ENTICARE

NEW PATIENT PACKET

REASON FOR TODAY'S VISIT: _____ DATE: _____
MOTIVO DE LA VISITA DE HOY *FECHA*

RELATIONSHIP TO PATIENT: _____ LEGAL GUARDIAN: _____
RELACIÓN CON EL PACIENTE *GUARDIÁN LEGAL*

PATIENT INFORMATION:
INFORMACION DEL PACIENTE

Patient Name: _____ DOB: ____ /____ / ____ Age: _____
Nombre del paciente *Fecha de nacimiento* *Edad*

Sex: ❑ Male ❑ Female Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Other
Sexo *Hombre* *Mujer* *Estado Civil* *Soltero* *Casado* *Divorciado* *Viudo* *Otro*

Mailing Address: _____ City: _____ State: _____ Zip: _____
Dirección de envio *Ciudad* *Estado* *Codigo Postal*

Other Address: _____ City: _____ State: _____ Zip: _____
Otra dirección *Ciudad* *Estado* *Codigo Postal*

Home Phone: _____ Cell Phone: _____ Work Phone: _____
Teléfono de casa *Teléfono movil* *Teléfono de trabajo*

Preferred method for appointment reminders (check all that apply): ❑ Home Phone ❑ Cell Phone ❑ Text ❑ Email
Metodo preferido para recordatorios de citas *Teléfono de casa* *Teléfono movil* *Texto* *Correo electronico*

Email (print clearly): _____
Correo Electronico (imprima claramente)

Pharmacy Name & City: _____ Cross Street: _____ Phone: _____
Nombre de farmacia y ciudad *Calles que cruzan* *Teléfono*

REFERRAL INFORMATION:
INFORMACION REFERENCIAL

Referring Facility: _____ Address / Location: _____
Oficina de referencia *Direccion*

Referring Provider Full Name: _____ Phone: _____
Nombre complete del proveedor de referencia *Teléfono*

Primary Care Physician Full Name: _____ Phone: _____
Nombre complete del medico de atencion primaria *Teléfono*

❑ **SELF PAY**
SIN SEGURO

Responsible Party/Guardian (if patient is a minor): _____ Phone: _____
Persona responsible (Si el paciente es menor de edad) *Teléfono*

PRIMARY INSURANCE CO: _____ ID / Policy #: _____
Seguro Primario *ID/Número de póliza*

Policy Holder Name: _____ Group #: _____
Nombre del titular de la póliza *Número de grupo*

Relationship to Patient: _____ DOB: ____ /____ / ____
Relación con el paciente *Fecha de nacimiento*

SECONDARY INSURANCE CO: _____ ID / Policy #: _____
Seguro Secundario *ID/Número de póliza*

Policy Holder Name: _____ Group #: _____
Nombre del titular de la póliza *Número de grupo*

Relationship to Patient: _____ DOB: ____ /____ / ____
Relación con el paciente *Fecha de nacimiento*

Federal Privacy Standards require the following information:
Los Estandares Federales de Privacidad requieren la siguiente información

Race: ❑ White ❑ Hispanic ❑ Asian ❑ African American ❑ American Indian / Alaskan Native
Raza *Blanco* *Hispánico* *Asiático* *Afro Americano* *Indio Americano / Nativo de Alaska*
❑ Native Hawaiian or Other Pacific Islander ❑ Other Race ❑ Unreported / Refused to Report
Nativo de Hawai u otra isla del Pacifico *Otra raza* *No informado / rechazado a informar*

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Refused to Report
Etnicidad *Hispánico o Latino* *No Hispánico o Latino* *Rechazado a informar*

Preferred Language: ❑ English ❑ Spanish ❑ Other
Idioma preferido *Inglés* *Español* *Otro*

HIPAA APPROVED CONTACTS:
CONTACTOS APROBADOS POR HIPAAA

- *Please list the individuals you give permission to have access to and discuss your protected health information.*
  Enumere las personas a las que les da permiso para tener acceso y discuta su información de salud protegida.
- *Write 'NONE' if there are no authorized individuals.*
  Escriba 'NINGUNO' si no hay personas autorizadas

Name: _____ DOB: _____ Phone: _____ Relation to patient: _____
Nombre *Fecha de nacimiento* *Numero de Telefono* *Relación*

Name: _____ DOB: _____ Phone: _____ Relation to patient: _____
Nombre *Fecha de nacimiento* *Numero de Telefono* *Relación*

