



**EASTSIDE  
EAR, NOSE  
AND THROAT**

**Bellevue Office**  
1800 116<sup>th</sup> Ave NE  
Suite #102  
Bellevue, WA 98004  
Phone: 425-451-3710  
Fax: 425-451-2636

**Kirkland Office**  
12333 NE 130<sup>th</sup> Lane  
Suite #440  
Kirkland, WA 98034  
Phone: 425-899-3838  
Fax: 425-899-3844

**Redmond Office**  
8301 161<sup>st</sup> Ave NE  
Suite #200  
Redmond, WA 98052  
Phone: 425-869-4855  
Fax: 425-869-4858

**Patient Registration Form**

PATIENT NAME: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(First) (M) (Last) (Birthday) (Age)

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip Code)

Social Security #: \_\_\_\_\_  M  F Marital Status:  Single  Married  Divorced  Separated  Widowed

Parent/Guardian: \_\_\_\_\_ Home Phone # ( ) \_\_\_\_\_  
(First) (M) (Last)

Patient's Employment: \_\_\_\_\_ Work Phone # ( ) \_\_\_\_\_

Occupation: \_\_\_\_\_ Cell Phone # ( ) \_\_\_\_\_

EMERGENCY CONTACT PERSON OTHER THAN ABOVE NAMES: \_\_\_\_\_  
Name Phone Number Relationship

Race:  Caucasian  Hispanic or Latino  African American  Asian  Multiracial  Other: \_\_\_\_\_  Decline to Answer

Ethnicity:  Hispanic or Latino  Non Hispanic or Latino  Decline to Answer

Language:  English  Mandarin (Cantonese)  Mandarin (Chinese)  French  Japanese  Korean  Russian  Somali  
 Spanish  Vietnamese  American Sign Language  Other: \_\_\_\_\_  Decline to Answer

**TO RESPECT YOUR PRIVACY, HOW CAN WE REACH YOU REGARDING YOUR HEALTH INFORMATION, LAB TEST RESULTS, MEDICATION BILLING?**

Choose all that apply: Preferred Daytime phone# \_\_\_\_\_

1) Leave message on voice mail: ( ) \_\_\_\_\_  
 Home  Cell  Work

2)  Do not leave message on voice mail

3) Leave message with: \_\_\_\_\_  
Name Relationship

X \_\_\_\_\_  
Signature

Patient Email Address: \_\_\_\_\_

**PREFERRED LOCAL PHARMACY**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: ( ) \_\_\_\_\_

Referring Provider: \_\_\_\_\_

PCP Provider: \_\_\_\_\_  
(Primary Care Physician Name)

**PAYMENT IN FULL IS DUE AT TIME OF SERVICE UNLESS INSURANCE CARD(S) PROVIDED**

<b>PRIMARY INSURANCE NAME:</b>	<b>ID#:</b>	<b>GROUP #:</b>
Policyholder/Employee Name:	Policyholder DOB:	Relationship to insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
<b>SECONDARY INSURANCE NAME:</b>	<b>ID#:</b>	<b>GROUP #:</b>
Policyholder/Employee Name:	Policyholder DOB:	Relationship to insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other

**PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING**

Assignment Release Financial Agreement: I authorize treatment of the above named person and agree to pay all the fees for such treatment. I hereby authorize my insurance benefits to be paid directly to the provider of services and I am financially responsible for the non-covered services. I also authorize the physicians to release any information requested. I understand that my Insurance may deny payment for any reason including but not limited to the following: services not authorized by Primary Care Provider, services not authorized/covered by insurance co., referral from PCP's office at specialist office at time of appointment. I acknowledge that failure to meet my financial obligations may result in the referral of my account to a collection agency. \*\*\*\* Any unpaid balance over 60 days are subjected to late fees \*\*\*\*

**WE RESERVE THE RIGHT TO CHARGE \$50.00 FOR CANCELED OR NO SHOW APPOINTMENTS WITHOUT 24 HOURS ADVANCE NOTICE.**

\_\_\_\_\_  
Patient Signature (If patient is minor/Parent or Legal Guardian)

\_\_\_\_\_  
Date

# PROLIANCE SURGEONS®

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[www.eastsideent.com](http://www.eastsideent.com)

Please note that in many instances your visit today, and on subsequent visits, could include a charge for more than just an office visit. Many times the services rendered in the office, such as scopes used for diagnostic purposes, hearing test, biopsies, aspirations, excision of lesions, insertion of ear tubes, injection procedures into the ear or nose, ultrasound of neck, are charged separately from the office visit and may be deemed as a deductible or co-share item. Your insurance company requires that we bill our services using a coding system known as CPT (Current Procedural Terminology). The endoscopic exams and procedures rendered are found in the "surgery" section of the CPT code book and your insurance explanation of benefits may identify these items as "surgery". This does not mean we are implying you had an operation, this is merely the way the CPT code book is organized for ease of use by both the insurance companies and the physicians.

