CALIFORNIA SINUS CENTERS

Doctor: _____ **Acct: _____** **Date: _____**

o 3351 El Camino Real, Suite 200 Atherton, California 94027 (650) 399-4630*p* (650) 365-3978*f*
o 2123 Ygnacio Valley Rd, Bldg K, Suite 100 Walnut Creek, CA 94598 (925) 300-4680*p* (925) 906 9780*f*

Please print neatly and fill out every item as accurately as possible. Ask a staff member if you require assistance in filling out this form.

Name: _____
First **Middle** **Last**

Date of Birth: _____ ☐ **Male** ☐ **Female** **SSN** _____-_____-_____
mm/dd/yyyy

Address:_____
Street **City** **State** **Zip**

Home Phone: (_____) _____ **Cell Phone:** (_____)_____

Employer: _____ **Work Phone:** (_____) _____

Email: _____ **Race** _____

Ethnicity: Hispanic_____Non-Hispanic_____Other_____ **Preferred Language_____**

Emergency contact: _____ _____ (_____)_____
Name **Relationship** **Phone**

Primary Insurance Information	**Secondary Insurance Information**
Insurance name:	**Insurance name:**
Insurance ID :	**Insurance ID :**
Group or Policy Number:	**Group or Policy Number:**
Policy Holders Name:	**Policy Holders Name:**
Policy Holders Relationship to Patient:	**Policy Holders Relationship to Patient:**
Policy Holders SSN: Date of Birth:	**Policy Holders SSN: Date of Birth:**

Primary Care Physician (Family Doctor) _____
Name **Address/Phone**

Referring Physician_____
Name **Address/Phone**

Medicare Lifetime Signature on File:
I request that payment of authorized Medicare benefits be made on my behalf to Sacramento Ear Nose and Throat Surgical Medical Group, Inc. (dba California Sinus Centers) for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Centers for Medicare Services and its agents any information to determine these benefits payable for related services.

Private Insurance Authorization for Assignment of Benefits/Information Release:
I, the undersigned, authorize payment of medical benefits to Sacramento Ear Nose and Throat Surgical Medical Group, Inc. . (dba California Sinus Centers) for any services furnished me by the physician. I understand that my agreement with my insurance company is a separate agreement between myself and my insurance company and that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company, or their agent, information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

_____ _____
Signature **Date**

ADULT

Revised 3/25/2009

How did you hear about our practice?(i.e. Dr, friend, web, yelp)_____

What is the reason for your visit today? _____

List all current medications, including any over the counter (OTC) medications or supplements:
☐ **Not taking any medications**

Name of Medication and Dosage

List any drug allergies or medicines you cannot take ☐ No known drug allergies

Name of Medication	Type of Reaction

Pharmacy: Name:_____ Address:_____
Phone #:_____ Fax #:_____

Have you ever had allergy testing? ☐ **No** ☐ **Yes**
Have you ever taken allergy shots? ☐ **No** ☐ **Yes**

Are you allergic to any of the following?
☐ **Latex** ☐ **Tape** ☐ **Foods _____**
☐ **Other _____**

Social History

Current Occupation: _____ ☐ **Disabled** ☐ **Retired** ☐ **Student**

Marital status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** ☐ **Cohabitating**

Tobacco use?
☐ **Never** ☐ **Yes** ☐ **Quit**

Alcohol use? ☐ **No** ☐ **Yes**

Past Health History

Please indicate any diseases that you have had or been diagnosed with by a doctor

☐ **No Major Illnesses**

Childhood Diseases
- ☐ Chicken Pox
- ☐ Other_____

Cancer
- ☐ Breast
- ☐ Lung
- ☐ Other _____

Congenital (Birth) Problems
- ☐ Congenital Malformation
- ☐ Down's Syndrome
- ☐ Other_____

Ears, Nose & Throat
- ☐ Ear Infections
- ☐ Hearing Loss
- ☐ Sinus Infections
- ☐ Sleep Apnea
- ☐ TMJ Dysfunction
- ☐ Other _____

Heart
- ☐ Angina (chest pain)
- ☐ Heart Attack
- ☐ Hypertension
- ☐ Murmur
- ☐ Mitral Valve Prolapse
- ☐ Other _____

