ENT ASSOCIATES OF SANTA BARBARA

John D. McCaffery, M.D.
Jaime Munroe, PA-C

PATIENT INFORMATION

Name _____ Social Security _____

Address _____ Gender ☐ M ☐ F

City _____ State _____ Zip _____ Date of Birth _____ / _____ / _____

Home Telephone # _____ Work Telephone # _____ Cellphone # _____

Emergency Contact _____ Relationship _____ Telephone # _____

Email address (see below regarding usage of this) _____

Who is your primary doctor? _____ How did you hear about us? _____

Preferred Pharmacy (list city or crossroad) _____

Primary Language _____ Race _____ Ethnicity _____

Current occupation or grade in school _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to ENT Associates of Santa Barbara all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all insurance submissions.

I have read, understand and agree to the Financial Policy of ENT Associates of Santa Barbara.

I acknowledge that I have received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

I authorize the electronic transfer of information from previously used pharmacies, including current and previously prescribed medicines.

I authorize permission for ENT Associates of Santa Barbara to establish a patient portal link where I will have secure access to medical information, as required by the federal government.

Signature _____ Relationship _____ Date _____ / _____ / _____

PAST MEDICAL HISTORY

PLEASE MARK ANY OF THE CONDITIONS THAT YOU HAVE HAD:

- ☐ High blood pressure
- ☐ Lung cancer
- ☐ Kidney problems
- ☐ Arthritis
- ☐ Cervical cancer
- ☐ Depression
- ☐ Allergic rhinitis
- ☐ Melanoma
- ☐ None of the above
- ☐ Breast cancer
- ☐ Sleep apnea
- ☐ Thyroid problems
- ☐ Head and neck cancer
- ☐ Bleeding disorders
- ☐ Asthma
- ☐ Skin cancer
- ☐ Down syndrome
- ☐ Fibromyalgia
- ☐ Diabetes
- ☐ Prostate cancer
- ☐ Anemia
- ☐ Lung disease
- ☐ Lymphoma
- ☐ Sleep apnea
- ☐ Stomach ulcer
- ☐ High cholesterol
- ☐ Colon cancer
- ☐ Stroke/aneurysm
- ☐ Heart disease
- ☐ Leukemia
- ☐ Seizures
- ☐ Reflux (GERD)
- ☐ Back/spine disease

SURGICAL HISTORY

PLEASE MARK IF YOU HAVE HAD ANY OF THE FOLLOWING SURGERIES:

- ☐ Prostate surgery
- ☐ Ear tubes
- ☐ Orthopedic surgery
- ☐ Brain surgery
- ☐ Tonsillectomy
- ☐ Heart surgery
- ☐ Metallic implant
- ☐ Appendectomy
- ☐ Hysterectomy
- ☐ Joint replacement
- ☐ Gallbladder
- ☐ Wisdom teeth
- ☐ Lasik/cataract surgery
- ☐ Ear surgery
- ☐ Thyroidectomy
- ☐ None of the above

FAMILY HISTORY

Does anyone in your family have problems with anesthesia?	☐ Yes	☐ No
Does anyone in your family have easy bleeding or bruising?	☐ Yes	☐ No
Does anyone in your family have hearing loss?	☐ Yes	☐ No

ALLERGIES

PLEASE LIST YOUR MEDICATION ALLERGIES:

_____ _____ _____

_____ _____ _____

MEDICATIONS

PLEASE LIST YOUR MEDICATIONS:

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Pediatric and Adult ENT | Certified, American Board of Otolaryngology
Disorders of the Ears, Nose, Throat, Sinuses, Voice, Hearing, Dizziness, Head and Neck Surgery
Dr. John McCaffery is President of Hearing Services of Santa Barbara and contracts with them for Audiologic services.

5333 Hollister Ave., Suite 155, Santa Barbara, CA 93111 (805) 964-6926 | 2040 Viborg Rd., Suite 230, Solvang, CA 93463 (805) 964-6926
www.entsb.com

TOBACCO & ALCOHOL USE

Do you or did you use tobacco?

☐ Non-smoker ☐ Former smoker ☐ Current daily smoker ☐ Occasional smoker

-If so, how much?

☐ Occasional ☐ ½ pack per day ☐ 1 pack per day ☐ 2 or more packs per day

-When did you quit?

☐ <1 year ago ☐ 1-5 years ago ☐ 6-10 years ago ☐ >10 years ago

Do you drink alcohol?