EMERGENCY CONTACT (REQUIRED):
CONTACTO DE EMERGENCIA (REQUERIDO)

Name: _____ DOB: _____ Phone: _____ Relation to patient: _____
Nombre *Fecha de nacimiento* *Numero de Telefono* *Relación*

What is your Height?_____ Weight?_____
¿Cuál es su altura? *¿Peso?*

MEDICATIONS:
❑ None
MEDICAMENTOS *Ninguno*

- *Please list all the medications you are taking, including supplements (attach list as needed).*

Escriba todos los medicamentos que está tomando, incluidos los suplementos. (adjunte a lista según sea necesario)

ALLERGIES:
❑ None
ALERGIAS *Ninguno*

Are you allergic to: ❑ Latex ❑ Contrast Dye ❑ Adhesive Tape ❑ Iodine
¿Eres alérgico a *Látex* *Tinte de contraste* *Cinta adhesive* *Yodo*

- *Please list any medications you are allergic to and how each affects you.*

Escriba cualquier medicamento al que sea alérgico y cómo la afecta cada uno

SURGERY HISTORY:
❑ None
HISTORIA DE CIRUGÍA *Ninguno*

Have you ever had problems with anesthesia? ❑ Yes ❑ No
¿Alguna vez ha tenido problemas con la anestesia? *Si* *No*

Please explain: _____
Por favor explique

PROCEDURE	DATE (MO/YR)

FAMILY HISTORY:
❑ None
HISTORIA FAMILIAR *Ninguno*

Please list any family history of your **Father, Mother, Siblings, Children** and **Grandparents**.
*Escriba los antecedentes familiares de su **Padre, Madre, Hermanos, Hijos** y **Abuelos***

CONDITION *CONDICIÓN*	RELATIONSHIP *RELACIÓN*
Problems with anesthesia *Problemas con la anestesia*	
Thyroid disease *Enfermedad de tiroides*	
Thyroid cancer *Cáncer de tiroides*	
Throat cancer *Cáncer de garganta*	
Other cancer: *Otro cáncer*	
Early hearing loss *Pérdida de la audición*	
Heart disease *Enfermedad del corazón*	
High blood pressure *Alta presion sanguinea*	
Diabetes *Diabetes*	
Stroke *Derrame Cerebral*	
Asthma *Asma*	
Kidney problems *Problemas de riñon*	
Bleeding / Clotting problems *Problemas de sangrado / coagulación*	
Other: *Otro*	

SOCIAL HISTORY:
HISTORIA SOCIAL

Are you a: ❑ Non-smoker ❑ Former Smoker ❑ Current Smoker
Eres un *No Fuma* *Ex-fumador* *Actual fumador*

If **'Former Smoker':**
Si 'Ex fumador'
How long did you smoke?_____
¿Cuánto tiempo fumaste?
When did you quit? _____
¿Cuándo dejaste de fumar?

If **'Current Smoker':**
Si 'Fumador actual'
How many packs per day do you smoke? _____
¿Cuántos paquetes al día fumas?
How long have you smoked? _____
¿Cuántos tiempo has fumado?
Are you interested in quitting? ❑ Yes ❑ No
¿Estás interesado en dejar de fumar? *Si* *No*
Do you drink? ❑ Yes ❑ No
¿Bebes alcohol? *Si* *No*
If **'Yes':** How often do you drink? ❑ Daily ❑ Few per week/mo ❑ Rarely
En caso afirmativo, ¿con qué frecuencia bebes? *Diario* *Pocos por semana/mes* *Rara vez*

RECREATIONAL DRUG USE:
USO RECREATIVO DE DROGAS

❑ Never ❑ Previous ❑ Current
Nunca *Anterior* *Presente*

Drug: _____
Droga
Last Used: _____
Utilizado por última vez

Female Patients Only:
Solo pacientes femeninos
Are you now or is there a chance that you are pregnant? ❑ Yes ❑ No
¿Está usted ahora o existe la posibilidad de que esté embarazada? *Si* *No*

MEDICAL HISTORY: **ALL PATIENTS**

HISTORIAL MÉDICO: TODOS LOS PACIENTES

Have you ever been **DIAGNOSED** with any of the following conditions?
*¿Alguna vez ha sido **DIAGNOSTICO** con alguna de las siguientes condiciones?*

