CALIFORNIA HEAD & NECK SPECIALISTS
EAR, NOSE & THROAT CENTER

Name: _____ Date of Birth: ____/_____/_____ Gender: ☐ M ☐ F Date:_____

Address: _____ City: _____ State: _____ Zip: _____

Telephone Home: _____ Work: _____ Cell: _____

E-mail: _____ Social Security #: _____

Marital Status: _____ Are you employed? ☐ Yes ☐ No Employer Name: _____

Preferred Language: _____ Ethnicity: _____

INSURANCE INFORMATION

Primary Insurance: _____ ID#: _____ ☐ PPO ☐ HMO ☐ EPO ☐ POS ☐ Medi-Cal

Subscriber Name: _____ Subscriber DOB: _____/_____/_____

Secondary Insurance: _____ ID#: _____ ☐ PPO ☐ HMO ☐ EPO ☐ POS ☐ Medi-Cal

Subscriber Name: _____ Subscriber DOB: _____/_____/_____

In case of emergency, whom should we contact? (Please list an individual not living with you)

Name: _____ Phone: _____

Address: _____ Relationship: _____

Primary Care Physician: _____ Phone: _____

Were you referred?: ☐ Yes ☐ No if so, who?: _____

Parents name (if under 18): _____

Medical History

Have you ever had? (please check all that apply):

☐ Allergic rhinitis
☐ Anemia
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Atrial Fibrillation
☐ Cancer (Type: _____)
☐ Chest Pain
☐ Circulatory Disorder
☐ Congestive Heart Failure
☐ Depression
☐ Diabetes
☐ Emphysema
☐ Glaucoma
☐ Gout
☐ Headache
☐ Hearing Loss
☐ Heart Attack
☐ Heartburn
☐ Herniated Disc
☐ High Blood Pressure
☐ Hyperlipidemia
☐ Hypothyroid
☐ Insomnia
☐ Kidney Failure
☐ Migraine
☐ Mitral Valve Disorder
☐ Obstructive Sleep Apnea
☐ Osteoporosis
☐ Sinusitis
☐ Skin Disorder
☐ Smoking
☐ Stroke
☐ Thyroid Cancer
☐ Visual Impairment
☐ Vertigo
☐ Irritable Bowel Syndrome
☐ Laryngitis
☐ Allergies (Type: _____)

☐ Other Please explain: _____

Family History

Has anyone in your immediate family ever had any of the following? (please check all that apply):

☐ Cancer (Type: _____) Family member? _____ ☐ Hearing Loss Family member? _____

☐ Hypertension (High Blood Pressure) Family member? _____ ☐ Diabetes Family member? _____

☐ Allergies (Type: _____) Family member? _____

Are you currently taking any medications and/or herbal supplements? ☐ Yes ☐ No If yes, please list medication/supplement and include dosage:

_____

_____

Do you have any medication allergies? ☐ Yes ☐ No

If yes, please explain: _____

Are you allergic to latex? ☐ Yes ☐ No

Surgical History

List any operations you have had: please provide the date of surgery.

1. _____ 3. _____ 5. _____

2. _____ 4. _____ 6. _____

Social History

Do you use tobacco (cigarettes, pipe, chew, etc.)? ☐ Yes ☐ No What kind of tobacco? _____

☐ Daily amount _____ ☐ Weekly amount _____ ☐ Occasional amount _____

Do you drink alcohol? ☐ Yes ☐ No

☐ Daily amount _____ ☐ Weekly amount _____ ☐ Occasional amount _____

Do you use Drugs? ☐ Yes ☐ No If yes, what type? _____

Pharmacy Information

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone: _____ Pharmacy Fax: _____

Preventive Care

1. Have you ever had an Influenza immunization _____ If so, when _____ and where _____?

2. Have you ever had a Pneumonia Vaccination _____ If so, when _____ and where _____?
(Men and Women aged 65 and older)

3. Have you ever had a Colorectal Cancer Screening _____ If so, when _____ and where _____?
(Men and Women aged 50-75)

Results of test _____?

4. Have you ever been diagnosed with Clinical Depression _____ If so, when _____ and where _____?

5. Have you ever been screened for Osteoporosis _____ If so, when _____ and where _____?
(Female patients only aged 65 and older)

6. Do you have or have you been diagnosed with presence or absence of urinary Incontinence _____?

(Women aged 65 and older) _____ If so, when _____ and where _____?

7. Have you ever had a mammogram _____ If so, when _____ and where _____?
(Female patients aged 50 through 74)

PLEASE NOTE THAT ANYTHING HAVING TO DO WITH PROBLEMS OF THE EARS WILL REQUIRE AN AUDIOGRAM WITH THE AUDIOLOGIST, PRIOR TO SEEING THE PROVIDER!

Communication Consent Form

In order to comply with HIPAA (Health Insurance Portability and Accountability Act of 1996) regulations, we ask that our clients review and sign this Communication Consent Form. Please note it is the patient's responsibility to notify this office if anything should change regarding this form and who we should release patient information to.