For most patients, your plan requires you to pay a copay at the time of your visit. You may also receive a bill from our office for an amount that has been deemed part of your deductible or co-share amount. These balances are due upon receipt of your bill and will receive a billing fee if not paid within the billing cycle.

We are providing this letter to assist in interpreting the billing and explanation of benefits that you may receive. Please contact your health plan if you need further information regarding the way in which they processed your claim.

I acknowledge receipt of this information.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Please print)

Patient, Parent or Guarantor signature: \_\_\_\_\_

### **Patient Financial Responsibilities**

Proliance Eastside Ear, Nose & Throat, a division of Proliance Surgeons is committed to providing you with the highest quality medical care. Because patients are ultimately responsible for the charges associated with their care, even when insurance is in place, you may find the following information helpful. We realize you have choices for your medical care and appreciate you choosing Proliance Eastside Ear, Nose & Throat.

#### **Patient Responsibilities**

You can help ensure an efficient experience by assisting with the following:

- Providing us with your picture identification, insurance card and Social Security number to enable us to submit your claims timely and accurately
- Knowing your insurance benefits and limitations
- Ensuring there is an authorization for our providers to treat you if it is required by your insurance, including obtaining a referral
- Providing us with copies of any pertinent medical records, including tests (MRI/CT/Arthrogram) and x-rays
- Paying your estimated portion of the charges at the time of service
- Paying any additional amount owed when due
- Completing required incident/accident forms within 30 days of date of service
- Maintaining a current account with Proliance Surgeons at all times
- Providing us with at least 24 hours advance notice should you need to cancel or reschedule an appointment

Please note that co-payments, co-insurance and deductibles are a contractual agreement between you and your insurance carrier. We cannot change or negotiate these amounts.

#### **Insured Patients**

We will bill your primary and secondary insurance carrier in a timely manner. If you are disputing payment with your insurance carrier or have a balance over \$100.00 with us, you must notify our business office and make payment arrangements .

**Co-Pays/Deductibles/Co-Insurance** - Please be prepared to pay for your portion of the charges on the date of service. Office procedures (e.g., casting, scopes, tests, x-rays) will be billed separately from the office visit.

**Surgery** - If surgery is indicated, a pre-payment of both physician and facility fees is required for all elective, non-emergent procedures prior to the surgery being performed. Your out-of-pocket cost is estimated based on your benefits and our fees. Anesthesia and other providers are separate fees.

**Non-Participating Insurance** - If we do not participate in the insurance you have, we will file a claim as a courtesy. All unpaid claims will become your responsibility 45 days following filing and be immediately due and payable.

#### **Uninsured Patients**

**Office Visits** - A \$255.00 deposit is required prior to the appointment. If visits and services are paid in full at the time of service, we offer a 20% discount (see exclusions below). Office procedures (e.g., casting, scopes, tests, x-rays) will be billed separately from the office visit.

**Surgery** - For uninsured patients having surgery, we offer a 20% discount when charges are paid before or on the day of service (see exclusions below).

**Exclusions** - The discounts referenced above do not apply in cases of cosmetic procedures, motor vehicle accidents, third party insurance claims or in other cases when the patient may be reimbursed in full.

Private pay patients who receive retroactive Medicaid coverage need to immediately notify our business office.

**Motor Vehicle Accidents (MVA) Insured and Third Party Patients**

We do not extend discounts for MVA-insured accidents, third party insurance claims or in other cases when patients may be reimbursed in full. We will bill the MVA insurance carrier one time. The bill becomes your responsibility if not paid by the carrier in 30 days. We regret that we are not in a position to confer with attorneys or defer payment obligations while a case settles. If your personal injury protection benefit on your MVA policy is exhausted, we will bill your private insurance at your request provided we are furnished the necessary information at the date of service.

**Workers' Compensation**

If your visit is work-related, we will need the case number and carrier name prior to your visit in order to bill the workers' compensation insurance carrier. If your workers' compensation claim is not yet accepted and you have no other insurance, we require a \$255.00 deposit that will be refunded after the claim has been opened.

