

New Patient Appointment

You are scheduled for an appointment with _____ on _____
at _____.

Location:	South:	St. Peters	DePaul
	2325 Dougherty Ferry Road	4800 Mexico Rd	12277 DePaul Drive
	Suite 106	Suite 103	Suite 303, South Bldg.
	St. Louis, MO 63122	St. Peters, MO 63376	Bridgeton, MO 63044
	314-821-5002	636-936-5002	314-770-0708

When you come for your appointment, please bring the following items with you:

The enclosed forms. Please make sure you **complete them fully in ink** *before* you arrive for your appointment.

A Photo I.D. (Such as your Driver's License)

A referral from your family physician. (If required by your insurance company; this will be your responsibility)

Your Insurance Card

Test Results (if applicable)

A list of all medications that you are currently taking including vitamins and herbal supplements with dosages.

Permission To Treat and File Insurance. If patient is a minor child brought in by someone other than the legal guardian, you must bring a notarized letter from the legal guardian giving permission for the child to be treated and insurance to be filed.

IMPORTANT NOTE: If you have a referral or test results faxed to our office, please have them faxed to (314) 821-5029. Then, please call (314) 821-5002 24 to 48 hours prior to your appointment to make sure we have received them!!!

Your co-pay will be collected at the time of your visit.

If you are unable to keep your appointment, please call (314) 821-5002 to cancel or reschedule. . **24 hours' notice must be given in the event you cannot keep an appointment. Should you not provide this notice, a cancellation fee of \$50 may be added to your account. Cancellations for ancillary services may be a higher fee.**

Thank you!!

Ear, Nose, Throat & Plastic Surgery, Inc.

Welcome To Our Office!

Name: _____ Today's Date: _____
 First Middle Last

Home Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Cell Phone: _____

Birthdate: _____ Age: _____ Weight: _____ Height: _____

Gender: Male Female

Race: _____ Ethnicity: _____ Language: _____

Email Address: _____ May we send information here? Yes No

Occupation: _____ SSN: _____

Employer: _____ Years There: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Work Phone: _____

Emergency Contact: _____ **Relationship to Patient:** _____

Home Phone: _____ Work Phone: _____

Referred By: _____ **Phone #:** _____

Primary Care Physician: _____ **Phone #:** _____

Pharmacy Name, Street, Zip & Phone #: _____

INSURANCE INFORMATION

Name of Primary Insurance Company:

City: _____ State: _____ Zip: _____

Policy Holder's Name: _____ Date of Birth: _____

SSN: _____

Address if different than patient: _____

Policy Number: _____ Group Number: _____

Name of Secondary Insurance Company:

City: _____ State: _____ Zip: _____

Policy Holder's Name: _____ Date of Birth: _____

SSN: _____

Address if different than patient: _____

Policy Number: _____ Group Number: _____

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, copay and non-covered service amounts. See our complete financial policy for details.

Signature of Patient or Responsible Party: _____

Date: _____

AUTHORIZATION FOR RELEASE OF INFORMATION, ASSIGNMENT OF INSURANCE BENEFITS,
ACKNOWLEDGMENT OF FINANCIAL RESPONSIBILITY, RELEASE OF MEDICAL RECORDS
CONSENT FOR OFFICE PROCEDURES

I hereby authorize Ear, Nose, Throat & Plastic Surgery, Inc. (the "Company") to release to the named Insurer(s) such information as may be necessary to complete the processing of any medical claims filed in connection with the treatment I received from the Company.

I hereby assign to the Company and authorize and direct the named Insurer(s) to pay directly to the Company any and all Basic, Major Medical, Extended Coverage, Trust Fund, Indemnity, Automobile Medical, No-fault Insurance and Liability benefits normally due to me under the aforesaid coverage, as my interest may appear therein.

I hereby acknowledge that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for actual payment. I hereby further acknowledge that it is my responsibility to pay any deductible amount and coinsurance. I hereby further acknowledge that I will personally pay any and all charges not paid by my insurance within sixty (60) days from billing thereof and that it will be my sole responsibility to collect such amounts from my insurance carrier. I hereby further acknowledge that if I do not pay you as required herein, I will be responsible to pay all of your collection cost, including (a) the charges of any collection agency to which you refer my account, (b) reasonable attorneys' fees (if you refer my account to any attorney) and (c) court cost.