Patient Name: _____ Date of Birth: ____/____/____

I give permission to be contacted in the following manner (please fill in phone numbers and check all that apply):

Home Telephone #: _____ Cell Phone #: _____

OK to leave message with information _____

OK to leave message at home or on the cell phone with the following family members: (list name(s) and relationship to patient)

1. _____ 2. _____

Relationship: _____ Relationship: _____

Written Communication

OK to mail to my home address: _____

List the person or persons (including spouse, if applicable) that you authorize us to release information to.
Please include their relationship to you and their phone numbers.

Name: _____ Relationship to Patient: _____ Phone: _____

Name: _____ Relationship to Patient: _____ Phone: _____

Patient Printed Name: _____ Date: _____

Patient Signature: _____

Parent/Guardian Signature: _____ Date: _____

(Needed if child is less than 18 years of age)

Witness Printed Name: _____ Date: _____

Witness Signature: _____

Billing Policy

- Payment to Ritvik P. Mehta M.D./ CALHNS is required when services are rendered.
- Prior to the first visit, it is the patient's responsibility to verify the amount of their deductible with their insurance company and bring the full amount to the first visit.
- California Head & Neck Specialists accepts cash, checks, money orders, VISA, MasterCard, American Express and Discover payments for services rendered.
- At each visit, all copayments and coinsurance amounts must be paid to Ritvik P. Mehta M.D./CALHNS prior to receiving services and/or seeing the physician.
- Insurance claims are filed on behalf of the patient. However, all deductibles and copayments are the patient's responsibility when services are rendered.
- If a patient fails to notify California Head & Neck Specialists of a secondary insurance company at the time of their initial visit, the patient is fully responsible for any amount not paid by their primary insurance company.
- It is the patient's responsibility to inform California Head & Neck Specialists of any insurance coverage change. If updated insurance information is not provided, the bill is the patient's full responsibility.
- Patients without insurance and those unable to pay their deductible and/or copayments are required to schedule and attend a meeting with the office manager to arrange a payment plan prior to services being rendered and/or seeing the physician. At each visit, the agreed-upon payment must be made prior to services being rendered and/or seeing a physician.
- If a check written to California Head & Neck Specialists is returned unpaid for any reason by the issuing bank, patients are liable for each returned check together with a service charge of $25, which must be paid to California Head & Neck Specialists.
- If a collection agency is required in order to collect a patient's past due amount, the patient will be charged for the collection agency's fee in addition to the past due amount.
- Referrals: If a patient's insurance company requires a referral be obtained prior to services rendered at a specialist, it is the PATIENT'S responsibility to obtain the referral from their primary physician and present it during their initial visit in order to be seen by the physician. If a patient inadvertently sees the physician without a required referral, the PATIENT will be billed for the visit.
- If subsequent referrals are required, it remains the patient's responsibility to obtain and present the referrals to California Head & Neck Specialists.
- It is every patient's responsibility to notify California Head & Neck Specialists of a change in address, phone number and/or insurance information.
- Patients must present insurance cards for re-verification at each visit.
- Attention Worker's Compensation Patients:
- Any patient failing to notify California Head & Neck Specialists during their first visit that treatment is related to a worker's compensation issue will be charged a $25 fee to cover the cost of updating and changing existing California Head & Neck Specialists records. Services rendered must be filed as worker's compensation and cannot be filed with personal insurance companies. If filed with a personal insurance company, payment will have to be returned by California Head & Neck Specialists when that insurance company discovers it's a worker's comp issue. If California Head & Neck Specialists were to attempt to collect the amount due as worker's comp, the bill would be rejected because the patient was not initially pre-authorized to be treated by California Head & Neck Specialists. All charges would then become the patient's full responsibility. Worker's comp patients are responsible for securing approval for treatment by their case worker for the initial visit. California Head & Neck Specialists will then secure approval for subsequent visits. Worker's comp patients are required to bring the following items to their first appointment: date of injury, claim number, name of worker's comp insurance company, name of case worker and case worker's phone and fax numbers.
- The following charges will be charged directly to the patient if you do not do the following:
    1. No show or cancel 72 hours prior to an allergy test appointment. $50.00 charge.
    2. No show or cancel 72 hours prior to a VNG, ABR, ECOG, ENOG or VEMP appointment. $75.00 charge.
    3. No show or cancel Surgery 2 weeks prior to surgery. $250.00 charge.
    4. No show or cancel any other appointment 24 hours prior to arrival time. $25.00 charge.
- A $50 fee is charged directly to patients if California Head & Neck Specialists needs to complete additional paperwork such as disability forms.
- A $50 fee is charged to patients if California head & Neck Specialists needs to forward medical records to a lawyer
- If California Head & Neck Specialists does not accept a patient's health insurance but the patient has out-of-network benefits, California Head & Neck Specialists will file the claim on behalf of the patient. Any higher out-of-pocket expenses are the patient's responsibility. Patients are strongly encouraged to contact their insurance company to verify the conditions and requirements of out-of-network doctor visits.
- All HMO patients are strongly encouraged to verify that California Head & Neck Specialists/Ritvik P. Mehta M.D. is an accepted provider and must present the appropriate completed referral paperwork prior to being seen by a physician.