Acid reflux (GERD) *Reflujo ácido (ERGE)*	❑ Yes *Si*	❑ No *No*
Alcohol abuse *Abuso de alcohol*	❑ Yes *Si*	❑ No *No*
Anemia *Anemia*	❑ Yes *Si*	❑ No *No*
Anxiety *Ansiedad*	❑ Yes *Si*	❑ No *No*
Asthma *Asma*	❑ Yes *Si*	❑ No *No*
Atrial fibrillation *Fibrilación auricular*	❑ Yes *Si*	❑ No *No*
Bronchitis, chronic *Bronquitis crónica*	❑ Yes *Si*	❑ No *No*
Cancer, breast *Cáncer de mama*	❑ Yes *Si*	❑ No *No*
Cancer, lung *Cáncer de pulmón*	❑ Yes *Si*	❑ No *No*
Cancer, prostate *Cáncer de próstata*	❑ Yes *Si*	❑ No *No*
Cancer, skin *Cáncer de piel*	❑ Yes *Si*	❑ No *No*
Cancer, thyroid *Cáncer de tiroides*	❑ Yes *Si*	❑ No *No*
Cataracts *Cataratas*	❑ Yes *Si*	❑ No *No*
Congestive heart failure *Insuficiencia cardíaca congestiva*	❑ Yes *Si*	❑ No *No*
Deep vein thrombosis (DVT) *Trombosis venosa profunda*	❑ Yes *Si*	❑ No *No*
Dementia *Demencia*	❑ Yes *Si*	❑ No *No*
Depression *Depresión*	❑ Yes *Si*	❑ No *No*
Diabetes mellitus *Diabetes mellitus*	❑ Yes *Si*	❑ No *No*
Elevated cholesterol *Colesterol elevado*	❑ Yes *Si*	❑ No *No*
Emphysema (COPD) *Enfisema*	❑ Yes *Si*	❑ No *No*
Environmental allergies *Alergias ambientales*	❑ Yes *Si*	❑ No *No*
Epilepsy *Epilepsia*	❑ Yes *Si*	❑ No *No*
Gastric ulcer *Úlcera gástrica*	❑ Yes *Si*	❑ No *No*
Glaucoma *Glaucoma*	❑ Yes *Si*	❑ No *No*
Heart attack or cardiac stents *Ataque al corazón*	❑ Yes *Si*	❑ No *No*
Hemophilia *Hemofilia*	❑ Yes *Si*	❑ No *No*
Hepatitis B *Hepatitis B*	❑ Yes *Si*	❑ No *No*
Hepatitis C *Hepatitis C*	❑ Yes *Si*	❑ No *No*
HIV / AIDS *VIH / SIDA*	❑ Yes *Si*	❑ No *No*
Hypertension *Hipertensión*	❑ Yes *Si*	❑ No *No*
Migraine headaches *Migrañas*	❑ Yes *Si*	❑ No *No*
Multiple sclerosis *Esclerosis multiple*	❑ Yes *Si*	❑ No *No*
Parkinson's disease *Enfermedad de Parkinson*	❑ Yes *Si*	❑ No *No*
Pulmonary embolism (PE) *Embolia Pulmonar*	❑ Yes *Si*	❑ No *No*
Renal failure *Insuficiencia renal*	❑ Yes *Si*	❑ No *No*
Rheumatoid arthritis *Artritis Reumatoide*	❑ Yes *Si*	❑ No *No*
Sleep apnea *Apnea del sueño*	❑ Yes *Si*	❑ No *No*
Stroke *Accidente cerebrovascular medico*	❑ Yes *Si*	❑ No *No*

Other:
Otro

REVIEW OF SYMPTOMS:

¿REVISIÓN DE SÍNTOMAS?

Do you **NOW** have any of the following symptoms?
¿AHORA tiene alguno de los siguientes síntomas?