**Other Charges**

**No Show** - Please provide us with at least 24 hours advance notice if you need to cancel or reschedule an appointment. We may charge a fee for missed appointments .

Please provide us with at least 48 hours advance notice if you need to cancel or reschedule an appointment and an interpreter has been scheduled. Otherwise, you may be charged for the interpreter.

**Forms** - There may be a charge associated with our completion of some forms. We require payment of the charge before returning the completed form to you. A signed Release of Information may also be necessary. Please allow five business days for us to complete forms.

**Payment**

**Payment Options** - We accept cash, checks, major credit/debit cards and money orders for payment (no post-dated or third party checks) . We charge a \$40.00 NSF fee for any returned checks.

**Delinquent Accounts** - We charge a \$10.25 monthly account management fee on balances over 45 days old. We may assign an account to collections if balances are unpaid after 60 days. Patients assigned to collections may be denied additional service.

**Alternative Payment Arrangements** - If you are unable to pay your balance when due, please contact our business office to make alternative arrangements . Any patient with a past due amount may be denied additional service until the amount is paid or the patient is complying with an alternative payment arrangement.

**Bankruptcy/Prior Bad Debt** - Patients who have previously filed for bankruptcy or never satisfied their payment obligations for prior episodes of care with Proliance Eastside Ear, Nose & Throat or other Proliance Surgeons care centers may be required to pay for their portion of new charges at the time of service .

Patient Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
Patient/Guarantor Signature

## **HIPAA SHORT FORM NOTICE OF PRIVACY PRACTICES**

We understand that health information about you and your health is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by this office, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

### **We are required by law to:**

- Make sure that health information that identifies you is kept private
- Give you this Notice of our legal duties and privacy practices with respect to health information about you; and
- Follow the terms of the Notice that is currently in effect.

### **How we may use and disclose health information about you:**

- For treatment
- For payment
- For health care operations
- For appointment reminders
- As required by Law
- To avert a serious threat to health and safety
- As required by the Military or Veterans and Workers Compensation
- Public Health risks
- Health oversight activities
- Lawsuits and disputes
- Law enforcement
- Coroners, health examiners and funeral directors
- National Security and Intelligence activities
- Protective Services for the President and others
- Security Officials for Inmates

### **Your rights regarding Health Information about you:**

- Right to Inspect and copy
- Right to Amend
- Right to an Accounting of Disclosures
- Right to Request Restrictions
- Right to Request Confidential Communications
- Right to a Paper copy of this Notice (*full Notice is available upon request*)

### **Changes to this Notice:**

We reserve the right to change this Notice. We will post a copy of the current Notice in our facility with the current effective date on the first page.

### **Complaints:**

If you believe that your privacy rights have been violated, you may file a complaint with us. All complaints must be in writing. Please contact the administrator at the location where you were treated to file a complaint.

### **Acknowledgment of Receipt of this Notice:**

We will request that you sign a separate form acknowledging you have received a copy of this notice. This acknowledgment will become part of your records. This acknowledgment provides that you have declined to accept the Complete Notice and instead requested this Short Form. We post a copy of the Current Complete Notice of Privacy Practices in our facility, on our web site at address: [www.proliancesurgeons.com](http://www.proliancesurgeons.com), and you may also ask for a copy.

Last Update: September 16, 2008

**ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES**

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Our Notice of Privacy Practices provides information about how we may use and disclose the medical information that we maintain about you. It also explains how you can access this information. By signing, you acknowledge that you have reviewed the Notice of Privacy Practices of Proliance Surgeons, Inc., P.S.

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

Patient Name: \_\_\_\_\_ Dr. \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Occupation: \_\_\_\_\_ Marital Status \_\_\_\_\_

**Patient medical history form.** Please provide the following medical information to the best of your ability.

What problems are you here for today and are you in pain? \_\_\_\_\_

Current Height: \_\_\_\_\_ Weight: \_\_\_\_\_

List any Allergies to Medications & Reaction

NKDA (No Known Drug Allergies)

Medication Allergies	Type of Reaction	Other Allergies	Type of Reaction

**Non-Medication Allergies:** Please Circle if allergic to: Eggs, Peanuts, Seafood, Iodine, Latex, Tape, Contrast Dye, other \_\_\_\_\_

LIST ALL MEDICATIONS YOU ARE TAKING (Prescription, over-the-counter or herbal supplements)

NO MEDICATIONS

Medication	Dosage	How often taken	Medication	Dosage	How often taken

### Past Medical History

1). Please check the "NO" or "YES" box to indicate if you have any of the following illnesses; for "YES" answers please explain.

