Advantage ENT & Audiology

Dr. David Van Kooten **Dr. David Hartemink** **Dr. Justin C. Yan**

PLEASE USE ONLY BLACK INK

TODAY'S DATE:_____

Patient Information:

Last Name_____First Name_____ Middle Initial_____

Mailing address_____**APT#_____**City_____State_____Zip_____

Home Phone_____Cell Phone_____Can we text? YES NO

Work Phone_____Employer_____

Date of Birth_____Age_____Sex_____Social Security No._____

Email_____ Is it ok to communicate with you via email? Yes _____No_____

Race_____Ethnicity_____Language_____Refuse to Answer_____

Pharmacy Information

Pharmacy Name_____Pharmacy City/Cross streets_____

Referring Physician information

Primary Care Physician_____Phone Number _____

Referring Physician_____Phone Number_____

Is this a work related injury/illness? Yes No Is this a car accident related injury/illness? Yes No

- **Document if you have disability Medicare coverage! (Not age related)**

Primary Insurance Information

Primary Insurance Name_____ID #_____Group No._____

SPECIALIST COPAY $_____Policyholder's name_____

(If patient is not the policyholder, please complete the section below)

Policyholder's Address_____Phone _____

Policyholder's Social Security No._____Policyholder's Employer_____

Policyholder's Marital Status_____Policyholder's Date of Birth_____

Patient's relationship to Policyholder_____

Secondary Insurance Information

Secondary Insurance Name_____ID #_____Group No._____

SPECIALIST COPAY $_____Policyholder's name_____

(If patient is not the policyholder, please complete the section below)

Policyholder's Address_____Phone number_____

Policyholder's Social Security No._____Policyholder's Employer_____

Policyholder's Marital Status_____Policyholder's Date of Birth_____

Patient's relationship to Policyholder_____

Auto Injury/ Work Comp

Auto injury or Work Comp?_____Claim No._____Date of accident_____

Emergency Contact

Name_____ Phone_____ Relationship to patient_____

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Print Patient Name_____Date of Birth_____

AUTHORIZATION TO PROCESS CLAIMS

I authorize the release of any information required to process claims, utilization review and quality assurances for services rendered and hereby assign my insurance benefits to be paid directly to my physician.*

_____ _____
Signature of Patient or Guardian Date

ACKNOWLEDGEMENT OF FINANCIAL POLICY

I have read and acknowledge the financial policies of the office. This policy includes a $50.00 fee for failing to cancel an appointment with 24-hour notice. **I also understand it is my responsibility to update insurance information with the office and to have a current referral from my primary care office if required by my plan**.

_____ _____
Signature of Patient or Guardian Date

HIPAA ACKNOWLEDGEMENT

I acknowledge that I have read the Notice of Privacy Practices, including marketing contact. (A copy is available in the office upon request) We may text appointment reminders to a cell phone if one is provided.

_____ _____
Signature Patient or Guardian Date

***** Is there anyone we can talk to about medical issues? YES / NO**
Name_____Phone Number _____Relationship_____
Name_____Phone Number _____Relationship_____

Can we leave a voicemail regarding medical issues? YES / NO Phone Number_____
Can we communicate via text message? YES / NO Phone Number _____

ELECTRONIC PRESCRIPTION ACCESS

I acknowledge that the office may use an electronic system to look at/and prescribe medications

_____ _____
Signature Patient or Guardian Date

*****The authorization to process claims, the financial policy, the HIPAA acknowledgement and E-prescribing access must be signed to be seen in our office.**

Dr. David Van Kooten **Dr. David Hartemink** **Dr. Justin C. Yan**

Welcome to our office. Please provide answers to the following questions so we may better care for you.

Patient Name_____**DOB** _____**Today's Date** _____

Reason for today's visit _____

Medications* ** (Include all reasons for your medications)

Do you take any prescription medications or supplements? No_____Yes_____

1_____ 4 _____7 _____

2_____ 5_____ 8 _____

3_____ 6_____ 9 _____

Have you had a flu vaccine since last September? YES NO **If yes, Where**? _____

Medical History (diabetes, heart disease, high cholesterol, asthma, allergies, cancer history etc)

1 _____ 5 _____

2 _____ 6 _____

3 _____ 7 _____

4 _____ 8 _____

Allergies

Do you have an allergy to latex? No ___Yes ___ Do You have a seafood or Iodine allergy? No___Yes____

Do you have an allergy to any medications? No_____ Yes _____ if so, please list.

1_____ 4 _____

2 _____ 5 _____

3_____ 6 _____

Surgical History (List any surgeries you have had. PLEASE, include right or left)

1_____ 3 _____

2 _____ 4 _____

Have you ever had problems with general anesthesia? No _____Yes _____

Have you ever had a blood transfusion? No _____Yes _____

Hospitalizations (where, when, what were you seen for?)

