ROCKY MOUNTAIN ENT ASSOCIATES

1400 S. Potomac St. Suite 240 • Aurora, CO 80012
14100 E. Arapahoe Road • Centennial, CO 80112
Phone 303.750.8600 • Fax 303.743.7800

Pediatric Patient Intake Form

Date:_____ Name:_____ DOB:_____ Age:_____

Parent/Guardians Name(s): _____

Who referred you to us? (Referring Physician): _____

Please list the names of current medical providers:

Primary Care Provider:_____ Phone:_____

Other Provider:_____ Phone:_____

What is your preferred pharmacy?

Name/Location:_____ Phone:_____

What is the reason for the patient's visit today?

_____

_____

How long have the symptoms been present? _____

What makes them better? _____

What makes them worse? _____

What treatment(s) have been tried? _____

_____

What tests have been done? _____

Has allergy testing been done? _____ ***If yes, when?*** _____

MEDICAL HISTORY

Please list your prescribed, over-the-counter, or herbal medicines. Include doses and number of times taken per day:

☐ I am currently not taking medications

Name	Strength	# Taken	How Often	Start Date	End Date

Please List Any Allergies:

☐ No known allergies

Agent/Substance	Reaction	Agent/Substance	Reaction

Date:_____ **Name:**_____ **DOB:**_____ **Age:**_____

Has the patient had any of the following health problems? Check all that apply

- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmurs
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Asthma
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Pneumonia
- ☐ Stroke
- ☐ Seizures
- ☐ Head Injury
- ☐ Migraines
- ☐ Meningitis
- ☐ Back problems
- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Bleed Disorder
- ☐ Anemia
- ☐ Kidney infections
- ☐ AIDS/HIV+
- ☐ Thyroid problems
- ☐ Sinus Disease
- ☐ Hearing Loss
- ☐ Reflux Disease
- ☐ Ulcers
- ☐ Arthritis/ Joint Pain
- ☐ Cystic Fibrosis
- ☐ Down's syndrome
- ☐ Cancer, Type: _____

☐ **None of these listed**

Other Conditions:	Date Diagnosed	Other Conditions:	Date Diagnosed

Please List Prior Surgeries: ☐ No surgeries

Surgery	Date	Surgery	Date
		☐ ☐	

Patient's Hobbies/Activities: _____ Is the patient exposed to smoking? ☐ Yes ☐ No

Who lives in the patient's home? _____ Is the patient in daycare/school? ☐ Yes ☐ No What grade? _____

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 Grand Father											
Paternal Grand Mother											
Maternal Grand Father											
Maternal Grand Mother											

Please check if you have had and of the following in the last month:

	General: No Problems		Nose: No problems		Heart :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 allergies
	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		Hematology: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		

Patient Registration Form

PATIENT INFORMATION (Please Print)

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Jr. ☐ Sr. ☐ Other_____

Patient's Name (Last)_____ (First)_____ (Middle)_____

Also Known As Name (Last)_____(First)_____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Other

Social Security Number _____-_____-_____ ☐ Female ☐ Male Date of Birth_____/_____/_____

E-Mail Address_____

Phone Numbers Work_____ ☐ Day ☐ Evening Home_____ ☐ Day ☐ Evening

Cellular_____ Pager_____

Address_____

City, State, ZIP (+4)_____

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer_____ Occupation_____

Emergency Contact Name_____ Phone Number_____

Emergency Contact Relationship to Patient_____

Referring Provider Name_____

RESPONSIBLE PARTY INFORMATION

Responsible Party Name (Last)_____ (First)_____ (Middle)_____

Also Known As Name (Last)_____(First)_____

Social Security Number _____-_____-_____ ☐ Female ☐ Male Date of Birth_____/_____/_____

E-Mail Address_____

Phone Numbers Work_____ ☐ Day ☐ Evening Home_____ ☐ Day ☐ Evening

Address_____

City, State, ZIP (+4)_____

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer_____ Employer Phone Number_____

Patient Relationship to Responsible Party_____

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Name of Insured_____ Patient Relationship to Insured_____

Insured Employer Name_____

Insurance Company/Phone Number_____ (_____)_____

Subscriber ID (Policy Number)_____ Group ID_____ Copay Amount_____

Effective Date_____ Termination Date_____ ☐ Female ☐ Male

Insured Date of Birth_____/_____/_____ Insured's Social Security Number _____-_____-_____

Insurance Company Address_____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Name of Insured_____ Patient Relationship to Insured_____

Insured Employer Name_____

Insurance Company/Phone Number_____ (_____)_____

Subscriber ID (Policy Number)_____ Group ID_____ Copay Amount_____

Effective Date_____ Termination Date_____ ☐ Female ☐ Male

Insured Date of Birth_____/_____/_____ Insured's Social Security Number _____-_____-_____

Insurance Company Address_____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature_____ ***Date***_____

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:
Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.
If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice. ***The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).***

_____ (Patient/Representative initials) **I consent to receive text messages** from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).
The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is_____.

The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is_____.

Revocation
I hereby revoke my request for future communications via email and/or text.
__I hereby revoke my request to receive any future appointment reminders, feedback, and general health via text messages.
__ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email.
NOTE: This revocation only applies to communications from this Practice.
Patient Name: _____

Patient/Patient Representative Signature: _____

Date: _____ Time: _____

Consent for Photographing or Other Recording for Security and/or Health Care Operations
____ (Patient/Representative Initials) **I consen**t to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment, payment or health care operations purposes or otherwise permitted or required by law.

____ (Patient/ Representative Initials) **I do not consent** to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities).

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.
____ (Patient/ Representative initials) I wish to designate the following family member / friend to pick up an order on my behalf:
Name: _____ Date: _____
Name: _____ Date: _____

____ (Patient/ Representative initials) I do not want to designate anyone to pick-up my prescription order.

Patient/Parent/Guardian/Patient Representative Signature _____ **Date:** _____

Patient/Parent/Guardian/Patient Representative Name (Printed) _____

Patient Name (Printed): _____ **Date of Birth:** _____

A photocopy of this consent shall be considered as valid as the original.

Updated: February 24, 2016 replacing October 28, 2015, June 12, 2015 & November 21, 2013 version

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**
Printed Name of Witness	Employee Job Title
Signature of Witness	**Date**

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.*

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: _____

Consent to Procedure (continued)

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

I, _____, have read the Payment of Procedure Policy and agree
(Print Name)
to pay my patient balance if this surgical procedure is applied to my deductible or co-insurance.

_____ _____ _____
(Signature) (Patient DOB) (Date)