☐ Never ☐ Socially ☐ 1-2 drinks a day ☐ >3 drinks a day

HOUSEHOLD

Marital Status:

☐ Single ☐ Married ☐ Partner ☐ Widowed ☐ Divorced

Household members:

☐ Self ☐ Spouse ☐ Children ☐ Parents ☐ Siblings

REVIEW OF SYMPTOMS

PLEASE MARK IF YOU HAVE HAD ANY OF THE FOLLOWING:

☐ Frequent headaches	☐ Arthritis/joint pain	☐ Urinary tract infections	☐ Migraines
☐ Liver disease/hepatitis	☐ Difficulty urinating	☐ Weakness in arms or legs	☐ Breathing difficulty
☐ Kidney stones	☐ Numbness	☐ Coughing up blood	☐ Prostate enlargement
☐ Stroke or aneurysm	☐ Pneumonia	☐ Unusual vaginal bleeding	☐ Changes in eyesight
☐ Tuberculosis	☐ Recent night sweats	☐ Fainting spells	☐ Syphilis/HIV
☐ Blood in urine	☐ Dizziness	☐ Ankle swelling	☐ High blood pressure
☐ Glaucoma	☐ Stomach ulcers	☐ Diabetes	☐ Cataracts
☐ Cancer/leukemia	☐ Thyroid problems	☐ Eye surgery	☐ Indigestion or heartburn
☐ Recent fever/chills	☐ Ringing in the ears	☐ Rectal bleeding	☐ Unexplained weight loss
☐ Heart problems	☐ Heart surgery	☐ Depression	☐ Angina/chest pain
☐ Gallstones	☐ Easy bleeding/bruising	☐ Heart rhythm problems	☐ Gallbladder surgery
☐ Problems at birth	☐ Heart failure	☐ New or changing moles	☐ Melanoma
☐ Constipation or diarrhea	☐ Recent skin changes	☐ None of the above	

Please list any additional medical problems or surgeries: _____

_____

_____

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Jaime Munroe, PA-C

Thank you for choosing ***ENT Associates of Santa Barbara*** as your health care provider. We are committed to building a successful physician relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please read our financial policy, ask us any questions you may have and sign in the space provided. A copy will be provided to you upon request.

1. ***PAYMENT***
   EFFECTIVE 03/01/2016: Payment is expected at the time of your visit. Payment will include any unmet deductible, co-insurance, co-payment amount, past-due balances or non-covered charges.
   As a courtesy, we will obtain this information from your insurance company. Due to the many different insurance products, our staff cannot guarantee your eligibility and coverage. We will accept cash, check or credit card. If your personal check is rejected by your bank for insufficient funds, the original payment due and a service fee of $45 will be due in full immediately by cash or credit card only.

2. ***INSURANCE***
   We are participating providers with most major insurance plans. As a courtesy, we will file all of these insurance claims. Please remember that insurance is a contract between the patient and the insurance company, and ultimately it is the patient's responsibility to verify insurance coverage, benefits and services. If you are unable to provide your insurance information at the time of service, then you will be required to pay for services at the time of the visit. If your insurance changes, please notify us before your next appointment so we can make the appropriate changes.

3. ***ADDITIONAL SERVICES***
   In some cases, procedures such as nasal endoscopy, office laryngoscopy and audiologic testing are applied to your deductible. This means you may receive charges for these services (if performed) in addition to your routine office charge. In most cases, the actual amount billed is predetermined by your insurance company if they have a contract with Dr. McCaffery.

4. ***YOUR PORTION OF THE CHARGES***
   You will be responsible for your share of charges as defined by your insurance policy PLUS any charges for treatments that your insurance carrier will NOT pay. If we have not received payment from your insurance company within 90 days of the date of service, you will be expected to pay the balance yourself.

5. ***IF YOUR INSURANCE COMPANY REQUESTS INFORMATION FROM YOU***
   You must respond to any information requests from your insurance carrier or your claim(s) could be denied, and you would be responsible for payment yourself.

6. ***NONPAYMENT***
   If your account is over 90 days past due, you will receive a letter stating that you have 25 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency.

continued on next page

7. MISSED APPOINTMENTS

Our policy is to charge for missed appointments. If your appointment is not canceled within 24 hours, you will be charged a $50 fee. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointments.

8. DIVORCED PARENTS OF PATIENTS

By signing below, the adult who signs a minor child into our practice on the day of service accepts responsibility for payment. This office does not promise to send bills or records to the other parent/guardian for issues related to payment or communication. We will communicate about treatment and payment with the parent who signs in that day. It is the responsibility of parents to communicate with each other about any treatment and payment issues.

ENT Associates of Santa Barbara is committed to providing the best treatment to our patients. Thank you for your understanding of our financial policy.

I have read and understand the financial policy and agree to abide by its guidelines.