Fatigue *Fatiga*	❑ Yes *Si*	❑ No *No*
Fever *Fiebre*	❑ Yes *Si*	❑ No *No*
Headache *Dolor de cabeza*	❑ Yes *Si*	❑ No *No*
Sleep disturbance *Trastorno al dormir*	❑ Yes *Si*	❑ No *No*
Weight gain *Aumento de peso*	❑ Yes *Si*	❑ No *No*
Weight loss *Pérdida de peso*	❑ Yes *Si*	❑ No *No*
Congestion *Congestión*	❑ Yes *Si*	❑ No *No*
Sneezing *Estornudos*	❑ Yes *Si*	❑ No *No*
Runny nose *Nariz que moquea*	❑ Yes *Si*	❑ No *No*
Watery eyes *Ojos llorosos*	❑ Yes *Si*	❑ No *No*
Blurred vision *Visión borrosa*	❑ Yes *Si*	❑ No *No*
Diminished visual acuity *Actividad visual disminuida*	❑ Yes *Si*	❑ No *No*
Itching and redness *Picazón y enrojecimiento*	❑ Yes *Si*	❑ No *No*
Decreased hearing *Disminución de la audición*	❑ Yes *Si*	❑ No *No*
Decreased sense of smell *Disminución del sentido del olfato*	❑ Yes *Si*	❑ No *No*
Difficulty swallowing *Dificultad para tragar*	❑ Yes *Si*	❑ No *No*
Dry mouth *Boca seca*	❑ Yes *Si*	❑ No *No*
Ear pain *Dolor de oído*	❑ Yes *Si*	❑ No *No*
Nose bleed *Sangrado de nariz*	❑ Yes *Si*	❑ No *No*
Ringing in ears *Zumbidos en los oídos*	❑ Yes *Si*	❑ No *No*
Sinus pain *Dolor de sinusitis*	❑ Yes *Si*	❑ No *No*
Sore throat *Dolor de garganta*	❑ Yes *Si*	❑ No *No*
Swollen glands *Glándulas inflamadas*	❑ Yes *Si*	❑ No *No*
Cough *Tos*	❑ Yes *Si*	❑ No *No*
Shortness of breath at rest *Dificultad para respirar al descansar*	❑ Yes *Si*	❑ No *No*
Wheezing *Resollar*	❑ Yes *Si*	❑ No *No*
Irregular heartbeat *Latido del corazón irregular*	❑ Yes *Si*	❑ No *No*
Diarrhea *Diarrea*	❑ Yes *Si*	❑ No *No*
Heartburn *Acidez*	❑ Yes *Si*	❑ No *No*
Nausea *Náusea*	❑ Yes *Si*	❑ No *No*
Vomiting *Vómitos*	❑ Yes *Si*	❑ No *No*
Easy bruising *Fácil de moretearse*	❑ Yes *Si*	❑ No *No*
Prolonged bleeding *Sangrado prolongado*	❑ Yes *Si*	❑ No *No*
Joint stiffness *Rigidez articular*	❑ Yes *Si*	❑ No *No*
Leg cramps *Calambres en las piernas*	❑ Yes *Si*	❑ No *No*
Muscle aches *Dolores musculares*	❑ Yes *Si*	❑ No *No*
Eczema *Eczema*	❑ Yes *Si*	❑ No *No*
Hives *Urticaria*	❑ Yes *Si*	❑ No *No*
Rash *Sarpullido*	❑ Yes *Si*	❑ No *No*
Dizziness *Mareo*	❑ Yes *Si*	❑ No *No*
Seizures *Convulsiones*	❑ Yes *Si*	❑ No *No*
Tremors *Temblores*	❑ Yes *Si*	❑ No *No*

EUSTACHIAN TUBE DYSFUNCTION

DISFUNCION DEL TUBO EUSTACHIANO

During the last month, how much of a problem was each of the following:
Durante el ultimo mes, que tan problematico fue cada uno de los siguientes

0 = no problem | 2 = moderate problem | 5 = very severe
0 = no hay problema I 2 = problema moderato I 5 = muy severo

Pressure in the ears *Presión en los oídos*	0	1	2	3	4	5
Pain in the ears *Dolor en los oídos*	0	1	2	3	4	5
Ears feel clogged or underwater *Las orejas se sienten obstuidas o bajo el agua*	0	1	2	3	4	5
Ear problems when you have a cold or sinusitis *Problemas de oído cuando tiene un resfriado o sinusitis*	0	1	2	3	4	5
Crackling or popping sounds *Sonidos de crujidos o estallidos*	0	1	2	3	4	5
Ringing in the ears *Zumbido en los oídos*	0	1	2	3	4	5
Muffled feeling in ears *Sensación amortiguada en los oídos*	0	1	2	3	4	5

Total Score _____ **+ 7 = Mean Item Score**_____
Puntuación total *+ 7 = Puntuación de elementos medios*

Are these symptoms in : ❑ Left ear only *Izquierdo* ❑ Right ear only *Derecho* ❑ Both ears *Ambos*
¿Son estos síntomas en el oído

