of appetite	☐	**Throat: No problems**	☐	Palpitations	☐	Blackouts	☐	Contact allergy
☐	**Eyes: No Problems**	☐	Recent voice change	☐	**Gastro: No problems**	☐	Sensory disturbances	☐	Environmental allergy
☐	Blurry vision	☐	Difficulty breathing	☐	Nausea/vomiting	☐	Motor disturbances	☐	Food allergy
☐	Double Vision	☐	Difficulty swallowing	☐	Vomiting blood	☐	Depression	☐	Latex allergy
☐	Change in vision	☐	Can't clear throat	☐	Heartburn	☐	Memory difficulties	☐	**Heme:No problems**
☐	Eye pain	☐	Chronic cough	☐	Abdominal pain	☐	**Endocrine: No problems**	☐	Anemia
☐	Excess tearing	☐	Hoarseness	☐	Constipation	☐	Increased appetite	☐	Bleeding tendency
☐	**Ears: No Problems**	☐	Sore throat	☐	Blood in stool	☐	Heat intolerance	☐	Prior transfusion
☐	Hearing loss	☐	Loss of taste	☐	Diarrhea	☐	Cold intolerance	☐	
☐	Ringing in ears	☐	**Pulmonary: No problems**	☐	**Genitourinary: No Problems**	☐	Increased water intake	☐	
☐	Ear pain	☐	Wheezing	☐	Painful urination	☐	**Muscle/Joint: No Problems**	☐	
☐	Ear drainage	☐	Coughing	☐	Frequent urination	☐	Joint pain/limited motion	☐	
☐	Ear fullness	☐	Coughing up blood	☐	Blood in urine	☐	Muscle weakness	☐	
☐	Dizziness	☐	Pain with breathing	☐		☐	Back pain	☐	

Please check if any blood relatives have any of the following:

Family Member	Alive/ Deceased	Diabetes	High Blood Pressure	Breast Cancer	Heart Disease	Lung Cancer	Colon Cancer	Heart Attack	High Cholesterol	Asthma	Hearing Loss
Father											
Mother											
Daughter(s)											
Son(s)											
Sister(s)											
Brother(s)											
Paternal Grandfather											
Paternal Grandmother											
Maternal Grandfather											
Maternal Grandmother											

PATIENT REGISTRATION FORM (eCW)

PATIENT INFORMATION (Please print)

Patient's Legal Name: (Last)_____(First)_____(MI) _____

Preferred Full Name (if different from above): _____

Address: _____

City, State, Zip: _____

Home Phone Number (landline):_____Cell:_____Work: _____

E-Mail Address:_____Date of Birth: _____

Gender Identity: ☐ Female ☐ Male ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer ☐ Choose not to disclose
☐ Additional Gender category not listed _____

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ White
☐ Hispanic ☐ Chose not to disclose ☐ Other not listed _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Choose not to disclose

Preferred Language: ☐ English ☐ Spanish ☐ ASL ☐ Japanese ☐ Mandarin ☐ Korean ☐ French ☐ Indian: Hindi, Tamil, Gujarati etc
☐ Swahili ☐ Russian ☐ Arabic ☐ Vietnamese ☐ Haitian Creole ☐ Bosnian/Croatian/Serbian/Serbo-Croatian
☐ Albanian ☐ Burmese ☐ Tagalog ☐ Farsi-Iranian/Persian ☐ Portuguese ☐ Cambodian ☐ Other not listed_____

Patient Social Security Number:___-_____-_____

RESPONSIBLE PARTY INFORMATION (*If not self*) (Information used for patient balance statements)

Responsible party: ☐ Another patient ☐ Guarantor ☐ Self Check here if address and telephone information is same as patient ☐
Responsible party name: (Last)_____(First)_____(MI) _____
Date of birth: MM_____/DD_____/YYYY_____ Sex: ☐ Female ☐ Male
Responsible Party Social Security Number:___-_____-_____Phone number: _____
Address:_____
City, State:_____ZIP: _____

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.
Policy Holder's Name: Last_____,First:_____DOB_____

