WELCOME TO LOUDOUN EAR NOSE AND THROAT

Betsy Vasquez, M.D. Lisa Fox, M.D. Kelly Pilson, Au.D

In order to provide the best care to our patient we ask that the NEW PATIENT REGISTRATION forms be completed in their entirety. Any personal information provided will be kept in the strictest confidence. HIPAA regulations require written consent from our patients prior to sending information to medical entities, (i.e. Insurance companies, Referring providers, etc.) and insurance companies require specific information in order to process your medical claim. If you are unable to provide all the information, we will kindly accept full payment and provide you with the necessary paperwork to submit your claim directly to your insurance company for direct reimbursement.

Patient Name:______________________ Date of Birth:__________Age:_______ Sex:_________

As it appears on insurance carrier records. Your chart will be filed and appointments will be entered under this name.

Street ______________________ City______________State _______Zip___________

Home Phone:______________ Cell Phone:____________Emerg name & phone #:______________

Email:______________________

Primary Dr.'s Name:______________________Did your Primary Dr. refer you?___________

If yes, Primary Dr.'s Address and phone:______________________

How were you referred? (Circle source) *Physician Family/Friend Insurance List/Book Internet Search Yellow Pages*

Primary Insurance Information

Please have your insurance card and picture ID ready. A copy will be kept in the patient chart.

(LENT does not bill to secondary insurance companies)

Please Circle: BCBS BCBSFEDERAL BCBSCAREFIRST CIGNA AETNA OTHER______________ SELF PAY

If patient is under 18,Guardian's Name: ______________________

Policy Holder's Name:______________________Policy Holder'sDOB:__________SS#:____________

Relationship to patient:______________________

I agree to all the terms regarding insurance reimbursement, financial responsibility and HIPAA consent as written below.

***SIGN HERE*X** ______________________________

*Today's Date:*_____ ______________

Failing to sign indicates you will pay for your visit today and request direct reimbursement from your health plan. This is a refusal of assignment of benefits to the provider.

Assignment of Benefits

If my insurance should deny any and all charges then I agree to be personally and fully responsible for any and all balances. **I understand that I am financially responsible for any balances not covered by my insurance carrier.** Healthcare Carriers will only pay for services determined to be reasonable and customary under Section 1862(a)(1) of the Medicare Law. Private and commercial insurances can deny coverage for the following reasons:

a. LENT, Dr. Lisa Fox or Dr. B Vasquez are not specialists in the particular insurance plan.
b. Patient is not listed as covered member or dependent.
c. Patient policy has terminated at time of service and/or patient did not present new insurance information.
d. Patient went to non-participating facility for x-rays or surgery.
e. Insurance will only cover a limited amount toward diagnostic in office testing.
f. Medicare will not cover hearing aids, fittings, hearing aid replacements, or hearing aid repairs, nor certain in office diagnostic testing.

I certify that the information given for payment is correct. I authorize direct payment of surgical/medical benefits to Dr. B Vasquez, & Dr. L. Fox, LENT for services rendered by him/her or under his/her supervision. I request payment of authorized benefits be made on my behalf.

Consent to Use and Disclosure of Protected Health Information (HIPAA)

Your protected health information will be used by LENT or disclosed to others for the sole purpose of medical treatment, obtaining payment or supporting day-to-day health care operations of the practice. You should review the NOTICE OF PRIVACY PRACTICES for a more complete description of how protected health information may be used or disclosed. You may review the notice prior to signing this consent.

You may request a restriction on the use or disclosure of your protected health information in writing. If LENT agrees to your

Health Questionnaire

Patient Name:____________________

Today's Date:__________ What is your Height_____ Weight _____

REASON FOR VISIT:

The Doctor would like you to write down your symptoms. Please be specific.

Why are you here today?

Family History: Does any blood relative suffer from the following?

Please circle all that apply.

Epilepsy	Thyroid	Osteoporosis	High Cholesterol
Migraine	Hayfever	Arthritis	Alcoholism
Mental Illness	Asthma	Heart Disease	Hepatitis
Glaucoma	Anemia	Stroke	Cancer
Diabetes	Bleeds easily	Hypertension	Other specify:_____

Do you take any medication? NO
YES (list)__________

Are you allergic to medications? NO
YES (list)__________

Hospital Admissions: Not including pregnancies

Year Illness/Operation

Patient Medical History. Please circle all that apply or write NONE. _____

Decreased hearing	Loss of appetite	Tremors
Ringing in ears	Difficulty swallowing	Frequent Headaches
Frequent ear infections	Heartburn/Peptic Ulcer	Numbness/Tingling
Dizzy/fainting spells	Persistent Nausea/Vomiting	Arthritis/Rheumatism
Failing vision/eye pain	Chronic Abdominal Pain	Recurrent Back Pain
Double/blurred vision	Jaudice/Hepatitis	Rashes/Hives
Recurrent nose bleeds	Diverticulosis/Crohns/Colitis	Psoriasis/Eczema
Sinus trouble	Hemorrhoids/Hernia	Sleeping or Concentration Difficulty
Frequent sore throats	Unrination/Overactive Bladder	Depression
Prolonged hoarseness	Decrease/Painful in force/flow	Nervousness
Hayfever/Seasonal allergies	Blood in Urine	Memory Loss
Pneumonia/Pleurisy	Kidney Stones	Mental Illness
Bronchitis/Chronic cough	Frequent Urine Infections	Rheumatic/Scarlet Fever
Asthma/Wheezing	Sexually Transmitted Diseases	Tuberculosis
Shortness of breath with exertion laying flat	Irregular Weight Gain/Loss	Herpes
	Anemia/Bruise Easily	Aids/HIV
High Blood Pressure	Cancer	Progressive or recent hair loss
Heart Murmur	Chronic Fatigue	Street Drugs
Irregular Pulse/Palpitations	Diabetes	Acupuncture/Tatoos
Thyroid Disease	Seizure/Stroke	Other _____

Have you taken any over the counter, or prescription allergy or reflux medications? NO
YES (list)__________

Spinal Problems specify:_____

Alcohol _____ oz. per week

Coffee/Tea ____ cups per day

Smoking ___ cigs/day ____x yrs Year Quit ____

Occupation:__________

PHARMACY Name:__________

PHARMACY Phone:__________

Office Policies

Due to the changes in insurance and patient responsibilities, our office has established policies to better inform and protect the patient and the practice. All policies must be initialed in order to complete the registration process and see the practitioner. A copy may be provided at your request.