1 _____4 _____

2 _____5 _____

3 _____6 _____

Family History (circle what applies and list who in your family had the issue)

Hearing loss____Heart disease____Anesthesia problems___Diabetes___Cancer(if yes what type?)_____

Have you used recreational drugs of ANY type in the past 12 Months?_____**What kind**?_____When?_____

CIRCLE APPROPRIATE ANSWERS BELOW

Are you a… Current smoker Nonsmoker Former smoker

Additional Info For Current smoker

1. How often do you smoke cigarettes? Everyday Some days, but not everyday

2. How many cigarettes a day do you smoke? 5 or less 6-10 11-20 21-30 31 or more

3. Are you interested in quitting? Ready to quit Thinking about quitting Not ready to quit

Additional Info For Former smokers…

Light smoker (1-9 cigs/day) Moderate smoker (10-19 cigs/day) Heavy smoker (20-39 cigs/day)

Alcohol use ***CIRCLE APPROPRIATE ANSWERS***

1. How often do you have a drink containing alcohol in the last year?

Never Monthly or less 2-4 times a month 2-3 times a week 4 or more times a week

2. On a typical day when you are drinking, how many drinks did you have?

1 to 2 drinks 3 to 4 drinks 5 to 6 drinks 7 to 9 drinks 10 or more drinks

3. How often do you have 6 or more drinks on one occasion? Never Less Than Monthly Weekly Daily (most days)

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Review of System

Patient Name_____ Date of Birth_____Today's Date_____

Do you have any of the following? (Please circle ALL that apply to you)

ENT: ear infection, ear drainage, hearing problem, dizziness, change in smell/taste, nasal drainage, nasal obstruction, facial pain, nasal trauma, snoring, voice change, pain with swallowing, chronic cough, neck mass, head and neck cancer, mouth lesions/sores, tonsillitis, shortness of breath, difficulty swallowing, ear pain, nosebleed, ringing in the ears, sinus infections

Ophthalmologic: glaucoma, Blurred vision

General/ Constitutional: chills, fatigue, fever, recent weight gain, recent weight loss

Cardiovascular: high blood pressure, chest pain at rest, chest pain with exertion, palpitations

Respiratory: asthma, wheezing

Gastrointestinal : heartburn, nausea

Skin: eczema, rash

Hematology: easy bleeding, family history of bleeding, swollen glands

Musculoskeletal: joint pain, neck pain

Psychiatric: anxiety, depressed mood

Infectious Diseases: HIV, hepatitis A, hepatitis B, hepatitis C, tuberculosis

Neurologic: stroke, headache, seizures/epilepsy

Endocrine: diabetes, thyroid problems

Patient Signature_____Date_____

7850 Vance Dr Suite #225 Arvada, CO 80003
500 W 144th Ave Suite #100 Westminster, CO 80023
3555 Lutheran Pkwy Suite #160 Wheat Ridge, CO 80033

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To comply with Federal HIPAA (Health Insurance Portability and Accountability Act) guidelines Dr. Van Kooten and Dr. Hartemink have implemented the following policy regarding Patient Privacy and Confidentiality. There are posters in the office with ALL the HIPAA guidelines. This sheet serves as notification of our policy. (A copy of the entire HIPAA law is available at any time)

PRIVACY NOTICE

Our office holds patient record information confidential. However, we will use this information for the following reasons: TREATMENT, PAYMENT & HEALTHCARE OPERATIONS. The following is a list of who your information might be disclosed to:

- Primary care physician or other physicians involved in your care
- Diagnostic Facilities
- Hospitals
- Labs
- Insurance Companies
- Billing and Collection Services
- Workers' Compensation

DISCLOSING RECORD INFORMATION

Release of information to any other entity (not listed above) will require a signed request from the patient or guardian. This request must be dated, show who the information is to be released to, their address and specify what information will be released. These authorizations are good for one time only. Additional requests will require a separate authorization. We will keep a record of any disclosure of your medical records. This information will be available for your review.

YOU HAVE A RIGHT TO ACCESS YOUR RECORDS

Patients can review and obtain copies of their records. Our office requires a written request:

- In compliance with Federal and State Laws our office will have records available within 10 days of receipt of the request.

MARKETING

This office, on occasion, will mail information to our patients regarding upcoming sales, promotions or information that may be of value to our patients. I acknowledge that I understand that I may receive some of this information and this office may receive reimbursement for the cost of these mailings from a third party. I also understand that I have the right to opt-out, in writing, at any time and no longer receive these mailings. Appointment and reminder calls/cards are not bound by these policies.

OTHER INFORMATION

If we need to contact you by telephone and leave a message we will only leave the practice name, the person calling and our phone number. We WILL NOT leave any medical information on an answering machine or with anyone other than the patient or guardian. It will then be your responsibility to return the call.

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Patient Financial Policy

Billing & Payment: Payment is expected at the time of service unless prior arrangements have been made. Co-pays are required at the time of service prior to being seen. We accept cash, Master Card, Visa, Discover, American Express and checks with valid driver's license. If you pay in cash you will receive a receipt. It is your responsibility to know your co-payment.

Insurance: If your insurance coverage requires a referral from your primary care doctor it is your responsibility to have that sent to our office prior to making an appointment. As a courtesy we will submit your bill to your insurance company. Your insurance company will send an Explanation of Benefits (EOB) to you as well as to us. If there is any amount owed by you due to co-insurance or deductible we will send you a statement reflecting that. If the bill is not paid within 90 days of the date of service, the balance will be due and payable by you. Payment for our services is your responsibility. Please call your insurance company if you have any questions or complaints about your coverage.

Non-Insured Patients: Patients with no insurance are asked to pay for their visit at the time of service. The staff will collect the office visit charge before seeing the doctor. If any other services are preformed (Audio testing, use of Microscope, etc) those charges will be expected at the time they are done.

Forms: Disability forms, FMLA forms, restrictions forms/question forms sent by your employer, and letters to attorneys will be provided after requested pre-payments are received. If you require documentation for your HRA spending account, please request a copy of your bill at the time of service, otherwise there will be a $25.00 fee assessed if we have to provide it to you later.

Missed Appointments: Missed appointments or failure to call the office 24 hours before scheduled appointment will result in a $50.00 charge.

We appreciate your assistance and look forward to serving you.