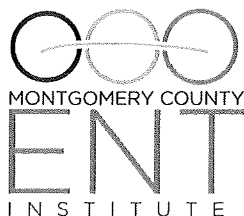


Ear, Nose, Throat Sinus & Allergy Care, Facial Plastics
Audiology & Hearing Aids

375 Township Line Road, Elkins Park, PA 19027
Telephone (215) 887-7380 Fax (215) 887-7373

1650 Huntingdon Pike Suite 318, Meadowbrook, PA 19046
Telephone (215) 938-8400 Fax (215) 887-7373

Dear

This is to confirm your appointment at our office on: _________ At:_______ ☐ AM ☐ PM

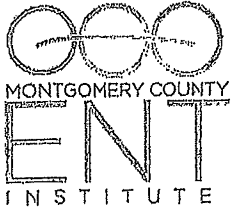
_______Melissa Schwartz DO

_______Danielle Tristani, PA-C

_______Elyse Verdeyen, PA-C

Enclosed are new patient forms for you to complete and bring with you the day of your appointment. We ask that you please arrive 15 minutes prior to your appointment time.

Enclosures



PATIENT CONSENT & FINANCIAL POLICY

Welcome to Montgomery County ENT Institute. We are committed to giving you the best care possible. All patients are seen by appointment only. We make every effort to see you at your scheduled time. We would like to take this opportunity to inform you of our office policy.

** Please bring your insurance cards to all visits. Your photo ID will be required due to the Federal Trade Commission guidelines. Copays are due at each visit. We accept cash, checks, Visa and Mastercard.

**For patients with insurance plans which require a referral, referrals must be obtained from your primary care physician PRIOR to your appointment. If you do not have a referral, you will be asked to either reschedule your appointment or pay for the visit in full, at the time of service.

** If you are unable to keep your scheduled appointment, please contact our office at least 24 hours in advance. Failure to notify our office will result in a $25.00 cancellation fee.

** Physician practices are bound by a strict set of billing guidelines. Any additional test or procedure must be billed separately per insurance company requirements. Examples of these may include but are not limited to hearing or allergy tests; using a microscope to look in the ear; using an endoscope to look in the nose; or using a laryngoscope to look into the throat. Some insurance carriers may classify certain procedures as surgery. There are a limitless number of carriers and policies that exist and we cannot know the terms of your individual policy. You need to be aware these charges may be subject to benefits other than your office visit copay that you will be financially responsible for. The amount you pay as a patient is between you and your insurance company based on your policy. All patients are ultimately responsible for their own bill and a clear understanding of their insurance policy.

** There is a $25.00 fee for checks returned for insufficient funds.

** In the event the patient fails to make payments for services rendered, the account may be turned over to a collection agency. A collections fee of 40% will be added to the unpaid balance.

By signing this form, I am giving my permission for the physicians and staff of Montgomery ENT Institute to treat me, including the performance of testing and/or procedures, as deemed necessary in the exercise of their professional judgment.

Signature of Patient or Responsible Party ______________________________

Relationship______________________________ Date____________________

CONFIDENTIAL REGISTRATION FORM

PATIENT INFORMATION Please Print Clearly

Name: First_______________ Last_______________ Sex: M or F

Address:_______________ City:_______________ State & Zip Code:_______________

Date of Birth:_______________ Age:_______________ Social Security #:_______________

Tel Home #_______________ Cell #_______________ Work #_______________

Spoken Language:_______________ Race:_______________ Ethnicity:_______________

Email Address:_______________

Primary Physician:_______________ Physician Address:_______________

Physician City, ST,Zip_______________ Physician tel #:_______________

Parent and/or Guardian Information:_______________

If patient is a minor: Mother's Name:_______________ Date of Birth:_______________

Father's Name:_______________ Date of Birth:_______________

PHARMACY INFORMATION

PHARMACY NAME AND TEL#_______________

PHARMACY ADDRESS_______________ CITY,ST,ZIP_______________

INSURANCE INFORMATION

PRIMARY CARRIER:_______________ Carrier Tel#:_______________

Identification #:_______________ Group#:_______________

Subscriber Name:_______________ Relationship to Patient:_______________

Subscriber Employer & Address:_______________

Subscriber Social Security #:_______________ Subscriber Date of Birth:_______________

SECONDARY CARRIER:_______________ Carrier Tel#:_______________

Identification#:_______________ Group#_______________

Subscriber Name:_______________ Relationship to Patient:_______________

Subscriber Social Security #:_______________ Subscriber Date of Birth:_______________

I Verify that the above information is correct to the best of my knowledge. I understand that all personnel affiliated with the practice will maintain my health information according to federal regulations.

Patient Signature:_______________ Date:_______________

Melissa Neumann Schwartz, DO LLC

Authorization of Benefits

For Non-Medicare Patients:

I authorize any holder of medical or other information about me to release this information to my insurance company, its intermediaries or carriers, or another physician's office. I hereby authorize direct payment of medical and/or surgical benefits to include major medical benefits to which I am entitled to Melissa Schwartz, DO, LLC or also permit a copy of this authorization to be used in place of the original. The assignment will remain in effect until revoked by me in writing. I understand that, as these services were performed for me or my legal dependent, I am financially responsible for all personal balances.