Any agreed upon payment plans will be in writing and sent to the patient for signature. The document must be returned to our office with the first payment installment. Payment plans will be allowed as follows: 1) If the patient owes a balance of less than \$100, the full amount must be paid in no more than two payments within 60 days. 2) If a patient owes a balance between \$100 & \$499, the full amount must be paid in no more than three payments within 90 days. 3) If patient owes a balance of \$500 or more, at least 25% of the total balance must be paid monthly until the debt is satisfied.

1. It is your responsibility to inform us of all present and past medical conditions. This includes any surgeries, past treatments, allergies, tests performed.
2. It is your responsibility to follow up with us to receive any test results. In this electronic age, it is very important for you to take the initiative to receive your results. Do not assume that we will contact you after you have any tests completed. Once your tests are completed, please call our office and you will be informed as to how to receive your results. We may require you to come into the office to receive them.

I hereby authorize Dr. Richard L. Barnes, Dr. Christopher D. Bell, NP Irina Baazov and whomever they designate as assistants to perform the following procedures if deemed necessary: NASAL ENDOSCOPY SINUSCOPY, NASOPHARYNGOSCOPY/LARYNGOSCOPY, AUDIOLOGICAL TESTING, INJECTIONS, VIDEOSTROBOSCOPY, OFFICE SURGERY, AND DEBRIDEMENT OF SINUSES.

I hereby authorize Ear, Nose, Throat & Plastic Surgery, Inc. (the "Company") to obtain medical records from physicians or facilities as necessary for my medical treatment. As of Jan. 1, 2010, an extra fee will be charged for completion of any and all forms received by the office. This is not a covered benefit by your insurance company, and you will be held personally responsible for these charges when forms are received.

In the case of a minor child, I acknowledge that I am the legal guardian of a minor child that I have asked to be seen by one of the physicians in this practice. If I am unable to accompany said minor child to an appointment, I will provide a notarized letter to the practice granting my permission for the minor child to be treated and insurance filed.

It is the policy of Ear, Nose, Throat & Plastic Surgery, Inc. to provide services to all persons without regard to race, color national origin, religion, sex, age or disability. No person shall be excluded from participation in or be denied the benefits of any service or be subjected to discrimination because of race, color, nationality, religion, sex, age or disability. Please notify the office manager in writing within seven (7) working days if you have complaints pertaining to the above-stated policy. IN WITNESS WHEREOF, I EXECUTE THIS DOCUMENT AS OF THE _____ DAY OF

_____, 20____.

SIGNATURE OF PATIENT OR GUARDIAN

RIGHTS OF THE PATIENTS:

- Every patient has the right to courtesy, respect, dignity, privacy, responsiveness, and timely attention to his/her needs regardless of age, race, sex, national origin, religion, cultural, or physical handicap, personal value and beliefs.
- Every patient has the right to every consideration of his privacy and individuality as it relates to his social, religious and psychological well-being.
- Every patient has the right to confidentiality. Has the right to approve or refuse the release of medical information to any individual outside the facility, except in the case of transfer to another health facility, or as required by law or third-party payment contract.
- Every patient has the right to express grievances or complaints without fear of reprisals.
- Every patient has the right to continuity of health care. The physician may not discontinue treatment of a patient if further treatment is medically indicated, without giving the patient sufficient opportunity to make alternative arrangements.
- Every patient is provided complete information regarding diagnosis, treatment and prognosis, as well as alternative treatments or procedures and the possible risks and side effects associated with treatment. If it is medically inadvisable to disclose to the patient such information, the information is given to a person designated by the patient or to a legally authorized individual.
- Every patient has the right to make decisions regarding the health care that is recommended by the physician. Accordingly, the patient may accept or refuse any recommended medical treatment.
- Every patient has the right to appropriate treatment and care to include the assessment/management of pain.
- Every patient has the right to understand the practices charges. You have the right to an explanation of all charges related to your health care.
- Every patient has the right to all resuscitative measures; therefore, we will not honor Advance Directives.
- If a patient is adjudged incompetent under applicable State health and safety laws by a court or proper jurisdiction, the rights of the patient are exercised by the person appointed under State law to act on the patient's behalf.
- If a state court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with State laws may exercise the patient's right to the extent allowed by State law.