Lungs
- ☐ Asthma
- ☐ COPD
- ☐ Cystic Fibrosis
- ☐ Tuberculosis
- ☐ Other _____

Digestive
- ☐ Hepatitis – Type: A B C
- ☐ Reflux
- ☐ Other _____

Bones/Joints
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Other_____

Skin
- ☐ Psoriasis
- ☐ Eczema
- ☐ Other _____

History of any Other Condition Not Listed
- ☐ _____

Brain/Nervous System
- ☐ Headache
- ☐ Seizures
- ☐ Stroke
- ☐ Other _____

Mental/Emotional Health
- ☐ Anxiety Disorder
- ☐ Bi-Polar
- ☐ Depression
- ☐ Other _____

Glands/Hormones
- ☐ Diabetes
- ☐ Grave's Disease
- ☐ Thyroid Disease
- ☐ Other _____

Allergies/Immune System
- ☐ AIDS/HIV
- ☐ Other _____

Female Patients Only: Are you pregnant? ☐ **Yes** ☐ **No** ☐ **Possibly / Not Sure**

Please indicate any major surgeries you have had: ☐ **No Surgery**

1. _____
2. _____
3. _____

Have you ever had problems with anesthesia (being put to sleep for surgery)?

☐ **No** ☐ **Yes** _____
(Please describe)

Have you ever had a serious injury? ☐ **No** ☐ **Yes** _____
(Please describe)

Tests & Immunizations

Pneumococcal Vacceine: Date administrered
Vaccine type: Pneumovax 23 _____ Pneumococcal_____

Colon Cancer screening: date screened: _____/_____/_____
Screen type: Colonoscopy _____
Flexible Sigmoidoscopy _____
Fecal Occult Blood Testing (FOBT) _____

Family History

Please list any of your BLOOD RELATIVES who have a history of any of the following and give their relationship to you:

☐ **Family history unknown**

			Relationship to you and details
Problems/Complications with Anesthesia	☐ **No**	☐ **Yes**	_____
Heart Problems (Including Hypertension)	☐ **No**	☐ **Yes**	_____
Lungs	☐ **No**	☐ **Yes**	_____
Bleeding/Clotting Problems	☐ **No**	☐ **Yes**	_____
Other Major Health Problems	☐ **No**	☐ **Yes**	_____

Please answer yes or no to any other SYMPTOMS that you have now or have had RECENTLY

		General:			**Stomach/GI Problems**
☐ No	☐ Yes	Fever	☐ No	☐ Yes	Heartburn/Indigestion
	☐ Yes	Weight loss		☐ Yes	Other:_____
		☐ Planned ☐ Unintentional			*(Please describe)*
	☐ Yes	Weight gain			**Urinary or Female/Male Problems**
	☐ Yes	Sleeping Problems	☐ No	☐ Yes	Pain/Bleeding
	☐ Yes	Other: _____		☐ Yes	Other:_____
		(Please describe)			*(Please Describe)*
		Eye Problems:			**Bone/Muscle problems:**
☐ No	☐ Yes	Blurred vision	☐ No	☐ Yes	Painful Joints
	☐ Yes	Double vision		☐ Yes	Pain/Stiffness in Neck
	☐ Yes	Other:_____		☐ Yes	Other:_____
		(Please describe)			*(Please Describe)*
					Breast or Skin problems:
		Ear Problems:	☐ No	☐ Yes	Rash
☐ No	☐ Yes	Dizziness		☐ Yes	Sores
	☐ Yes	Drainage		☐ Yes	Other:_____
	☐ Yes	Hearing Loss			*(Please describe)*
	☐ Yes	Infection			**Brain or Nerve Problems:**
	☐ Yes	Itching	☐ No	☐ Yes	Change in smell
	☐ Yes	Pain		☐ Yes	Change in taste
	☐ Yes	Ringing		☐ Yes	Change in Vision NOT Corrected with Glasses
	☐ Yes	Other:_____			
		(Please describe)		☐ Yes	Memory Loss
		Nose Problems:		☐ Yes	Headache
☐ No	☐ Yes	Nasal Congestion		☐ Yes	Facial Pain
	☐ Yes	Itching		☐ Yes	Other:_____
	☐ Yes	Nosebleeds			*(Please describe)*
	☐ Yes	Postnasal Drainage			
	☐ Yes	Other:_____			**Blood or lymph problems:**
		(Please describe)	☐ No	☐ Yes	Excessive Bleeding
		Mouth Problems:		☐ Yes	Easy bruisability
☐ No	☐ Yes	Hoarseness or Other Voice Change		☐ Yes	Neck Mass/Swelling
	☐ Yes	Snoring		☐ Yes	Other:_____
	☐ Yes	Sore Throat			*(Please describe)*
	☐ Yes	Swallowing Difficulty			
	☐ Yes	Other:_____			**Immune Problems:**
		(Please describe)	☐ No	☐ Yes	Hives
		Heart Problems		☐ Yes	Unusual Infections
☐ No	☐ Yes	Lightheadedness		☐ Yes	Other:_____
	☐ Yes	Chest Pain		☐ Yes	*(Please describe)*
	☐ Yes	Irregular Heartbeat/Palpitations			
	☐ Yes	Other:_____			**Other medical problem not listed:**
		(Please describe)	☐ No	☐ Yes	_____
		Lung Problems:			_____
☐ No	☐ Yes	Frequent Cough			*(Please describe)*
	☐ Yes	Difficulty Breathing/Short of Breath			
	☐ Yes	Other:_____			
		(Please describe			

