CALIFORNIA SINUS CENTERS

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.

Doctor:_____ Acct: _____Date:_____

Patient Information		**Guarantor/Responsible Party information**	
Child's Name: First, Middle, Last		**Guarantor/Responsible Party Name: First, Middle, Last**	
Child's Date of Birth:	☐ **Male** ☐ **Female**	**Date of Birth:**	☐ **Male** ☐ **Female**
SSN:		**SSN:**	
Address (including zip):		**Address:** ☐ **Same as child**	
Home Phone: **( )**		**Work Phone:** **( )**	**Cell Phone** **( )**
Emergency Contact Name: **Relationship:**		**Employer:** **Address:**	
Phone: ( )		**Relationship to Patient: (for other please specify relationship)** ☐ **Parent** ☐ **Legal Guardian** ☐ **Other**	
Parent/Guardian Email Address:			

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) _____

Referring Physician_____

Medicare/Medi-Cal Lifetime Signature on File*:*

I request that payment of authorized Medicare benefits be made on the patient's behalf to Sacramento Ear Nose and Throat Surgical Medical Group, Inc. (dba: California Sinus Centers) for any services furnished the patient by the physician. I authorize any holder of medical information about the patient to release to the Centers for Medicare 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. for any services furnished the patient 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 the patient. This information will be used for the purpose of evaluating and administering claims of benefits. I also understand that in the event I have no insurance coverage, I am responsible for all billed charges.

_____ _____

Responsible Party's Signature Date

What is the reason for your child's 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 your child can not take ☐ **No known drug allergies**

Name of Medication	Type of Reaction

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

Has your child ever had allergy testing?
☐ **No**
☐ **Yes**

Has your child ever taken allergy shots? ☐ **No** ☐ **Yes**

Is your child allergic to any of the following?
☐ **Latex** ☐ **Tape** ☐ **Foods _____**
☐ **Other _____**

Past Health History

Please indicate any diseases or problems that your child has had or been diagnosed with by a doctor
☐ **No Major Illnesses**

Childhood Diseases
☐ **Chicken Pox**
☐ **Measles**
☐ **Mumps**
☐ **Other _____**

Congenital (Birth) Problems
☐ **Congenital Malformation**
☐ **Down's Syndrome**
☐ **Prematurity (# of weeks_____)**
☐ **Cystic Fibrosis**
☐ **Other _____**

Other Problems
☐ **Acne**
☐ **Asthma**
☐ **Diabetes**
☐ **GERD/Reflux**
☐ **Sleep Apnea**
☐ **Other _____**

(For Teenage Female Patients) ***Are you pregnant?*** ☐ **Yes** ☐ **No** ☐ **Possibly / Not Sure**

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

1. _____
2. _____
3. _____

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
Problems/Complications with Anesthesia	☐ **No**	☐ **Yes**	_____
Heart Problems (Including Hypertension)	☐ **No**	☐ **Yes**	_____
Lungs	☐ **No**	☐ **Yes**	_____
Bleeding/Clotting Problems	☐ **No**	☐ **Yes**	_____ **(Please describe**
Other Major Health Problems	☐ **No**	☐ **Yes**	_____ **(Please describe)**

Social History

Is your child currently attending school? ☐ **Yes** ☐ **No** ***What grade level?*** _____

Does your child use tobacco? ☐ **Never** ☐ **Quit** ☐ **Yes**

Does your child use any other drugs? ☐ **No** ☐ **Not Sure** ☐ **Yes** _____ **(Please describe)**

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

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 #: _____

CHILD / TEEN

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.**
- **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: _____

CALIFORNIA SINUS CENTERS

3351 El Camino Real, Suite 200
Atherton, Ca 94027
(650) 399-4630

From the South:
Take 101 North toward San Francisco
Take the Woodside Road/CA-84 W Exit
Merge onto Woodside Road/CA-84 W
Take the ramp toward CA-82 S/El Camino Real South (the second exit for CA-82)
Follow the exit ramp to Redwood Avenue, turn Right
Merge Right onto El Camino Real/CA-82 South
Turn Left onto Loyola Avenue
If you reach the stoplight at Atherton Ave / Fair Oaks, you have gone too far.
Pull into the first driveway on your Left for Patient Parking

From the North:
Take 101 South toward San Jose
Take the Woodside Road/CA-84 W Exit
Merge onto Woodside Road/CA-84 W
Take the ramp toward CA-82 South/El Camino Real South (the second exit for CA-82)
Follow the exit ramp to Redwood Avenue, turn Right
Merge Right onto El Camino Real/CA-82 South
Turn Left onto Loyola Avenue
If you reach the stoplight at Atherton Ave / Fair Oaks, you have gone too far.
Pull into the first driveway on your Left for Patient Parking

From the East:
From 880
Take the Decoto Road/CA-84 W Exit toward Dumbarton Bridge
Merge onto CA-84 W (Portions are toll road)
Turn Left onto Marsh Road/CA-84, continue to follow Marsh Road
Turn Right onto Middlefield Road
Turn Left onto 5th Avenue
Turn Left onto El Camino Real/CA-82 S
Turn Left onto Loyola Avenue
If you reach the stoplight at Atherton Ave / Fair Oaks, you have gone too far.
Pull into the first driveway on your Left for Patient Parking

If your starting location allows, we do recommend traveling to our office via Highway 280. Take Highway 280 to Highway 84 (Woodside Road) East, then Highway 84 to El Camino Real/CA-82 South. Once you are on El Camino Real, the directions are the same as above.

Pictures of the office exterior can be found at:
http://diamondprops.com/athertonsquare/photos.html

Note: 3351 El Camino Real is the only two-story building on the block.

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 YOU ARE TAKING:
_____

QUESTIONS FOR YOUR DOCTOR: _____

Patient / Guardian Signature_____
Date_____

THANK YOU !!!

CHILD / TEEN