	NO	YES		NO	YES
Hearing Problems	<input type="checkbox"/>	<input type="checkbox"/> _____	Stomach or Intestinal Problems	<input type="checkbox"/>	<input type="checkbox"/> _____
Hypertension (high blood pressure)	<input type="checkbox"/>	<input type="checkbox"/> _____	Allergy Problems/Therapy	<input type="checkbox"/>	<input type="checkbox"/> _____
Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/> _____	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/> _____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/> _____	Neurological Problems	<input type="checkbox"/>	<input type="checkbox"/> _____
Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/> _____	Cancer (Type)	<input type="checkbox"/>	<input type="checkbox"/> _____
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/> _____	History of MRSA	<input type="checkbox"/>	<input type="checkbox"/> (year) _____
Cholesterol	<input type="checkbox"/>	<input type="checkbox"/> _____	Anesthesia Problems	<input type="checkbox"/>	<input type="checkbox"/> _____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/> _____	Other Medical Diagnosis	<input type="checkbox"/>	<input type="checkbox"/> _____

2). Please list any surgeries and dates you have ever had (including ear, nose & throat surgery).

NO SURGERIES


Have you fallen more than twice in the past year?  No  Yes If YES how many times: \_\_\_\_\_

Can you climb two flights of stairs without stopping due to shortness of breath?  No  Yes

Have you had an EKG/ECG (Electrocardiogram)?  No  Yes Where/When \_\_\_\_\_

Have you had a blood transfusion  No  Yes

Do you see a Cardiologist?  No  Yes If yes, whom \_\_\_\_\_ Date of last visit \_\_\_\_/\_\_\_\_/\_\_\_\_

Do you exercise?  No  Yes How often? \_\_\_\_\_

### Social History:

	NO	YES	What type?	How Much?
Do you drink beverages with Caffeine?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Do you currently smoke Tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
If <b>NO</b> , did you previously?	<input type="checkbox"/>	<input type="checkbox"/>	Year stopped? _____	_____
Do you chew Tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Do you drink Alcoholic beverages?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Do you use Recreational drugs?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Patient medical history form:** Please provide the following medical information to the best of your ability.

Check "NO" or "YES" if you have had any of these symptoms in the past.

**Constitutional**

NO YES

- Chills
- Fatigue
- Fever
- Night Sweats
- Weight Gain
- Weight Loss

**Cardiovascular**

NO YES

- Chest Pain
- Heart Murmur
- Palpitations
- Hypertension
- Pacemaker

**Metabolic/Endocrine**

NO YES

- Cold Intolerance
- Heat Intolerance
- Increased Thirst
- Diabetes
- Thyroid Problems

**Head, Eyes, Ears, Nose, Throat**

NO YES

- Blurred Vision
- Choking on Liquids
- Choking on Solids
- Double Vision
- Dizziness
- Drooling
- Difficulty Swallowing
- Ear Drainage
- Hearing Loss
- Hoarseness
- Mouth Ulcers
- Ear Pain
- Throat Pain
- Tinnitus (Ear Noises)
- Vertigo
- Visual Changes

**Gastrointestinal**

NO YES

- Abdominal Pain
- Constipation
- Diarrhea
- Heartburn
- Vomiting

**Neurological**

NO YES

- Difficulty Falling Asleep
- Difficulty Staying Asleep
- Excessive Daytime Sleepiness
- Non Restorative Sleep
- Numbness In Extremities
- Passing Out
- Tingling
- Tremor
- Weakness
- Seizures

**Respiratory**

NO YES

- Sleep Apnea
- Shortness of Breath
- Snoring
- Wheezing/Asthma/COPD/TB

**Dermatologic**

NO YES

- Itching
- Rash
- Change in Mole
- Skin Lesion

**Hematologic**

NO YES

- Easy Bleeding
- Easy Bruising
- Lymphadenopathy
- Blood Clots in Blood Vessels

**Psychiatric**

NO YES

- Anxiety
- Depression
- Hallucinations

**Family Medical History**

Please check the "NO" or "YES" box to indicate whether any relatives have had any of the following illnesses:

If YES, please indicate which relative(s) have the problem.

	NO	YES	Mother	Father	Brother	Sister	MAT GM	MAT GF	PAT GM	PAT GF	OTHER/WHO
Hearing problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart problems/Murmurs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes (type)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer (type)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anesthesia Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
DECEASED (cause)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
History of MRSA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(if yes, year)_____