THE EPWORTH SLEEPINESS SCALE

LA ESCALA DE SUEÑO DE EPWORTH

- How likely are you to doze off or fall asleep in the following scenarios in contrast to just feeling tired?
  ¿Qué posibilidades hay de que se duerma en los siguientes escenarios en contraste con solo sentirte cansado?
- Even if have not done some of these thing recently, try to work out how they would have affected you.
  Incluso si no ha hecho algunas de estas cosas recientemente, trate de averiguar cómo le habrian afectado.
- Use the scale to choose the most appropriate number for each situation and circle the correct one.
  Use la escala para elegir el número más apropiado para cada situación y circule el correcto

0 = Would Never Doze *Nunca duerme*

1 = Slight Chance of Dozing *Poca probabilidad de quedarse dormido*

2 = Moderate Chance of Dozing *Posibilidad moderada de dormirse*

3 = High Chance of Dozing *Alta probabilidad de dormirse*

SCENARIO *ESCENARIO*	CHANCE OF DOZING *PROBABILIDAD DE DORMIRSE*
Sitting and reading *Sentado y leyendo*	0 1 2 3
Watching television *Viendo televisión*	0 1 2 3
Sitting inactive in public place, e.g., theater or meeting *Sentado inactivo en un lugar publico, por ejemplo, teatro o reunión*	0 1 2 3
As a passenger in a car for an hour without a break *Como pasajero en un automóvil por una hora sin descanso*	0 1 2 3
Lying down to rest in the afternoon *Acostarse para descansar por la tarde*	0 1 2 3
Sitting and talking to someone *Sentado y hablando con alguien*	0 1 2 3
Sitting quietly after lunch without alcohol *Sentarse en silencio después del almuerzo sin alcohol*	0 1 2 3
In a car, while stopped in a few minutes of traffic *En un automóvil, mientras se detiene en unos minutos de tráfico*	0 1 2 3

HEARING HISTORY QUESTIONNAIRE

CUESTIONARIO DE HISTORIA AUDITIVA

Please circle the appropriate response for each symptom.
Por favor circule la respuesta apropiada para cada síntoma.

Ringing or other sounds in ears *Zumbidos u otros sonidos en los oídos*	Yes *Si*	No *No*
Chronic ear infections *Infecciones crónicas del oído*	Yes *Si*	No *No*
Earwax build up *Acumulación de cerumen*	Yes *Si*	No *No*
Fullness in ears *Sensación tapada en los oídos*	Yes *Si*	No *No*
Pressure in ears *Presión en los oídos*	Yes *Si*	No *No*
Perforated eardrum *Tímpano perforado*	Yes *Si*	No *No*
Family history of hearing loss *Antecedentes familiares de pérdida auditiva*	Yes *Si*	No *No*
Exposed to loud noises *Expuesto a ruidos fuertes*	Yes *Si*	No *No*
Trauma to head *Trauma a la cabeza*	Yes *Si*	No *No*
Dizziness or vertigo *Mareos o vértigo*	Yes *Si*	No *No*
Sinus or allergy problems *Problemas de sinusitis o alergia*	Yes *Si*	No *No*
Have you had a hearing test? *¿Te has hecho una prueba de audición?*	Yes *Si*	No *No*
Have you had ear surgery? *¿Te han operado el oído?*	Yes *Si*	No *No*

ALLERGY HISTORY QUESTIONNAIRE

CUESTIONARIO DE HISTORIA DE ALERGIAS

How long have you had allergy symptoms?_____
¿Cuánto tiempo ha tenido síntomas de alergia?

Year-round or seasonal? _____
¿Todo el año o por temporada?

Have you been allergy tested before?_____
¿Se ha hecho alguna prueba de alergia antes?

If yes, did you receive immunotherapy?_____
En caso afirmativo, ¿recibió inmumoterapia?

Are you exposed to fumes, chemicals or dust at work? _____
¿Esta expuesto a humos, productos químicos o polvo en el trabajo?

What prescription medication have you tried for allergies? For how long?
¿Qué medicamentos recetados has probado para las alergias?