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last)_____ (First) _____
Phone number:_____ Do you have a living will? ☐ Yes ☐ No
Emergency contact relationship to patient:_____ ☐ Guardian
Address_____
City, State:_____ZIP: _____
Home phone:_____Work hone:_____Ext. _____

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).
I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative:_____Date: _____

Printed name of patient or personal representative:_____Relationship to patient: _____

Diagnostic Nasal Endoscopy Financial Notice

Payment of Procedure: Your insurance company considers Diagnostic Nasal Endoscopy with or without Removal of Polyps/Debridement, Nasopharyngoscopy, Rigid or Flexible a surgical procedure. These procedures are not covered by your office co-payment and may be subject to your deductible and additional co-insurance. If your surgical deductible has not been met, the allowable charge per your contract with your insurance company will be applied to the patient's responsibility. The charge may be anywhere from $0 - $3000.00. The amount your insurance covers depends on your individual contract. **This is not included in your post-operative care.**

The procedure codes used are as follows:

CPT **92511** Nasopharyngoscopy, Rigid
CPT **31575** Nasopharyngoscopy, Flexible
CPT **31231** Nasal Endoscopy, Diagnostic
CPT **31237** Nasal Endoscopy with Removal of Polyps/Debridement

ROCKY MOUNTAIN ENT ASSOCIATES
FINANCIAL POLICY

We would like to thank you for choosing Rocky Mountain ENT Associates for your care. We are committed to providing you with the best possible care. We want you to be informed of our office financial policy and require a signature to document that you have read and understand our policy. You will be given a copy for your records.

SERVICE

You are here to receive a service. There are charges associated with the services we provide. Services include, and are not limited to: consultation, evaluation, and procedures**. *If you see one of our audiologists in addition to the physician, there is a separate charge for their service.** Services provided outside of our office will be charged by the entity providing the service. (i.e: labs, radiology)

MISSED APPOINTMENT/LATE CANCELLATION

Our office will call to confirm your appointment two business days prior to the appointment date. Broken appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. In order to maintain our schedule, we request **24 hour notice** for cancellations or rescheduling of appointments.

CHECK IN

We respect and value your time. ***If you are more than 10 minutes late for your appointment, we may need to reschedule***. We apologize for any inconvenience this may cause you, but we do our best to run on time and by being punctual, everyone will be served in a timely and efficient fashion while receiving the highest quality care.
ESTABLISHED PATIENTS: We request that **all** of our established patients **arrive 10 minutes prior** to their appointment for check in.
NEW PATIENTS: If it is your first time to our office, please arrive 15 minutes prior to your appointment time with your **paper work completed**. If the paper work is not complete, please arrive **30 minutes** prior to the appointment time.

PAYMENT

For patients with a **co-pay** plan, payment is expected at the time of service*. When you check in for the appointment, we will collect the amount indicated on your card unless instructed otherwise. We accept credit cards, checks and cash. All insurance carriers have a fee schedule from which they will reimburse. Any services not covered, **deductibles and coinsurance** are your responsibility and will be billed to you by our office. Payment is due with-in 30 days.
***We do not collect co-pays at the time of service for our audiology services. If your plan applies a co-pay for these services, we will send a statement to you.** *Most Aetna and Cigna plans apply co-pays to both the office visit and to the audiology service.*

SCOPE FINANCIAL FORM

_____***I have read the*** Diagnostic Nasal Endoscopy Financial Notice ***and agree to pay my patient balance if this surgical procedure is applied to my deductible or co-insurance.***

If you do not have insurance, payment is required at the time of service. If special circumstances make immediate payment impossible, payment arrangements must be approved in advance.

INSURANCE

All services performed by our providers will be submitted as a courtesy to your insurance. Insurance plans vary considerably. It is your responsibility to provide accurate and timely insurance information.

INSURANCE REFERRALS:

It is your responsibility to understand the requirements of your insurance policy. If a referral is needed prior to seeing a specialist, you will need to obtain one through your primary care doctor office. If you choose to be seen without a valid referral in place, you will be responsible for any charges not covered by your insurance company.

Guardian/Responsible Party Signature:_____ Date: