Pinnacle ENT
ASSOCIATES LLC
CHESTER COUNTY OTOLARYNGOLOGY
& ALLERGY ASSOCIATES DIVISION

Patient Intake

Name: ______________________ DOB: __________ Appointment Date: __________

What is the purpose of today's visit? ______________________

Who is your primary care physician (not group/practice please)? ______________________

Did he/she refer you to us? ☐ Yes ☐ No If no, who did? ______________________

Who are your other physicians? ______________________

GENERAL MEDICAL INFORMATION

Patient's Weight (lbs): ______________ Height: ______________

List ALL Current Medical Conditions (treated and untreated): ______________________

____

List ALL Surgeries (include year):

____

____

____

List ALL Hospitalizations (include year):

____

____

____

List ALL Medications & Doses (include over the counter):

____

____

____

List ALL Allergies (drugs, food, environmental):

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____

____

FAMILY HISTORY: Please ✓ if there is a history of the following:

Mother	☐ Heart Disease	☐ Lung Disease	☐ Cancer	☐ Bleeding Disorder	☐ Anesthesia Complications
Father	☐ Heart Disease	☐ Lung Disease	☐ Cancer	☐ Bleeding Disorder	☐ Anesthesia Complications
Siblings	☐ Heart Disease	☐ Lung Disease	☐ Cancer	☐ Bleeding Disorder	☐ Anesthesia Complications

Name: ____________________ DOB: __________ Appointment Date: __________

SOCIAL HISTORY

Do or did you ever smoke/chew/cigars/pipe? ☐ Yes ☐ No When did you quit? ____________________

Did you ever take recreational/street drugs? ☐ Yes ☐ No What, how much & when? ____________________

Do you drink alcohol? ☐ Yes ☐ No Ounces per day: ____________________

Caffeine intake (coffee, tea, ice tea, chocolate) per day: ____________________

What kind of work do you do? ____________________

FOR CHILDREN: Is your child up to date with immunizations? ☐ Yes ☐ No

REVIEW OF SYMPTOMS

Please CHECK 'YES' for any of the following diseases or symptoms you have experienced RECENTLY:

CONSTITUTIONAL:	Fevers	☐ Yes ☐ No	Weight Loss	☐ Yes ☐ No
CVS:	Chest Pain	☐ Yes ☐ No		
PULM:	Cough	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
GI:	Heartburn	☐ Yes ☐ No		
MSK:	Neck Pain	☐ Yes ☐ No		
PSY:	Anxiety	☐ Yes ☐ No	Depression	☐ Yes ☐ No
DERM:	Hives	☐ Yes ☐ No	Skin Cancer	☐ Yes ☐ No
ENDO:	Thyroid Problems	☐ Yes ☐ No	Thyroid Cancer	☐ Yes ☐ No
NEUR:	Neurologic Disorder	☐ Yes ☐ No		
ID:	Immune Disorder	☐ Yes ☐ No		
HEME:	Bleeding/Bruising	☐ Yes ☐ No		

For females: are you currently pregnant? ☐ Yes ☐ No

Other: ____________________

____

____

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Financial Policy

Dear Patient—

Thank you for choosing us as your health care provider. The following is our Financial Policy. Our main concern is that you receive the proper and optimal treatments needed to restore your health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to contact us at 610-384-8300.

We ask that all patients read and sign our Financial Policy and HIPAA form as well as complete our Patient Information Form and Consent Form prior to having your examination, therapy and/or study. **Medicare patients may be required to sign an Advanced Beneficiary Notice (ABN) should we believe Medicare will not cover your service.**

All insured patients are required to sign the assignment of benefits for payment from the insurance company. We will submit your claim to the insurance company on your behalf, but if the insurance company does not pay your balance in full within 30 days, we ask that you contact the carrier. You will be billed for any noncovered services, deductibles, and/or coinsurance. For your convenience, we accept Visa, MasterCard, Discover®, cash and check or money order. There will be a charge of $25 for returned checks.

We require a 24-hour notice when canceling an appointment. You will be charged a fee of $25 for missed appointments or appointments not canceled within the 24-hour period. We require a 48-hour notice when canceling a procedure or special test performed in the office. You will be charged a fee of $50 for an in-office procedure or special test not canceled 48 hours in advance. We require a 48-hour notice when canceling a procedure performed at an outpatient ambulatory center. You will be charged a fee of $100 for an outpatient ambulatory center procedure not canceled 48 hours in advance.

There will be a charge of $12 for form completion. Payment is due on completion.

It is the responsibility of the patient to ensure any referrals, precertification or authorizations have been obtained prior to your appointment. In the event your plan procedures are not followed prior to your appointment, your appointment may be rescheduled.

Delinquent accounts will be turned over to an attorney or collection agency without notice. Accounts will be considered delinquent if unpaid after 60 days. In the event your account is turned over for collection, you will be responsible for all reasonable collection and court costs at the time the account is considered delinquent.

Again, thank you for choosing us as your health care provider. We appreciate the opportunity to serve you.

I accept the Financial Policy, acknowledge that I received the Notice of Privacy Practices for Pinnacle ENT Associates, LLC and have had the opportunity to ask questions.

Patient's Signature ______________________________ Date ______________

Assignment of Benefits

I hereby guarantee payment of all charges incurred at the office of Pinnacle ENT Associates, LLC. I hereby assign and direct to pay any and all benefits for medical services under this claim directly to Pinnacle ENT Alliance, LLC. I hereby authorize the release of any medical information requested by the insurance companies.

Patient's Signature ______________________________ Date ______________

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

I acknowledge that I received the NOTICE OF PRIVACY PRACTICES for

PINNACLE ENT ASSOCIATES, LLC

CHESTER COUNTY OTOLARYNGOLOGY & ALLERGY ASSOCIATES DIVISION

Name of Patient: ______________________________ DOB: ______________

Date of Receipt: ______________ Signature of Patient: ______________________________

(or patient's personal representative, parent or guardian)

Personal representative, parent or guardian information (if applicable):

Name: ____

Relationship to Patient (or other authority): ______________________________

I hereby authorize you to discuss or release any of my information to the following:
(such as spouse, parent, family member)

Name	Relationship

Signature of Patient or Personal Representative ______________________ Date ______________

PENN MEDICINE AFFILIATION NOTICE

PATIENT DISCLAIMER AND ACKNOWLEDGEMENT

Pinnacle ENT Alliance, LLC, through its practice, ***Chester County Otolaryngology & Allergy Associates,*** is pleased to be affiliated with Penn Medicine and to participate in the Penn ENT Specialty Network. As part of the network, Pinnacle ENT Alliance, LLC is working with Penn Medicine to improve the quality of care provided to its patients.

Pinnacle ENT alliance, LLC, through its practice, ***Chester County Otolaryngology & Allergy Associates,*** is an independent physician practice group and is not owned by or a part of the University of Pennsylvania Health System. Neither the University of Pennsylvania Health System nor the Hospital of the University of Pennsylvania dictates or directs the manner in which care is provided by Chester County Otolaryngology & Allergy Associates. Each physician affiliated with ***Chester County Otolaryngology & Allergy Associates*** exercises independent medical judgement in the care of his or her patients.

If you have any questions about the relationship that Pinnacle ENT alliance, LLC or ***Chester County Otolaryngology & Allergy Associates*** has with Penn Medicine, please ask your physician.

Please sign below to indicate that you have read this acknowledgement and have had an opportunity to ask questions.

Signature of Patient or Personal Representative ______________________ Date ______________