Cynthia Chrosniak, M.D.
Nicholas Mehta, M.D.
Kealan Hobelmann, M.D.

Allyson D. Bull, Au.D. Lic # 01237
Rita Murphy, Au.D. Lic # 01245

CONDITIONS OF REGISTRATION

CONSENT FOR TREATMENT:
By signing below, I hereby consent to the administration of such medical treatment, diagnostic and/or therapeutic procedures as recommended by the physician rendering care for myself and/or my child(ren).

REFERRALS AND AUTHORIZATIONS:
By signing below, I acknowledge that it is my responsibility, if I (we) have an insurance plan that requires any referrals, pre-certifications or authorization to receive any additional medical services, such as specialty care and diagnostic testing, to obtain such authorization from my (our) primary care physician (PCP) or insurance company prior to such non-emergency services being rendered. Additionally, if any aforementioned procedures are not done, I understand that this may cause reduced or rejected coverage for which I will be held responsible and that any of these aforementioned actions do not guarantee that my insurance company will pay for myself, spouse or my (our) child(ren)'s claims. Any denial of a claim is between the policyholder/subscriber and their insurance.

FINANCIAL AGREEMENT:
By signing below I agree that:

1. If for any reason a check is returned on my account I will be responsible for a $25 returned check fee in addition to the original fees for service(s);
2. There will be a $50 fee for any appointments not cancelled 24 hours prior to the date and time scheduled.
3. If this account is sent to an attorney for collections, I agree to pay any collection and reasonable fees, (additional 24% of balance due), court costs and other expenses incurred as a result of said collection, all actions have a venue of Montgomery County, MD, other venues not withstanding.
4. There will be a $200 cancellation fee for any surgery if I cancel within ten (10) business days of the scheduled procedure.

ACKNOWLEDGEMENT OF NOTIFICATION OF PRIVACY PRACTICES:
By signing below, I acknowledge the availability of the practice's Notice of Privacy Practices pamphlet, which provides information about how we may use and disclose your protected health information, and is compliant with the Health Insurance Portability and Accountability Act (HIPAA). We reserve the right to change the terms described, and should we do this we will post the changes in all of our offices and on our web site. You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment or health care operations.

Patients Name: _____ Date of Birth _____

Signature of patient or guardian_____ Date:_____

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DISCLOSURE TO FAMILY/FRIENDS

____ **I do not** want Chrosniak, Mehta, and Hobelmann, M.D. (provider) to disclose any information concerning my care or treatment by provider to individuals without my express written consent or legal authorization

____ **I authorize** provider to disclose any information relating to my care and treatment to the following named individual(s):

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

The authorization provided for the above are subject to the following limitations or restrictions:

_____

_____

This authorization provides that:

- I may revoke this authorization at any time, provided that the revocation is in writing to the Privacy Officer at this practice.
- Information used pursuant to this authorization may be subject to review by the recipient and no longer is governed by HIPAA privacy rules.
- I have the right to access my protected health information to be used or disclosed.
- I may receive a copy of this competed and signed authorization form.

_____ _____
Printed Patient Name *Date*

_____ _____
Signature of Patient or Legal Guardian *Relationship to Patient*

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Insurance Procedure Terminology

The physician you are seeing today is a surgeon. He/she ***may*** need to do one of the procedures below in the office today:

- Flexible endoscopy of the throat (laryngoscopy)
- Control of nosebleed (epistaxis)
- Nasal endoscopy of the sinuses
- Cerumen (wax) removal
- Fine needle aspiration or biopsy
- Incision and drainage of an abscess
- Ear drum drainage +/- tube placement

This is **not** a consent form for any of the above procedures. The codes used to describe the services for your insurance company are found in the "surgery" section of the CPT codebook. This does not mean we are implying that you had an operation.

According to CPT guidelines, all procedures performed in the office are considered "surgery." Your insurance company may apply a surgical co-insurance responsibility or deductible and you may receive a bill.

We are providing this letter to inform you of what you ***may*** see on your statement from the insurance company. Please know that we have correctly performed and documented these services as required by the CPT coding guidelines.

I have read and understand the information supplied above:

Patient Name _____

Signature of Patient or Guardian_____ Date _____

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REASON FOR VISIT: _____

Patient Name: _____ **Birth Date:** _____ **Sex: M__ F__**

If a child, Parent(s) Name _____

CONTACT INFORMATION

Home Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Preferred Appointment Reminder Method (check one) : Voice Call_____ Text Message _____

E-mail Address: _____

OTHER CONTACTS

Emergency Contact Name: _____ **Phone:** _____

Primary Care Physician: _____ **Referring Physician:** _____

Pharmacy Name: _____

Pharmacy Street:_____ **Pharmacy City:** _____

HEIGHT: _____ **WEIGHT:** _____

Signature of Patient/Guardian: _____ **Date:** _____

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NAME: _____ **DATE:** _____

Do you have a personal history of any of the following medical conditions? Circle all that apply.

Cancer (Type: _____)	Bipolar	Glaucoma
Migraines/Headaches	Anxiety	COPD
Atrial Fibrillation	Diabetes	Asthma
Heart Attack	Hepatitis B	Seizures
Cardiac Stent Placement	Hepatitis C	HIV/AIDS
Hypertension	Stomach Ulcer	Other _____
Bleeding Disorder	Kidney Failure	Other _____
Stroke/TIA	Thyroid Disease	Other _____
Sleep Apnea	TMJ	Other _____

Are you currently pregnant? YES / NO **Are you breastfeeding? YES / NO**

Do you have any <u>allergies to medications?</u> NO ____ YES____ if yes, to what? _____

_____

List <u>all medications</u> you are currently taking: _____

_____

_____

List any previous Head and Neck surgeries_____

Other surgeries _____

<u>SOCIAL HISTORY</u>

Nonsmoker / Former Smoker / Current Smoker

If current smoker, how many cigarettes per day?
5 or less 6-10 11-20 21-30 >31

Other tobacco use? YES / NO

Alcohol use in past year?
none 0-1 drinks/mo 2-4 drinks/mo 2-3 drinks/week 4+ drinks/week

<u>CURRENT SYMPTOMS</u>
(circle all that apply)

Ear Pain	Sinus Pain
Blocked Ear	Swollen Glands
Decreased Hearing	Decreased Sense of Smell
Ringing in the Ears	Difficulty Swallowing
Nosebleed	Sore Throat

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The below information is required as part of the PPACA (Patient Protection and Affordable Care Act) and requested by the U.S. Government.

Race:

_____ American Indian or Alaskan
_____ Asian
_____ Black or African American
_____ Refuse to Report/Unreported
_____ White

Ethnicity:

_____ Hispanic or Latino
_____ Non-Hispanic or Latino
_____ Refuse to Report/Unreported

Language:

_____ English
_____ Spanish
_____ Other _____

Printed Name _____

Patient or Legal Guardian Signature _____ *Date* _____