NASAL ENDOSCOPY CONSENT FORM

Patient Name:_____ DOB:_____

Nasal Endoscopy: **How do we look into your nose / sinuses?** When you come to CSC with a nose or sinus related problem, the doctors may want to perform a nasal endoscopy. This is a surgical procedure using sterile small cameras to look through the nostrils. This may allow your doctor to:

1. obtain drainage for culture
2. evaluate previous surgery, scar, openings, masses, polyps, causes of blockage
3. evaluate healing or complications of surgery
4. obtain specimens / biopsy for pathology evaluation
5. remove old blood, foreign material, packing, scabs/scar/blockage
6. educate you and others: We can use video glasses / TV screens to show inside also

The nurse will have you sign this permission form first and then offer to spray your nose to make the procedure easier. The spray is a combination of Afrin (to shrink tissue) and Lidocaine (to numb). This spray does taste bad and can cause teeth/throat numbness that wears off in about 20-30 minutes. Some patients may also have a sensation that they can't swallow - do NOT panic – this will pass. Two words you need to remember during this procedure:

"Ouch": allows us to know where it is tender
"Sneeze": allows us to get outta there fast

A few (very few) patients experience significant discomfort/pressure during the procedure. We will stop if this occurs. The video glasses/ TV Screens allow you to see and can decrease the anxiety related to this. Less than 2% of patients faint/get queasy also - called a vasovagal reflex - we will put these patients chairs back and allow them to relax for a few minutes and this goes away.

YOUR CONSENT:
The procedure and description of this procedure, the more common risks associated with it and the potential complications have been described to me. This includes: a small amount of pain/pressure, a mild amount of bleeding, and a reaction to the nasal spray. I have had an opportunity to ask questions. I am satisfied with my understanding and the responses that I have received. I hereby authorize CSC personnel to perform a sinus / nasal endoscopy. I hereby authorize the doctor or his/her associates, to provide such additional services as he or they may consider to be medically advisable, including but not limited to suctioning, culturing the drainage, biopsies and packing if needed. I also consent to the use of photographs/video images to advance medical education and understand that if any photographs are used, I will not be identified by name.

Note: There may be a balance that is your responsibility if not fully paid by your insurance. This is usually less than $200.

_____ _____

Date Patient's Signature / Legal Guardian

PRIVACY PRACTICES

This is a summary of our Privacy Practices, which describes how we may use and disclose your medical and personal information.

OUR PLEDGE TO PROTECT YOUR PRIVACY

The California Sinus Centers and Institute, their providers and staff are committed to protecting the privacy of your information. So that we may best meet your medical needs, we share your medical records with providers involved in your care. We share your information only to the extent necessary to collect payment for the services we provide, to conduct our business operations, and to comply with the laws that govern health care. We will not use or disclose your information for any other purpose without your permission.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

- to inspect and obtain a copy of your medical records with certain limitations;
- to request an amendment or addendum to your medical record;
- to an accounting of CS disclosures of your medical information;
- to request restrictions on certain uses and disclosures of your medical information;
- to request when and where to contact you;
- to request a copy of this Notice of Privacy Practices.