PRESCRIPTION *MEDICAMENTO*	FOR HOW LONG *POR CUANTO TIEMPO*

Please circle the appropriate number 1-5 according to severity:
Por favor circule el número apropiado 1-5 de acuerdo a la severidad:

0 = no problem | 1 = mild | 5 = very severe

0 = No hay problema | 1 = leve | 5 = muy severo

Nasal discharge *Secreción nasal*	0	1	2	3	4	5
Nasal obstruction *Obstrucción nasal*	0	1	2	3	4	5
Watery or itchy eyes *Ojos llorosos o con picazón*	0	1	2	3	4	5
Sneezing *Estornudos*	0	1	2	3	4	5
Wheezing *Resollar*	0	1	2	3	4	5
Cough *Tos*	0	1	2	3	4	5
Itching *Comezón*	0	1	2	3	4	5
Eczema *Eczema*	0	1	2	3	4	5
Hives *Ronchas*	0	1	2	3	4	5
Headache *Dolor de cabeza*	0	1	2	3	4	5
Chronic fatigue *Fatiga cronica*	0	1	2	3	4	5
Food intolerance *Intolerancia a la comida*	0	1	2	3	4	5
Frequent sinus or ear infections *Frecuentes infecciones de los senositis o de los oídos*	0	1	2	3	4	5
Frequent colds or sore throats *Resfriados frecuentes o dolor de garganta*	0	1	2	3	4	5
Learning disability *Discapacidad de aprendizaje*	0	1	2	3	4	5
Poor memory or concentration *Mala memoria o concentración*	0	1	2	3	4	5
Hyperactivity *Hiperactividad*	0	1	2	3	4	5
Abdominal gas or cramping *Gases abdominales o calambres*	0	1	2	3	4	5
Arthritis or muscle aching *Artritis o dolor muscular*	0	1	2	3	4	5
Asthma *Asma*	0	1	2	3	4	5

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Enticare P.C. takes your privacy seriously. We will not disclose your medical records (protected health information) to any party without your signed consent, except as stipulated in our Notice of Privacy Practices.

Name: _____ Date: _____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION INCLUDING HIV & AIDS RELATED INFORMATION

- I understand that neither Provider nor Recipient may condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization. In addition, I understand that Recipient may re-disclose the Records and that the Records may no longer be protected by the Federal privacy regulations.
- I acknowledge and agree that the protected health information authorized to be disclosed under this Authorization may include records for drug or alcohol abuse or psychiatric illness, and records of testing, diagnosis or treatment for HIV, HIV-related diseases and communicable diseaserelated information. • With respect to any communicable disease-related information protected by State confidentiality rules and disclosed under this Authorization, Recipient is prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by me pursuant to a separate written authorization or is otherwise permitted by applicable law.
- Further, with respect to any drug and alcohol abuse treatment information disclosed under this Authorization, this information has been disclosed from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit the recipient of this information from making any further disclosure of this information unless further disclosure is expressly permitted by me pursuant to a separate written authorization or is otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

RIGHT OF REFUSAL

- I acknowledge that I have had the opportunity to review Enticare P.C.'s Notice of Privacy Practices, which is displayed for public inspection at its facility and on its website. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records.
- I understand that I have the right to refuse to sign this authorization and that I do not have to sign this authorization to receive treatment at Enticare P.C. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Health Insurance Portability and Accountability Act (HIPAA). I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Enticare P.C. Privacy Officer at 3420 S. Mercy Road, Suite 107 Gilbert, AZ 85297.

EXPIRATION

This Authorization will remain effective until the expiration date specified below or, if no date is set forth below, for one-year following the date of this signing, at which time this Authorization will expire. A photocopy of this Authorization will be considered effective and valid as the original.

Date authorization expires (if any): _____

Signed by: _____ _____

Signature of Patient or Legal Guardian — Today's Date

_____

Relationship to Patient

Casa Grande
1968 N. Peart Road, Suite 20 Casa Grande, AZ 85122

Chandler
2051 W. Chandler Blvd, Ste 5 Chandler, AZ 85224

Gilbert
2730 South Val Vista Drive, Ste 161, Gilbert, AZ, 85295

Glendale
17215 N. 72nd Dr. Bldg D, Ste 140A Glendale, AZ 85308

Scottsdale
7301 E. 2nd Street, Ste 308 Scottsdale, AZ 85251

San Tan Valley
36457 N. Gantzel Road., Ste 101 San Tan Valley, AZ 85140

Maricopa
44870 W. Hathaway Ave., Ste. 6 Maricopa, AZ, 85139

Enticare
enticare.com
info@enticare.com

Phone (480) 214-9000 | Fax (480) 214-9999

ENTICARE

PROCEDURES IN OFFICE

Please be aware that certain procedures performed in our office are not included in the standard office visit. These procedures will be billed separately and in addition to office visit charges. We have become aware that some insurance carrier are classifying these procedures as "surgery" and applying the charges to your calendar year deductible. The result may be insurance payment for an office visit but NOT a procedure. In such cases, payment for the procedure will be due from the patient. Be assured that we are following accepted billing and coding guidelines.

The providers of Enticare PC only perform these procedures when deemed medically necessary to best diagnose and treat our patients. If you are presenting with a sinus, throat/voice complaint, symptoms of allergies, or hearing loss there is a good chance the provider will need to perform one or more of the following procedures.

Examples of in-office procedures include but are not limited to:

- CPT-31575 Flexible Laryngoscopy
  This procedure involves passing a long thin flexible fiber-optic scope through the nasal cavity and into the throat. The fiber-optic scope enables the physician to visualize areas of the throat not readily seen using laryngeal mirrors.
- CPT-31231 Nasal Endoscopy
  This procedure uses the flexible or rigid scope attached to a light source to view areas of the nasal cavities that cannot be viewed by the physician using the standard nasal speculum and head mirror.
- CPT-31237 Nasal Endoscopy with Debridement or Biopsy
  This is the same procedure as above with removal of crusting or tissue.
- CPT-92511 Flexible Nasopharyngoscopy
  This involves examining both the tissues of the nasal passages AND the pharynx and larynx.
- CPT-95004 Allergy Test
  This procedure is an Allergy test that can help confirm or rule out allergies and consequently reduce adverse reactions and limit unnecessary avoidance and medications.
- CPT 92567- Tympanometry
- CPT 92557- Audiometry
- CPT 92588- Otoacoustic Emissions (OAE)
  These are the codes used for audiology services. Tympanometry is used to tell the pressure of the ear drums. Audiometry and OAE is considered a basic hearing test, it is used to tell if hearing is normal.

Please contact your insurance provider to verify benefits and coverage information prior to having any services rendered.

_____ _____

Signature of Patient, Parent, or Legal Guardian | Relationship

_____ _____

Print Name | Date

Casa Grande
1968 N. Peart Road, Suite 20 Casa Grande, AZ 85122

Chandler
2051 W. Chandler Blvd, Ste 5 Chandler, AZ 85224

Gilbert
2730 South Val Vista Drive, Ste 161, Gilbert, AZ, 85295

Glendale
17215 N. 72nd Dr. Bldg D, Ste 140A Glendale, AZ 85308

Scottsdale
7301 E. 2nd Street, Ste 308 Scottsdale, AZ 85251

San Tan Valley
36457 N. Gantzel Road., Ste 101 San Tan Valley, AZ 85140

Maricopa
44870 W. Hathaway Ave., Ste. 6 Maricopa, AZ, 85139

Enticare
enticare.com
info@enticare.com

Phone (480) 214-9000 | Fax (480) 214-9999

ENTICARE

MEDICATION HISTORY CONSENT FORM

By signing below I give permission for **Enticare, PC** to access my pharmacy benefits data electronically through RxHub. This consent will enable **Enticare, PC** to:

- Determine the pharmacy benefits and drug co pays for a patient's health plan.
- Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- Display therapeutic alternatives with preference rank (if available) within a drug class for medications.
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- Download a historic list of all medications prescribed for a patient by any provider.

In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using RxHub.

_____
Patient Name (Print)

_____ _____
Patient Signature Date

COMMUNICATION CONSENT FORM

By signing below, I give Enticare PC permission to communicate with me via the e-mail given on the new patient paperwork. I understand that the purpose of any such communication will be for educational information, access to our portal, and for news related to our practice and or your provider that may affect you.

_____
Patient Name (Print)

_____ _____
Patient Signature Date

Casa Grande
1968 N. Peart Road, Suite 20 Casa Grande, AZ 85122

Chandler
2051 W. Chandler Blvd, Ste 5 Chandler, AZ 85224

Gilbert
2730 South Val Vista Drive, Ste 161, Gilbert, AZ, 85295

Glendale
17215 N. 72nd Dr. Bldg D, Ste 140A Glendale, AZ 85308

Scottsdale
7301 E. 2nd Street, Ste 308 Scottsdale, AZ 85251

San Tan Valley
36457 N. Gantzel Road., Ste 101 San Tan Valley, AZ 85140

Maricopa
44870 W. Hathaway Ave., Ste. 6 Maricopa, AZ, 85139

Enticare
enticare.com
info@enticare.com

Phone (480) 214-9000 | Fax (480) 214-9999

ENTICARE

PATIENT FINANCIAL POLICY

You will be responsible for payment of all services if any of the following circumstances apply:

- If you do not have insurance or failed to notify us that your insurance has terminated or changed;
- If you do not have a referral and/or authorization when required and have elected to be seen;
- If you are with an insurance company we are not contracted with; or,
- If a claim denial from the insurance company, for any reason, is not able to be resolved.

Valid Insurance: Insurance companies require the submission of all claims within a specified time limit. If you have changes in your insurance coverage, and you fail to inform us of the change within twenty-one days of your visit, you may be responsible for the charges. Denials often arrive after the filing limit has expired, thus preventing us from being able to re-file a new claim with your new carrier. To ensure that you are not responsible for the charges, please make sure that we always have up-to- date information regarding your insurance coverage. Again, any denied claims for lack of correct insurance information, will be applied to patient responsibility.

Referrals: If your plan requires a referral from your primary care physician, it is **YOUR** responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If your plan requires a referral and you do not obtain one, you will be held responsible for the visit charges in full at the time of service.

Coverage: An attempt will be made to obtain and comply with insurance company requirements. However, it is ultimately YOUR responsibility as a patient to verify your plan benefits, and whether or not Enticare PC is a contracted provider, prior to having any services rendered. Any and all face-to-face encounters with an Enticare provider qualifies as an office visit and will result in a claim submission to your insurance carrier. Co-payment, co-insurance and deductible amounts will apply and are the responsibility of the patient.

Disputes: Co-payment, co-insurance, and deductible amounts MUST be paid at the time of service. Any account balances will also be collected at the time of your visit. Any unpaid or disputed balances must be resolved within 90 days from the date of service. Enticare PC reserves the right to turn accounts over to a third party collection agency after 90 days. The responsible party or guarantor of this account will be responsible for all collection fees, legal fees, and any other fees associated with the account. If you have any questions, contact Enticare PC's Billing Department at **Billing@enticare.com**.

A $35.00 fee will be applied to all returned checks or disputed credit card transactions.

Medical Records: A fee of $1.00 per page up to $6.50 will be charged to patients requesting medical records for personal use, disability or non-surgical reasons. A records request form must be signed and received by Enticare PC before any records are disbursed per HIPAA. Please allow up to 14 business days.

No Show / Late Cancellation of Appointments:

To avoid a $25 no show fee you must:

- Give at least 24-hour notice of your inability to make it to your clinical appointment.

To avoid a $150 no show fee related to scheduled sleep studies, allergy testing, and or hearing testing, you must:

- Give at least 72-hour notice of your inability to attend your study/test

To avoid a $150 no show related to surgery you must:

- Give at least 5 business days notice of your need to modify your appointment.

In the event you missed three separate appointments without giving us the required notice, Enticare PC has the ability to discharge you as an active patient from our practice. In the event that your insurance plan does not allow us to charge a no show fee, Enticare PC holds as recourse the ability to discharge you as an active patient due to your inability to keep scheduled appointments.

Dismissal from Practice: Enticare PC reserves the right to dismiss patients who are not compliant with any one of the following:

- Refusal to comply with recommendations from the provider;
- Does not comply with office policies;
- Refuses to cooperate with staff;
- Repeatedly disputes fees that are fair and are consistent with the services provided;
- Displays threatening, hostile attitude or behavior to physicians or staff;
- Continues to abuse prescription drugs or controlled substances after physician intervention;
- Refuses to pay outstanding balances;
- 3 no-shows or other non-compliance issues that interfere or jeopardize patient treatment or safety;
- Breakdown of communication with patient and/or family resulting in a lack of trust that makes it medically impossible to treat the patient

By signing this form, you agree to all the information listed above, authorize the release of any medical information necessary to process your claims and authorize payment of medical benefits to Enticare PC, or supplier for services rendered.

Signature of Patient, Parent, or Legal Guardian	Print Name	Date

Casa Grande
1968 N. Peart Road, Suite 20 Casa Grande, AZ 85122

Chandler
2051 W. Chandler Blvd, Ste 5 Chandler, AZ 85224

Gilbert
2730 South Val Vista Drive, Ste 161, Gilbert, AZ, 85295

Glendale
17215 N. 72nd Dr. Bldg D, Ste 140A Glendale, AZ 85308

Scottsdale
7301 E. 2nd Street, Ste 308 Scottsdale, AZ 85251

San Tan Valley
36457 N. Gantzel Road., Ste 101 San Tan Valley, AZ 85140

Maricopa
44870 W. Hathaway Ave., Ste. 6 Maricopa, AZ, 85139

Enticare
enticare.com
info@enticare.com

Phone (480) 214-9000 | Fax (480) 214-9999