RESPONSIBILITIES OF THE PATIENT:

- Patients are responsible to be honest and direct about matters that relate to them, including answering questions honestly and completely.
- Patients are responsible to provide accurate past and present medical history, present complaints, past illnesses, hospitalizations, surgeries, existence of advance directive, medication and other pertinent data.
- Agree to accept all caregivers without regard to race, color, religion, sex, age, gender preference or handicap, or national origin.
- Patients are responsible for assuring that the financial obligations for health care rendered are paid in a timely manner.
- Patients are required to sign required consents and releases as needed.
- Patients are responsible for their actions if they should refuse a treatment or procedure, or if they do not follow or understand the instructions given to them by the physician or ENT Plastic Surgery employees.
- Patients are responsible for keeping their appointments. If they anticipate a delay or must cancel, they will notify the ENT Plastic Surgery as soon as possible.
- Patients are responsible for the disposition of their valuables, as Ear, Nose, Throat & Plastic Surgery does not assume the responsibility.
- Patients are responsible to be respectful of others, or other people's property and the property of ENT Plastic Surgery.
- Patients are to observe safety and no smoking regulations.
- Patients are responsible to follow up with us to receive any test results. Do not assume that we will contact you after you have any tests completed. Once your tests are completed, please call our office and you will be informed as to how to receive your results. We may require you to come into the office to receive them.

PATIENT COMPLAINT OR GRIEVANCE:

To report a complaint or grievance you may contact the facility Administrator by phone at 314-821-5002 or by mail at the address listed at the top of this page.

Complaints and grievances may also be filed through the following: State of Missouri Department of Health and Senior Services Missouri

Department of Health and Senior Services, PO Box 570, Jefferson City, MO 65109 or by phone at 573-751-6170.

All Medicare beneficiaries may file a complaint or grievance with the Medicare Beneficiary Ombudsman online at:

www.cms.hhs.gov/center/ombudsman.asp

BY SIGNING THIS DOCUMENT, I ACKNOWLEDGE THAT I HAVE RECEIVED THIS INFORMATION.

Patient/Patient Representative Signature

Date

EAR, NOSE & THROAT PLASTIC SURGERY, INCORPORATED

RICHARD L. BARNES, D.O., F.O.C.O.O., CHRISTOPHER D. BELL, D.O., IRINA BAAZOV NP

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

I understand that I have the right to obtain a copy of your most current Privacy Notice. I may request that you restrict how my protected health information is used or disclosed. I further understand that you are not required to agree with my request and that the decision to comply with my request will be at the discretion of my physician.

I understand that I have the right to request an amendment to my medical record and that you are not required to agree to my request. The decision to amend my medical record is at the discretion of my physician.

I have the right to revoke my consent in writing. A revocation will not apply to the use and disclosure of my information prior to revoking my consent.

I understand that my medical information will be disclosed when required by federal, state or local law or to any public health authority that is required to collect such information for the purpose of controlling disease, injury or disability.

I understand that a message to call your office may be left on my telephone recorder or with a family member but that no medical information will be left with anyone other than myself unless requested by myself in writing.

I further understand that if I wish someone other than myself to be involved in my medical care, I must identify this person in writing.

CONSENT

I have been informed and understand the Privacy Policy of Ear Nose & Throat, Plastic Surgery, Inc. I understand that all reasonable efforts will be made to protect my private healthcare information by the doctors and their staff.

I agree to permit my protected health information to be used and disclosed for purposes of treatment, payment, and health care operations.

I wish to have _____

(Name & Relationship)

involved in my medical care and I give my permission for him/her to discuss my medical care with my physician or his staff.

Signature

Date

Ear, Nose, Throat & Plastic Surgery, Inc.

Christopher D. Bell, D.O.
Irina Baazov, NP

Richard L. Barnes, D.O., F.O.C.O.O
Deana Juergens, Practice Administrator

Please answer each question by filling in the appropriate circle fully.

Do you have any medical problems?