WE MAY USE AND DISCLOSE YOUR PERSONAL AND HEALTH INFORMATION WITHOUT YOUR AUTHORIZATION FOR THE FOLLOWING PURPOSES:

- to provide you with medical treatment;
- to bill and receive payment for the treatment received;
- as required and permitted by law.
- for functions necessary to run the California Sinus Centers and Institute and assure that our patients receive quality care;
- for public health activities (e.g. reporting abuse);
- for research purposes in limited circumstances;
- to a coroner, medical examiner, funeral director or organ procurement organization for certain purposes;
- to a court or administrative order, subpoena, discovery request or other lawful process;
- to a health oversight agency, such as the California Department of Health Services;

We reserve the right to change our privacy practices and update this Notice accordingly. Please see more at: http://www.sacent.com/index.cfm/fuseaction/site.content/type/npp.cfm

I have read, agree and understood all of the above, my rights and Privacy Practices of California Sinus Centers, Institute and Affiliates.

_____ _____

Signature of Patient or Legal Representative Date

If Legal Representative, please indicate relationship to patient here:

Missed Appointments – " NO SHOW " fees

We are a very busy practice. We often have a waiting list for appointments that patients need. Please give us as much notice, if you need to cancel a visit – so we can get another patient cared for.

Please read and sign below:

- **All missed appointment fees are <u>not covered by insurance plans</u>. It may be your responsibility to pay before or at your next visit.**
- **If you need to cancel or reschedule an appointment, please call us at least 24 hours ahead.**
- **Appointment cancellations are only taken through office staff – emails, voicemails, and website communication do not apply.**
- **If you fail to arrive for your appointment and have not notified us 24 hours in advance, you may be charged.**
- **Staffing, materials, rent etc and our time are required to prepare for your appointment – and those expenses remain - whether you show or no show.**
- The " No Show Fee" is $30
- **If you have missed three appointments, please discuss your schedule with our office staff. You may benefit from seeing someone closer to you or seeing us on a different day or with different provider.**

Thanks for your understanding.

Patient Name (please print clearly) _____

I have read above, agree and understand.

Patient or Legal Guardian: Sign/ date here: _____

JOINT Patient Financial Policy Agreement

THANK YOU for choosing CalSinus and SacENT Medical Management to partner in your healthcare.
Your understanding of our JOINT Patient Financial Policy is important to our professional relationship.
WE are working together with you to assist in your care. You as a patient and us as providers will need to work together when it comes to your account.

Insurance: Knowing your insurance benefits, eligibility, covered benefits AND procedures is ***your*** responsibility. Please contact customer service at your insurance company for questions regarding your coverage. ***You may be fully responsible for charges not covered by your plan***. We can assist you with the codes that we often use to bill for our services. We will also assist with most prior authorizations. **Proof of Insurance**: You must furnish valid and up-to-date proof of insurance coverage. If you provide false or expired insurance information you will be responsible for the entire account at our cash patient rates. **Please notify us of any changes in insurance coverage prior to time of service**.

Claim submission: We will submit your insurance claims and assist you in any way reasonable to help get your claim paid – up to 30 days. Your insurance company may need you to supply information directly to them. Please be aware that the balance of your claim is your responsibility to pay whether or not your insurance company has paid.

Patient Responsibility for Payment: You will be responsible for payment of any **co-payment, co-insurance, deductible or service not covered by your insurance, as well as any collection fees.** All co-payments and past due balances are due at the time of your service. Patient balances noted on your monthly statement are due within 10 days of receipt. Our office does not accept cash for security reasons. We accept Visa, MasterCard and checks or pay via our website.

Non-Payment: Failure to pay will result in your account being referred to a collection agency, which may affect your personal credit rating. We will make several attempts to contact and work with you before referring to an agency. We will also ask delinquent patients to make arrangements to be seen elsewhere, as we can not assist further. If you are unable to pay your balance in full please contact our office ASAP.

