History and Physical Form

Name ______________________ Date of Birth ____________ Date __________

Reason For visit today? ____

Recent flu shot, when?_______ COVID-19 shot, when? 1st dose______ 2nd_______ 3rd_______

Please complete the following: Height: ______________ Weight: ____________

Past medical history: Please circle which is correct if in ( ). Please specify if ___.

☐ No past medical history.

☐ Allergic rhinitis
☐ Anxiety
☐ Asthma
☐ Autoimmune disorders
☐ Bleeding/clotting problem
☐ Cancer: ____________
☐ COPD
☐ Depression
☐ Diabetes (Type I or II)
☐ Ear infections
☐ Frequent nosebleeds
☐ Gastrointestinal reflux
☐ Hearing loss
☐ Heart attack
☐ Heart disease
☐ Hepatitis (A, B, C)
☐ High blood pressure
☐ High cholesterol
☐ HIV
☐ Hives
☐ Migraines
☐ Mouth ulcers
☐ Problems with anesthesia
☐ Prostate enlargement
☐ Renal failure
☐ Seizures
☐ Sinus infections
☐ Sleep apnea
☐ Stomach ulcer
☐ Stroke
☐ Thyroid dysfunction
☐ Other: ____

Surgical History: Have you ever had surgery? ☐ Yes. ☐ No.
If "Yes" please list surgery names and dates below.

1.	DATE:	6.	DATE:
2.	DATE:	7.	DATE:
3.	DATE:	8.	DATE:
4.	DATE:	9.	DATE:
5.	DATE:	10.	DATE:

Family History: Check below to report problems your family members have had.

☐ I was adopted. So, I don't know my family history. ☐ None. ☐ Unknown.

	Mother:	Father:	Sister:	Brother:	Other:
Problems with anesthesia					Specify ____________
Thyroid cancer					
Lung cancer					
Unspecified cancer					Specify ____________
Hearing loss before age 20					
Hearing loss after age 20					
Heart disease					
High blood pressure					
Asthma					
Stroke					
Diabetes					
Bleeding/Clotting problem					Specify ____________

Social History: ☐ None.

1. Do you ever drink alcohol? ☐ Yes. ☐ No, none.

If so, please indicate the quantity: ☐ 1-12 drinks per year. ☐ 1-13 drinks per month. ☐ 4-14 drinks per week. ☐ 1-2 drinks per day.

2. Do you use tobacco? ☐ Yes, currently. ☐ Yes, in the past. ☐ No, never.

If "Yes, currently": What form of tobacco do you use? ☐ Cigarettes. ☐ Chew. ☐ Other; __________

If "Yes, in the past": When did you quit? __________ How long did you use tobacco for? __________

3. Do you use recreational drugs? ☐ Yes, currently. ☐ Yes, in the past. ☐ No, never.

If "Yes, currently": What kind of recreational drug(s)?__________ How often? __________

If "Yes, in the past": What kind of recreational drug(s)? __________ When did you quit? __________

4. Do you drink caffeine? ☐ Yes. ☐ No.

If "Yes": How many per day? __________

Preferred Pharmacy:

Name: __________ Address or phone number: __________

Care Team:

Name of Primary Care Physician: __________

Other Care Team Physician Names: __________

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Allergies:

Do you have any allergies to drugs or medications: ☐ Yes. ☐ No.

If yes, list medication and reaction: __________

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Do you have any environmental, food, or latex allergies: ☐ Yes. ☐ No.

If yes, list allergy and reaction: __________

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Medication History:

Current prescription drugs and dosage: ☐ None.

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Current over the counter medications: ☐ None.

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Associates of Otolaryngology

Patient Registration Form

PLEASE PRINT YOUR INFORMATION AND COMPLETE IN ENTIRETY

Patient Name____ Date of Birth____________________

Mailing Address____ City/State/Zip____________________

Home Phone______________________ Cell Phone______________________ Male______ Female______

Patient Billing Policy

Payment Policy &Benefits

TO OUR PATIENTS: To help answer questions you might have, we have outlined out payment policies below. Please feel free to discuss these with us at any time, should you have additional questions.

Payment Policy: Accounts are payable after your insurance carrier has paid your claim, or within 30 days of your first statement. Self-pay patients will be asked to pay in full at the time of service. We accept all forms of payment. Please note: past due accounts will be turned over to a collection agency if the account is not paid in full within 90 days from the date of your first statement. If you require financial assistance or a payment plan, please call 303-744-1961 and ask for the in-house billing department. AOO may apply payments received to any outstanding balance. Patients will be financially responsible for any return check fees that AOO incurs.

Benefits: If we are filing with your insurance, please keep in mind that we do this as a courtesy to our patients, and that we will do everything in our power to collect from the insurance company. You will receive an "Explanation of Benefits" (EOB) from your insurance company that will explain how your claim was processed and paid by them. You will receive a statement from us for any balance that your insurance company has deemed as your responsibility. We try to provide the most accurate information regarding network participation (i.e. in-network vs out-of-network) to you as our patient. However, we always suggest that you verify the network participation of our facility with your insurance carrier.