Initials Here

I. Cancellation Policy

______ **24 hours notice is required to avoid the $75.00 missed appointment fee.** We cannot offer reminder calls due to staff limitations. In the event you miss your appointment or cancel the same day, the fee will be added to the patient's account and collected at the time of the follow up visit or over the phone. We also reserve the right to collect this fee using credit card information on file.

II. Copayments, Coinsurance, Deductibles

______ We collect all patient financial responsibility at the time of the visit. If we are in network with your health plan, any fee collected will be based on the appropriate "allowed amount." In most cases, even if we are not in network, we may still be able to submit your claim to your health plan. You will be provided a receipt if we are not able to submit your claim and you will be reimbursed directly from your plan based on your health plan benefit.

III. Surgery Deposits

______ If you and the doctor agree a surgery will be performed, a deposit will be required. This is a minimum charge of $100 up to 50% of the allowed amount for the surgeon only, depending on the type of surgery. Once payment has been received by your health plan, you will be reimbursed appropriately. NOTE: $100 of the deposit will be forfeited and is non-refundable if a patient 1) cancels a surgery for anything other than a family or medical emergency, 2) postpones the surgery past 1 month, 3) fails to show for a pre op visit and the surgery has to be canceled or rescheduled.

IV. Eligibility and Benefit Verification

______ Patient insurance eligibility and benefits are verified at the time of the visit. If we are unable to verify coverage, the patient will be responsible for the cost of the visit. A receipt will be provided for direct reimbursement from the patient's health plan, or the patient may cancel or reschedule the appointment without penalty. All denied claims for a patient's failure to provide information to the health plan in a timely fashion or for preexisting conditions will become patient financial responsibility. In the event a claim is denied for these or other reasons caused by the patient, we reserve the right to collect the cost at the next follow up visit, over the phone, or credit card information on file.

V. In Network Provider

______ It is the patient's responsibility to ensure Dr. Betsy Vasquez and Dr. Lisa Fox are in network with their health plan. Patients must bring referrals from primary care physicians at the time of the visit if required by their health plan. In most cases, even if we are not in network, we may still be able to submit your claim to your health plan. Denials by your health plan for non-coverage will result in patients being charged the full cost of the visit. In the event a claim is denied after submission to the health plan, for these or other reasons caused by the patient, we reserve the right to collect the cost at the next follow up visit, over the phone, or credit card information on file.

VI. Paperwork Fees

______ Our office charges a fee for completion of health care and work related forms, preparation of letters, copying of medical records, or replacement copies/faxes of referrals for CT/MRI, etc. This fee ranges from $5.00 to $25.00 plus .10 cents per copy of page. The fee will be added to the patient's account and collected at the time of pickup, the follow up visit or over the phone.

X____

Patient/Guardian Signature Print Name

My initials and signature indicate I have reviewed the above policies and agree to the terms.

X____

Provider Signature

Loudoun ENT Specialists 46090 Lake Center Plaza, Ste 104, Sterling, VA 20147 703-421-1700 ENTofLoudoun.com

Financial Agreement

Although we participate with many insurance carriers, there are times when patients are responsible for deductibles and coinsurance. We collect all these fees which are the patient responsibility at the time of the office visit. We will contact your insurance company to verify the amount you will owe based on the "allowed amount." We do not bill for copays, deductibles, or coinsurances.

For patients with specific **out of network health plans**, **Medicare**, or are **uninsured**, payment is required at the time of the visit.

Your signature below indicates:

1. I will pay my financial obligation as calculated according to the allowed amount at the time of the medical office visit, or prior to any surgery. **This office does not submit to secondary plans.**
2. or, I am a self pay patient and will pay the fee for service at the time of the medical office visit.
3. Loudoun ENT Specialists will submit my claim on my behalf and as required by a participating provider, when applicable.
4. Loudoun ENT Specialists will provide a receipt of payment if required for direct reimbursement. If for reasons beyond Loudoun ENT Specialist's control, my insurance reimburses the provider, I will be refunded appropriately.
5. Medicare patients will be charged the amount of the Medicare fee schedule of 2007. Our status with Medicare is: We are not accepting assignment and have opted out of the plan. Please submit all paperwork received from Loudoun ENT Specialist to your secondary insurance.
    a. Claims submitted to Medicare will result in immediate denial with no recoup of payment.
    b. A denial from Medicare is not due to our status with Medicare. Denials are a result of annual deductibles, missing or incomplete patient or secondary insurance information, or a claim sent to Medicare.
6. I understand that my credit card may be charged for remaining balances and/or outstanding fees as specified in the office policies.

Self Pay Patients please circle the reason for self pay status:

1. Loudoun ENT Specialists cannot verify eligibility with my health plan.
2. I am a Medicare patient.
3. Loudoun ENT Specialists does not accept nor submits to my health plan.
4. I am uninsured.

X ____

Patient signature Today's Date

X____

Provider Signature

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