Self-pay: Self-pay accounts are patients without insurance coverage. This includes patients covered by insurance plans in which the office does not participate, or patients without an insurance card on file with us. As of January 1, 2012 - self-pay for a New Patient visit is $400, a Return Patient visit is $200 and a CT scan for a new or return patient is $400. All prices are subject to change without notice – but usually only in January and July of each year.

Missed appointment: NO SHOW or missed appointments represent not only a cost to us, but also an inability to provide services to others who could have been seen. We require **at least 24 hours notice** of cancellation to avoid a **cancellation fee – ranges from $30-50** – depending on appt time held.
This financial policy helps the office provide quality care to many patients. If you have any questions please ask now. **I have read, understand, and agree to comply with the terms of your Joint Financial Policy – as such I have signed below.** Thank You, Calsinus staff & providers**.**

_____ _____
Patient Name / Guardian (please print clearly) then SIGNATURE then Date

_____ (Staff member) MR #: _____

Notice to Patients:
This notice is in compliance with Section 6003 of The Patient Protection and Affordable Care Act of 2010. PPACA mandates that all facilities which provide in-office ancillary services be required to disclose to their patients five to ten other facilities in the area providing the same service (CT-Sinus Xray). By signing this notice you are agreeing that a full list of options to receive your CT scan has provided to you.

Alternative Radiological Facilities/Providers:
California Advanced Imaging: 3301 El Camino Real, Atherton, CA 94027, **650.364.3080**
Health Diagnostics/3T MRI: 99 El Camino Real, Menlo Park, CA, 94025, **650.327.1121**
Norcal Imaging: Fremont, Oakland, Pleasanton, Walnut Creek
114 La Casa Via, Suites 100 and 200, Walnut Creek, CA, **925.937.6100**
2201 Walnut Avenue, Suite 150, Fremont, CA, **510.713.1234**

Stanford: 300 Pasteur Drive, Stanford, CA 94305 **650.723.4527**
Stanford Medicine Imaging Center: 451 Sherman Avenue, Palo Alto, CA 94306, **650.721.4624**
Stanford Medicine Outpatient Center: 450 Broadway Pavilion B, Redwood City, CA 94043 **650.723.6855**

WRI—Palo Alto Imaging: 400 Channing Avenue, Palo Alto, CA 94301, **650.323.1343**

Please print and sign your name below.

_____ (print name) DOB:_____

_____Signature _____Date

Thank you!

OUTCOME MEASURE QUESTIONNAIRE

Date: _____ Name: _____

We would like to know more about these problems and how they impact your life. There are no "right" or "wrong" answers, and only you can provide us with this information. **Please rate your problems as they have been RECENTLY**.

Magnitude Scale
Considering how severe the problem is when you get it and how frequently it happens, please rate each item below on how "bad" it is using the following scale:

0= No present/no problems
1= Very mild problem
2= Mild to slight problem
3=Moderate problem
4= Severe problem
5= Problem is as "bad" as it can be"

	MAGNITUDE
1. Stuffy / blocked nose……..	0 1 2 3 4 5
2. Runny nose. . . . . ……..	0 1 2 3 4 5
3. Decreased sense of smell or taste. . . …….	0 1 2 3 4 5
4. Post-nasal discharge / thick nasal discharge / debris……	0 1 2 3 4 5
5. Difficulty sleeping…….	0 1 2 3 4 5
6. Ear fullness / ear pain. . . . . ……. …….	0 1 2 3 4 5
7. Decreased hearing……..	0 1 2 3 4 5
8. Fatigue / worn out / decreased productivity. . . . . …….	0 1 2 3 4 5
9. Facial pain / pressure / headache . . . . . ……..	0 1 2 3 4 5
10. Cough / short of breath……	0 1 2 3 4 5
11. Feeling depressed or sad / frustrated……	0 1 2 3 4 5

Please feel free to add any additional comments below. Thank you for your help.

MEDICATIONS / CHANGES: _____

ALLERGIES: _____

HEIGHT:_____ **WEIGHT:**_____ **BLOOD PRESSURE:**_____/____ **PULSE:**_____

QUESTIONS FOR YOUR DOCTOR: _____

Patient / Guardian Signature_____ Date_____

THANK YOU!