THE COLORADO EAR, NOSE & THROAT GROUP

Proudly serving the greater Denver Area since 1962

Thank you!

We know paperwork stinks.
But it helps us take great care of you.
We're looking forward to meeting you. We take pride in the care we offer our patients.

Sincerely,

Dr. Kreutzer
Dr. Shah
Dr. Sohal

Patient Administrative Information **Colorado Ear Nose and Throat Group**

Please bring your Insurance Card and Driver License with this form to your appointment

Name: ________________________ Date of Birth: __________ Sex: M ___ F ___

Phone: Home ______________ Work ______________ Cell ______________

Address: ______________________ Address 2: ______________________

City: ______________________ State: ______________ ZIP: ______________

SSN#: ______________________ Pharmacy Phone: ______________________

Primary Care Physician: ______________________ Phone: ______________________

Employer/Profession/Student: ____

Email: ____

If Responsible Party is Other than Patient, Complete this Information:

Responsible Party: ______________________ Relationship to Patient: ______________________

Address (If Different):

Address: ______________________ Address 2: ______________________

City: ______________________ State: ______________ ZIP: ______________

Employer/Profession/Student: ____

Phone: Home ______________ Work ______________ Cell ______________

Insurance Information

Primary Insurance: ______________________ Policy Holder: ______________________

Date of Birth: ______________________ Policy ID#: ______________________

Employer: ____

Secondary Insurance: ______________________ Policy Holder: ______________________

Date of Birth: ______________________ Policy ID#: ______________________

Employer: ____

In Case of Emergency

Person to Notify in Case of Emergency: ______________________________

Emergency Contact Person's Phone: ______________________________

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NAME ______________________________________ **DATE** ____________________

DATE OF BIRTH ________________ **HEIGHT** ________________ **WEIGHT** ________________

REFERRING DOCTOR OR PRIMARY DOCTOR ______________________________ **PRIMARY PROBLEM (BE SPECIFIC)**

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ANY PRIOR TREATMENT FOR THIS (MEDICATION OR SURGERY) ____________________

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DR. KREUTZER GENERALLY FOCUSES ON YOUR PRIMARY PROBLEM DURING THIS VISIT DUE TO TIME CONSTRAINTS. *IF* THERE IS EXTRA TIME, WHAT ADDITIONAL PROBLEM WOULD YOU LIKE TO DISCUSS?

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For MD use only:

Ears ______________________________ **Nasal/sinus** ______________________________

Pharynx/Tonsils ____________________ **Larynx/endoscopy** ______________________

Neck ______________________________ **Facial/skin** ______________________________

Part 2 – Past Medical History **Colorado Ear Nose and Throat Group**

DO YOU HAVE? (PLEASE CHECK ANY/ALL)

Ringing or noise in ears
Hearing loss
Ear fullness/pressure
Dizziness/vertigo
Growths of Concern
Acid reflux (GERD)
Headache/facial pain
Nose congestion
Abnormal Nasal discharge
Facial/dental pain
Nose bleeds
Throat pain/pressure
Cough
Salivary gland problems
Loss sense of smell/taste
Snoring
Fatigue and sleepiness
Hoarseness/weak voice
Trouble swallowing
Deformity of nose or face
Skin cancers

ARE YOU ALLERGIC TO ANY MEDICATION? YES NO

IF "YES", WHAT WAS THE MEDICATION AND REACTION? ___________________________________

DO YOU HAVE ANY TROUBLE WITH ANESTHESIA? YES NO

LIST ALL MEDICAL PROBLEMS, FOOD ALLERGIES AND DRUGS USED TO TREAT THEM*

ILLNESS, PROBLEM, ALLERGY	DRUG

*** ATTACH SEPARATE SHEET IF MORE EXTENSIVE**

LIST OVER THE COUNTER MEDICATIONS, VITAMINS AND SUPPLEMENTS YOU TAKE*

MEDICATION, VITAMINS, SUPPLEMENTS	MEDICATION, VITAMINS, SUPPLEMENTS

*** ATTACH SEPARATE SHEET IF MORE EXTENSIVE**

LIST ALL PRIOR SURGERIES*

SURGERY	DATE

*** ATTACH SEPARATE SHEET IF MORE EXTENSIVE**

EVER USE TOBACCO? YES NO **USE ALCOHOL?** YES NO
AMOUNT ______________________ **AMOUNT** ______________________

MARIJUANA OR OTHER RECREATIONAL DRUGS? YES NO

EXPOSURE TO AIDS/HIV/HEPATITIS? YES NO

ANY HISTORY OF CLOTTING OR BLEEDING ISSUES? YES NO

Colorado Ear Nose and Throat Group

FINANCIAL POLICY

NOTE: Insurance co-pays are due prior to seeing the doctor

I understand that I am responsible for all charges incurred. This office will, as a courtesy to me, bill my insurance. I will furnish this office with all the information necessary to bill my insurance. Any balance due after insurance has processed **or denied** a claim, is due by me. Any patient balance due is to be paid in full upon receipt of billing statement.

Any unpaid balances after 90 days will be turned over to a collection agency for resolution.

I agree that if it is necessary to forward my account to a collection agency, I am responsible for the cost of collections including attorney fees and court costs. I authorize payment of medical benefits to the physician for services provided. I authorize release of medical information to insurance if needed to process claims.

I understand and agree to the financial policy as stated above.

________________________________ ________________
Patient / Responsible Party Signature Date

Please be advised that certain exams, including fiber-optic scopes, that need to be done for the doctor to view your sinuses or vocal cords, are considered a "surgical" code by many insurance companies and may be subject to your policy deductible. This may result in an additional balance due by the patient. This can apply to audiological services as well.

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Patient Initials

Colorado Ear Nose and Throat Group

PRIVACY PRACTICES

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

The Colorado Ear Nose and Throat Group has always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by another specialist doctor whom we may involve in your care. A copy of your visit notes will also be sent to your referring family doctor.

We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information in our computer.

We may share your medical information with our business associates, such as a transcription company. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person that answers the phone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail your files for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see.

You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer, LuAnn Tabuchi at (303)238-1366.

This notice goes into effect as of April 14, 2003.

ACKNOWLEDGEMENT

I have read and understand the privacy practices of Dr. Erik Kreutzer, Dr. Manan Shah, Dr. Maheep Sohal.

A copy is available to me at my request.

Date: ______________________________

Signed: ___________________________________

Print Name: ___________________________________

If signing as a parent or guardian, please note the name of the patient:

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If there is a family member or a friend you would like to give us permission to discuss your medical issues with, please list their names below. Otherwise, this will only be discussed with doctors or insurance companies requesting information on your behalf.

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