- ☐ Eye problems
- ☐ Vision changes
- ☐ Sinusitis
- ☐ Allergies in the past
- ☐ Ear problems
- ☐ Nose problems
- ☐ Throat/Neck problems
- ☐ High blood pressure
- ☐ Mitral valve prolapse
- ☐ Heart Attack in the past
- ☐ Asthma
- ☐ COPD
- ☐ Genitourinary problems
- ☐ Migraine headaches
- ☐ Seizures
- ☐ Anxiety/Depression
- ☐ Diabetes
- ☐ Thyroid problems
- ☐ Anemia
- ☐ Blood cancer
- ☐ Skin cancer
- ☐ Breast cancer
- ☐ Other, please list: _____
- ☐ None

Please List all Medications that you are currently taking (**we are not MyChart affiliated**):

Please List all Allergies to Medications and the reaction you have to them: _____

Please List all Surgeries: _____

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Deana Juergens, Practice Administrator

Please answer each question by filling in the appropriate circle fully.

Does anyone in the family have any medical problems?

Mother	☐ Yes ☐ No	If yes, please list: _____
Father	☐ Yes ☐ No	If yes, please list: _____
Children	☐ Yes ☐ No	If yes, please list: _____
Maternal Grand Mother	☐ Yes ☐ No	If yes, please list: _____
Maternal Grand Father	☐ Yes ☐ No	If yes, please list: _____
Paternal Grand Mother	☐ Yes ☐ No	If yes, please list: _____
Paternal Grand Father	☐ Yes ☐ No	If yes, please list: _____

Do you?

Drink Alcohol ☐ Yes ☐ No
If yes, amount: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ per day ☐ per week ☐ per month

Smoke ☐ Yes ☐ No
If yes, amount: ☐ 1 ☐ 2 ☐ 3
☐ packs/day ☐ packs/week
For how long? ☐ <5 yrs ☐ 5-10yrs ☐ 10-15 yrs ☐ >15 yrs

Use Smokeless Tobacco ☐ Yes ☐ No

Use Recreational drugs ☐ Yes ☐ No

Are you around smoke ☐ Yes ☐ No

Are you Employed ☐ Yes ☐ No

Please List Occupation: _____

Have you experienced any of the following in the last 6 months?

weight change	☐ Yes ☐ No
fever	☐ Yes ☐ No
chills	☐ Yes ☐ No
fatigue (feeling run down)	☐ Yes ☐ No
hearing loss	☐ Yes ☐ No
sore throat	☐ Yes ☐ No
nose bleeds	☐ Yes ☐ No
change in voice	☐ Yes ☐ No
ringing in ears	☐ Yes ☐ No
dizziness	☐ Yes ☐ No
allergies	☐ Yes ☐ No

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Irina Baazov, NP

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Deana Juergens, Practice Administrator

Please answer each question by filling in the appropriate circle fully.

Have you experienced any of the following in the last 6 months?

chest pain	☐ Yes	☐ No
irregular heart rhythm	☐ Yes	☐ No
take coumadin/blood thinners	☐ Yes	☐ No

nausea	☐ Yes	☐ No
vomiting	☐ Yes	☐ No
diarrhea	☐ Yes	☐ No
difficulty swallowing	☐ Yes	☐ No
heartburn	☐ Yes	☐ No

diabetes	☐ Yes	☐ No
thyroid disease	☐ Yes	☐ No
cold intolerance	☐ Yes	☐ No
heat intolerance	☐ Yes	☐ No

headache	☐ Yes	☐ No
memory loss	☐ Yes	☐ No
difficulty walking	☐ Yes	☐ No
blurring of vision	☐ Yes	☐ No

cough	☐ Yes	☐ No
wheezing	☐ Yes	☐ No
shortness of breath	☐ Yes	☐ No

runny nose	☐ Yes	☐ No
itchy eyes	☐ Yes	☐ No
stuffy nose	☐ Yes	☐ No

easy bruising	☐ Yes	☐ No
anemia	☐ Yes	☐ No
skin rashes	☐ Yes	☐ No
skin lesions	☐ Yes	☐ No

rheumatoid arthritis	☐ Yes	☐ No
lupus	☐ Yes	☐ No