Pinnacle ENT ASSOCIATES LLC

CHESTER COUNTY OTOLARYNGOLOGY & ALLERGY ASSOCIATES DIVISION

Patient Intake

Name: _____ DOB: _____ Appointment Date: _____

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

What is the purpose of today's visit? _____

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):

_____

_____

_____

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

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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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Mark A. Lisi, Au.D.
Erikka Resendiz, Au.D.
Jennifer E. Spaventa, Au.D.

Financial Policy

Patient: _____ DOB: _____

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 our billing office at 610-902-6092.

We ask that all patients read and sign our Financial Policy and HIPAA form as well as complete our Patient Intake form. Medicare patients may also be required to sign an ABN (Advanced Beneficiary Notice), should we believe that Medicare won't cover your services.

In order to accurately diagnose and treat your medical symptoms, your physician may recommend a procedure that is not included in the fee for your office visit. We will submit all claims to the insurance company on your behalf; however, you will be billed for any non-covered services, deductibles, co-pays and/or co-insurance. Some of these services include:

- Audiology (hearing) testing
- Earwax removal (impacted)
- Laryngoscopy (examination of the back of the throat and vocal cords)
- Nasal endoscopy (examination of the nasal passages and sinus openings)
- Biopsy or excision of lesion
- Foreign body removal
- Incision and drainage of abscess
- Fine needle aspiration (biopsy with a needle)
- Nasal cautery or packing (to control nasal bleeding)
- Myringotomy (incision of ear drum)

For your convenience we accept Visa, MasterCard, Cash, Check or Money Order. There will be a charge of $20.00 for returned checks.

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 a 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 costs at the time the account is considered delinquent.

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

_____ _____

Patient Name (Printed) DOB

_____ _____

Patient Signature (or Responsible Party) 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 of 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

Pinnacle ENT ASSOCIATES LLC

CHESTER COUNTY OTOLARYNGOLOGY & ALLERGY ASSOCIATES DIVISION

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 _____