______________________________ _______________
(Signature of patient of responsible party) Date

For Medicare Patients:

I request that payment of authorized Medicare benefits be made on my behalf to Melissa Schwartz, DO, LLC. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related service.

______________________________ _______________
(Name of Beneficiary) HIC #

I request that payment of authorized secondary benefits be made on my behalf to Melissa Schwartz, DO, LLC. I authorize any holder of Medicare information about me to release to my secondary insurer any information needed to determine these benefits payable for related services.

______________________________ _______________
(Signature of Patient) Date

Name________________________________ Date of Birth: ________________ Date__________

ENT Review of Systems (Circle if Present)

Ears:	Hearing Loss	Ear Noises	Ear Pain	Dizziness	Discharge	Jaw Joint Pain
Nose:	Obstruction	Nosebleeds	Trouble Breathing	Postnasal Discharge	
Throat:	Sore Throat	Trouble Swallowing	Change in Voice/Hoarseness	Snoring	
Neck:	Lump in Neck	Swelling	Pain		
Other:	Facial Pain	Facial Weakness/Paralysis	Headaches		

General Review of Symptoms (Circle if Present)

Cardiac:	Chest Pain	Palpitations	Irregular Heartbeat	Shortness of Breath	
Lungs:	Cough	Wheezing	Shortness of Breath	Sputum/Mucus	
Digestive:	Nausea	Vomiting	Abdominal Pain	Diarrhea/Constipation	Blood
Urinary:	Urgency	Frequency	Painful Urination	Blood in Urine	
Neuro:	Seizures	Weakness	Double/Blurred Vision	Numbness	Headaches
General:	Weight Loss/Gain	Depression	Anxiety	Skin/Hair Changes	Loss of Appetite

Past Medical History (Circle if Present)

High Blood Pressure	High Cholesterol	Angina	Irregular Heartbeat	Pacemaker
Heart Attack	Arthritis	Stroke	Seizures	Migraine
Emphysema/Bronchitis	Asthma	HIV/AIDS	Hepatitis	Tuberculosis
Blood Transfusions	Meningitis	Ulcers	Kidney Disease	Kidney Stones
Diabetes	Thyroid Problems	GERD/Reflux	Cancer ________________	

Other Past Medical History (Medical conditions not listed above)____________________________

Past Surgical History (Circle if Present)

Ear Tubes	Mastoidectomy	Tympanoplasty	Stapedectomy
UPPP/Snoring Surgery	Tonsils/Adenoids	Vocal Cord Surgery	Neck Surgery
Septoplasty	Rhinoplasty	Sinus Surgery	Other________________

Family History: Diabetes High Blood Pressure Heart Disease Stroke Cancer(s)____________

Other____________________

Social History: Alcohol Use (# per week): Drug Use: Occupation:

Current Tobacco Use (yes / no) Prior Tobacco Use (year quit__________)

Medications:

Vitamins & Herbal Supplements:

Latex Allergy (yes / no)

Medication Allergies:

MEDICATIONS REQUIRED

Please bring in your medication list the time of your appointment. Make sure you have your name and date of birth on your medication list.

Name of medication, strength of medication, and number of times a day taking medication.

Montgomery County ENT Institute
Melissa Neumann Schwartz, DO FAOCO, FAAOA
Danielle Tristani, PA-C
Elyse Verdeyen, PA-C
Ear, Nose, Throat Sinus & Allergy Care
Facial Plastics
Audiology & Hearing Aids

Acknowledgement of Receipt of Notice of Privacy Practices

Please list any persons other than yourself, who you authorize us to release your Protected Health Information (PHI). This includes: lab results, radiology reports, biopsy results, appointment reminders, etc.

____

____

Please check all that applies: If you are authorizing us to leave information regarding PHI, (lab results, radiology reports, biopsy results, appointment reminders, etc.)

- ☐ **Speak with other family members about medical information**
- ☐ **Leave medical information on home answering machine**
- ☐ **Leave medical information on cellphone voicemail**
- ☐ **Call cellphone to confirm appointments**

I have received a copy of the Notice of Privacy Practices for Montgomery County ENT Institute

____

Name of Patient (Print or Type)

____

Signature of Patient

____

Date

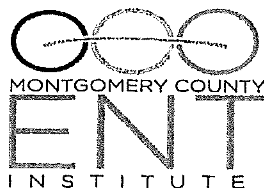
____

Signature of Patient Representative

(Required if the patient is a minor or an adult who is unable to sign this form)

____

Relationship of Patient Representative to Patient



HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

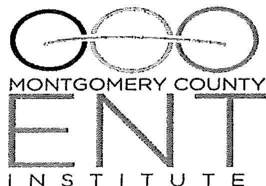
Treatment:
We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment:
Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations:
We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, **authorization** or opportunity to object unless required by law. **You may revoke the authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.



YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. We will not retaliate against you for filing a complaint.
Please send complaints in writing to ______________________, Compliance Officer
MONTCO ENT
375 Township Line Road
Elkins Park, PA 19027

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number, 215-887-7380.

Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.