Signature of patient or responsible party	Date	Please print the name of the patient

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OF SANTA BARBARA

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NOTICE OF HIPAA PRIVACY PRACTICES

ENT Associates of Santa Barbara

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

Our Legal Duty
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described In the Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

Uses and Disclosures of Health Information
We use and disclose health information about you for treatment, payment and health care operations.

Treatment: We may use or disclose your health information to a physician or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Health Care Operations: We may use and disclose your health information in connection with our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing.

Your Authorization: In addition to our use of your health information for treatment, payment or health care operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization when it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice or allowed under the law.

To Your Family and Friends: We may disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or another person to the extent necessary to help with your health care or with payment for your health care, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition or death. If you are present, then prior to use or disclosure of your health, incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment, disclosing only health information that is directly relevant to the persons' involvement in your health care. We will allow a person to pick up filled prescriptions, medical supplies, X-rays or other similar forms of health information only upon your written authorization. In case of your incapacity, we will use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in providing prescriptions, medical supplies, X-rays and/or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.
Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes.
We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to a correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose a portion of your health information to provide you with the results of tests, procedures and/or appointment reminders (such as voice mail messages, postcards, or letters).

Patient Rights
Access: You have the right to look at or obtain copies of your health information, with limited exceptions. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you. 10 for each page, $15.00 per hour for staff time to locate and copy your health information and postage if you want the copies mailed to you. If you prefer, we will provide a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, health care operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations, unless we cannot practically do so. (You must make your request in writing.) Your request must specify the alternative means or location and provide a satisfactory explanation of how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our website or by electronic mail (email), you are entitled to receive this Notice in written form.

Questions and Complaints
If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health & Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health & Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health & Human Services.

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received and understand ENT Associates of Santa Barbara's Notice of Privacy Practices containing a description of the uses and disclosures of my health information. I further understand that ENT Associates of Santa Barbara may update its Notice of Privacy Practices at any time and that I may receive an updated copy of ENT Associates of Santa Barbara's Notice of Privacy Practices by submitting a request in writing.

_____ _____ / _____ / _____ _____

Printed Patient Full Name | Date | Patient Signature

If completed by the patient's personal representative, please print name and sign below.

_____ _____ / _____ / _____ _____

Printed Patient Personal Representative | Date | Patient Representative Signature

For ENT Associates of Santa Barbara's Official Use Only

Complete this form if unable to obtain the signature of the patient or patient's personal representative. ENT Associates of Santa Barbara made a good faith effort to obtain the patient's written acknowledgment of the Notice of Privacy Practices but was unable to do so for the reasons documented below:

☐ Patient or patient's personal representative refused to sign

☐ Patient or patient's personal representative unable to sign

☐ Other _____

Printed Employee's Name _____

Employee's Signature _____ Date _____ / _____ / _____

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Credit Card Policy and Payment Agreement

Due to higher deductibles associated with most health insurance plans, there is now a greater portion of the charge that is deemed the patient's responsibility. **It is the policy of ENT Associates of Santa Barbara to have a credit or debit card on file for all patients. The credit or debit card on file will be used for co-pays, co-insurance, in-office purchases or balances due on your account.**

Your insurance plan is required to send you an Explanation of Benefits (EOB), which will state any balance remaining to be paid by you. If your insurance carrier assigns any additional patient responsibility amounts after the claim is processed, we will then send you a balance notification for that remaining amount which is not covered by your insurance. Should you decide to use an alternate method of payment, please contact our office within ten days from your notification date. **The credit card on file will ONLY be charged if the account goes unpaid 20 days after the date of your outstanding account balance notification.**

This policy is NO different than that of any other business (e.g., car rental or hotel) that asks for a guarantee of payment. Your credit card number is secure and confidential, as is all of your medical record information. If you do not have a credit card to store on file or your card is denied due to security reasons, we ask that you put down a $100 deposit at time of service.

This will in no way compromise your ability to dispute a charge or question your insurance company's determination of payment. Co-pays will still be due at the time of your visit.

By signing below, I agree to have my credit card charged for any balance that is due **after** my insurance has responded to the billed claims for services rendered by the office of ENT Associates of Santa Barbara. I understand that the office of ENT Associates of Santa Barbara agrees to charge ONLY that which is patient responsibility after billing my insurance. I understand that by signing below, I am not waiving my rights under my credit card company to dispute any charges applied to my credit card. I understand that ENT Associates of Santa Barbara is HIPAA & PCI compliant, and that all information provided is kept confidential and secure.

Check one: ☐ Visa ☐ Mastercard ☐ Other Account#: _____

Expiration Date: _____

Signature: _____

Name on Credit Card: _____

Today's Date: _____