Patient Payment Policy

We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care. For your convenience, we have answered a variety of commonly-asked financial policy questions below. If you need further information about any of these policies, please speak to any of the front staff members.

How may I pay? We accept payment by cash, check, debit and credit, VISA, Mastercard, American Express and Discover.

Do I need a referral? If you have an HMO plan, with which we are contracted, you need a referral and authorization from your primary care physician. We are unable to schedule any appointments without the direct referral authorization.

Copay/Outstanding Balances: All **Copays and outstanding balances** are due at time of service.

Unmet Deductibles: For patients with unmet Deductibles, you will be charged the following due at time of check in towards meeting your deductible:

IN-OFFICE CT SCANS: California Head & Neck Specialists owns 2 in-office CT scanners in our Carlsbad and Murrieta offices. Your physician may order a CT scan that may be performed on one of our scanners. Patients have the right to be treated at another imaging facility of their choice. We are making this disclosure in accordance with federal regulations.

If you DO NOT have insurance OR your insurance has not approved these services:

Self-Pay New Patient- $350.00

Self-Pay Audio- $150

Self-Pay Established Patient-$150.00

Self-Pay CT scans- $250

*Please note: There may be additional charges once claims are processed through insurance.

Which plans are CALHNS contracted with and what is my financial responsibility for services? Please contact your insurance company to see if we are in-network with your plan. Your financial responsibility depends on a variety of factors, explained below.

Ultimately, it is the patient's responsibility to know whether we are contracted with their insurance or not, and what their insurance does and does not cover. However, we will do everything possible to assist you with this process.

*Other charges that may accrue at the time of the visit: Nasal Endoscopy, nasopharyngoscopy with endoscope, removal impacted cerumen requiring instrument, binocular microscopy, labyrinthotomy, speech evaluation, tympanometry, allergy testing, VNG, VEMP/ECOG, and ABR, or other required procedures. Insurance may or may not cover for these additional charges. The patient will be held responsible for payment if the insurance does not cover the procedure.

Patient Acknowledgement

I have read and understood all of the above about the CALHNS Patient Payment Policy. I fully understand and agree to abide by the terms of the California Head & Neck Specialists Payment Policy. I attest that I am responsible for all copays, deductibles, co-insurance, and other charges at the time of my visit, or may be billed for procedures done the day of my appointment. If I have any questions, I understand that it is my responsibility to ask an employee of California Head & Neck Specialists.

Complaints:

You may complain to CALHNS or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. This notice was published and became effective on/or before April 14, 2003. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Patient Printed Name: _____ Date: _____

Patient Signature: _____

Assignment of Benefit Agreement

I hereby authorize my insurance company, including Medicare if I am a Medicare Beneficiary, to make payments to Ritvik Mehta, MD/ CALHNS for medical or surgical services or items rendered to me or my dependent by Ritvik Mehta, MD. Should my insurance carrier deny Ritvik Mehta, MD/CALHNS payment, I understand that I am financially responsible for the charges. I authorize Ritvik Mehta, MD, to release any and all of my records to my insurer, or any other third party payer, legally responsible for the payment of medical expenses. I certify that the information provided or to be provided by me is correct and complete to the best of my knowledge. It is my responsibility to update any and all personal, insurance and health information.

ZERO-TOLERANCE POLICY

I acknowledge that California Head & Neck Specialists has a **Zero-Tolerance** policy when it comes to patient acts of aggression, obscene language, property destruction, verbal, mental or physical threatening or malicious behavior of any kind. If this should occur, we will call the authorities and press charges if we feel necessary. We reserve the right to immediately terminate patient/physician relationship if this kind of act occurs.

Patient Acknowledgment

I have read and understood all of the above pages from Patient Questionnaire, Billing Policy, Privacy Policy and Zero Tolerance Policy. I fully understand and agree to abide by all terms of California Head & Neck Specialist's policies, including the Billing Policy. I confirm that all information stated above is the truth to the best of my knowledge. If I have any questions, I understand that it is my responsibility to ask an employee of California Head & Neck Specialists. **I also understand that if I am more than 15 minutes late for my appointment, the appointment will have to be rescheduled.**

Patient Printed Name: _____ Date: _____

Patient Signature: _____

A copy of this document will be provided to you upon request.

HIPAA Privacy Policy

This Notice of Privacy Practices describes how California Head & Neck Specialists (CALHNS) may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. 'Protected health information' is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. Uses and Disclosures of Protected Health Information: your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment:

CALHNS will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations:

CALHNS may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization. Your Rights Following is a statement of your rights with respect to your protected health information. You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e., electronically. You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints:

You may complain to CALHNS or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. This notice was published and became effective on/or before April 14, 2003. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Patient Signature: _____ Date: _____