I have read and understand the above-reference policy and benefits. Initial__________

Assignment of Benefits and Authorization to Pay

Assignment of Benefits:

I, the undersigned, hereby authorize AOO to release any medical or other information necessary to process my claims for services rendered to me or my dependent. **Initial**______

Authorization to Pay

I, the undersigned, hereby authorize payment of medical benefits to the physician for services rendered to me or my dependent in connection with any visit or surgery with my provider. **Initial**______

Collection/Billing Procedures and the TCPA Act

I authorize AOO, its assignees, and third-party billing/collection agencies to utilize all contact information I have provided to communicate with me. This includes, but is not limited to, home telephone, cell phone and email/text communications. I hereby grant permission and consent to AOO, its assignees, and third-party billing/collection agencies to place calls to my home telephone, cell phone; leave messages (whether voice or text); and utilize pre-recorded messages used as appointment or payment reminders. Information will only be supplied to AOO assignees and third-party billing/collection agencies in order to collect on outstanding balances. **Initial**__________

Cancellation & No-show policy

We understand there are times when you must miss an appointment due to emergencies or obligations for work or family. We would request that you call in to cancel or reschedule your appointment at 303-744-1961. If an appointment is not cancelled or you no-show an appointment, there will be a **$50.00** fee which will not be covered by your insurance company. We understand that delays can happen. We would request that you call us if you are running late for your appointment. If you are 15 min past your appointment time, you may have to reschedule, although we will do everything in our power to have you seen. **Initial**______

By signing below, I hereby acknowledge that I have read, understand and consent to all policies set forth herein.

Date: ________________ Patient/Guardian Signature______________________________________

Patient Consent

I authorize AOO to release/discuss my medical and/or billing information to the following individuals

Name____ **Relationship:**__________________

Name____ **Relationship:**__________________

Name____ **Relationship:**__________________

I do not wish to allow anyone to receive my information [ ]
I understand that it is my responsibility to notify AOO of any changes to this consent.

Name________________________ **Signature**______________________ **Date**__________

CORHIO
Colorado Health Information Exchange

Health information exchange is a method to make patient health information available electronically for doctors, hospitals and other care providers when it's needed for patient care. Health information is protected and exchanged under strict medical privacy and confidentiality procedures.

Why is this important?

Saves time: Physicians and other qualified health professionals have access to patient information compiled from across different computer systems (EMR) quickly. This means less time searching, calling and faxing for information, which reduces treatment delays for patients and allows care providers to spend more time with patients.

Improves care: with consistent information, physicians and other providers will get results and reports in one simplified format. Additionally, the patient's information will be more complete, which reduces errors and improves treatment recommendations.

Improves privacy: With enhanced security protections above what is possible with paper records, patient privacy is better protected.

What about my privacy?

This is a service you opt-in to. It is not mandatory. Only healthcare providers with your information can access CORHIO, and it is strictly monitored and covered un HIPAA regulations.

Want to be enrolled?

- Yes: leave the CORHIO form below blank
- No: please sign the CORHIO form below. Your referring physician and/or PCP will still get a copy of your visit.

More information can be found at www.corhio.org

ONLY CHECK THE FOLLOWNG BOX AND PRINT YOUR NAME TO OPT-OUT OF CORHIO

CORHIO (The Colorado Regional Health Information Organization) is a nonprofit organization dedicated to improving health care in Colorado. CORHIO provides a protected electronic system that allows doctors, hospitals, and other medical professionals to store and share records. CORHIO's vision is to provide a method to share health information so that every person in Colorado can obtain the best possible health care, where and whenever they need it.

[ ] I, ________________________________, have chosen to **opt-out** pf the participation in the Colorado regional Health Information Organization (CORHIO) HIE. I have signed the CORHIO opt-out form, and if I choose later to opt back in, I will be required to sign the opt-in form.

Endoscopy Billing Information Form

Please be advised there are times when your physician needs to perform an in-office procedure to correctly diagnose and treat problems of the ear, nose and throat. This is accomplished with the use of a Nasal Endoscope. It is a specialized tool used to help diagnose or detect problems such as nasal polyps, nasal blockage, recurrent sinusitis, and other diseases of the nose or throat.

A Nasal Endoscopy is a quick and painless in-office procedure. After spraying your nasal passages to anesthetize the lining and shrink tissue, a thin tube or endoscope is inserted into the nasal passage to visualize the internal anatomy of the nose, sinuses and / or throat.

Insurance companies always consider endoscopies a surgical procedure. We do not have control over how endoscopies are processed by insurance companies. This form is to notify you in advance so you are not surprised when you receive your explanation of benefits that states a Surgical Service was provided.

Your insurance company may reimburse a surgical service at a different rate than an office visit. The nasal endoscopy procedure is often applied toward your deductible and co-insurance. To find out what your financial responsibility for this procedure may be, contact your insurance carrier and request coverage information for CPT codes: 31231, 31237, and 31575.

I have read the above information and understand my insurance company may reimburse a nasal endoscopy as a surgical service with the deductible and co-insurance guidelines applied. I also agree to the financial responsibility established by my insurance carrier according to my individual policy.

Patient Name ______________________________ Date of birth ______________

Patient Signature ______________________________ Date ______________

Revised 7/23/2019 3:35pm