
OTOLARYNGOLOGY PLASTIC
SURGERY ASSOCIATES DIVISION

❒ 103 Progress Drive
Suite 200
Doylestown, PA 18901
(215) 348-1152

❒ 2100 N Broad St
Suite 102
Lansdale, PA 19446
(215) 368-5290

❒ 920 Lawn Ave
Suite 7
Sellersville, PA 18960
(215) 453-8900

## Patient Information

| | | |
|---|---|---|
| **Name:** | **DOB:** | **SSN:** |
| **Address:** | | |
| **Phone:** | **Work Phone:** | |
| **Cell:** « | **Email Address:** | |

## PCP and Referring Physician Information

| | |
|---|---|
| **PCP:** | |
| **Referring Provider:** | |
| **Address:** | |
| **Phone:** | **Fax:** |

## Responsible Party

| |
|---|
| **Name:** |
| **Address:** |

## Insurance Information

| | | |
|---|---|---|
| **Primary Insurance:** | **Subscriber Name:** | **Date of Birth:** |
| **Address:** | **Subscriber ID:** | |
| **Phone:** | **Group Number:** | |
| **Secondary Insurance:** | **Subscriber Name:** | **Date of Birth:** |
| **Address:** | **Subscriber ID:** | |
| **Phone:** | **Group Number:** | |

## Emergency Contact

| | |
|---|---|
| **Emergency Contact Name:** | **Phone Number:** |

## Pharmacy Information

| | |
|---|---|
| **Pharmacy Name:** | **Pharmacy Number:** |

## Patient Release

I certify the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for the purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I ACKNOWLEDGE THAT I AM FINANCIALLY RESPONSIBLE FOR AMOUNTS NOT PAID BY MY INSURANCE COMPANY FOR THE SERVICES I RECEIVED.

I permit a copy of this release to be used in place of the original.

Signature: _____ Date: _____

Pinnacle ENT
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## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

I acknowledge that I received the NOTICE OF PRIVACY PRACTICES for

**Pinnacle ENT Associates, LLC**
**Otolaryngology Plastic Surgery Associates Division**

Name of Patient:

Date of Receipt: _____

Signature of Patient: _____
(Or patient's personal representative, parent or guardian)

Personal representative, parent or guardian information (if applicable):

Name: _____

Relationship to patient (or other authority) _____

**I hereby authorize you to discuss or release any of my information to the following: (such as spouse, parent, family member)**

| **Name** | **Relationship** |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Signature of Patient or Personal Representative: _____

Dear Patient:

Thank you for choosing us as your health care provider. The following is our Financial Policy. Our main concern is that you receive the proper and optimal treatments needed to restore your health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to contact our billing office at 610-902-6092.

We ask that all patients read and sign our Financial Policy and HIPAA form as well as complete our Patient Information Form and Consent Form prior to having your examination, therapy, and/or study. **You will required to sign a ABN(Advanced Beneficiary Notice) if we do not participate with your insurance company. Medicare patients may also be required to sign an ABN, should we believe that Medicare won't cover your services.** Medicare may not cover your services if your diagnosis does not meet Medicare's policy for medical necessity or if you have met Medicare's maximum benefit for the services provided.

All insured patients are required to sign the assignment of benefits for payment from the insurance company. We will submit your claim to the insurance company on your behalf but if the insurance company does not pay your balance in full within 30 days, we ask that you contact the carrier. You will be billed for any non-covered services, deductibles, co-pays, and/or co-insurance. Co-pays and/or coinsurances are due at the time of service and will be charged an administrative fee of $11.50 if not paid at the time of service. For your convenience we accept Visa, MasterCard, cash, check or money order. There will be a charge of $25.00 for returned checks.

We require 24 hour notice when cancelling an appointment. You will be charged a fee of $20.00 for missed appointments or appointments not cancelled within the 24 hour period.

There will be a charge of $12.00 for form completion. Payment is due on completion of the form.

It is the responsibility of the patient to ensure any referrals, precertification or authorizations have been obtained prior to your appointment. In the event your plan procedures are not followed prior to your appointment, your appointment may be rescheduled.

Delinquent accounts will be turned over to an attorney or collection agency without notice. Accounts will be considered delinquent if unpaid after 60 days. In the event your account is turned over for collection, you will be responsible for all reasonable collection and court costs at the time the account is considered delinquent.

Again, thank you for choosing us as your health care provider. We appreciate the opportunity to serve you.

Patient's Signature

_____Date_____

**Assignment of Benefits**
I hereby guarantee payment of all charges incurred at the office of Pinnacle ENT Associates, LLC. I hereby assign and direct to pay any and all benefits for medical services under this claim directly to Pinnacle ENT Alliance, LLC. I hereby authorize the release of any medical information requested by the insurance companies.

Patient's Signature

_____Date_____

Pinnacle ENT
ASSOCIATES LLC
OTOLARYNGOLOGY PLASTIC
SURGERY ASSOCIATES DIVISION

## Affiliation Notice

*The following notice must be provided to and acknowledged by all patients seen at each Practice Site:*

PATIENT DISCLAIMER AND ACKNOWLEDGEMENT

Pinnacle ENT Alliance, LLC, through its practice, Otolaryngology Plastic Surgery Associates Division is pleased to be affiliated with Penn Medicine and to participate in the Penn ENT Specialty Network. As part of the network, Pinnacle ENT Alliance, LLC is working with Penn Medicine to improve the quality of care provided to its patients.

Pinnacle ENT Alliance, LLC, through its practice, Otolaryngology Plastic Surgery Associates Division is an independent physician practice group and is not owned by or a part of the University of Pennsylvania Health System. Neither the University of Pennsylvania Health System nor the Hospital of the University of Pennsylvania dictates or directs the manner in which care is provided by Pinnacle ENT Alliance, LLC, through its practice, Otolaryngology Plastic Surgery Associates Division . Each physician affiliated with Pinnacle ENT Alliance, LLC, through its practice, Otolaryngology Plastic Surgery Associates Division exercises independent medical judgment in the care of his or her patients.

If you have any questions about the relationship that Pinnacle ENT Alliance, LLC or Pinnacle ENT Alliance, LLC, through its practice, Otolaryngology Plastic Surgery Associates Division has with Penn Medicine, please ask your physician.

Please sign below to indicate that you have read this acknowledgement and have had an opportunity to ask questions.

_____ _____

Patient Signature Date

Pinnacle ENT
ASSOCIATES LLC
OTOLARYNGOLOGY PLASTIC
SURGERY ASSOCIATES DIVISION

Pinnacle ENT
ASSOCIATES LLC

OTOLARYNGOLOGY PLASTIC
SURGERY ASSOCIATES DIVISION

Thank you for electing to visit our specialists at Pinnacle ENT Associates, Otolaryngology Plastic Surgery Associates division. Our doctors specialize in ear, nose, and throat issues. We offer more specialized testing to better evaluate the problem you are seeking to diagnose and treat.

This form is to notify you in advance that the following procedures will most likely be done at your consult appointment. Your insurance company may process these differently depending on your insurance plan. Insurance companies always consider these tests a surgical procedure, and as such, are billed in addition to your office visit (regular or post op). Your insurance may apply additional copay, co-insurance and/or deductible. The below list is not an all-inclusive list, rather we are providing you with the most common ear, nose, and throat office procedures.

- 30901 Control of Nasal Hemorrhage, Simple
- 30903 Control of Nasal Hemorrhage, Complex
- 30905 Control of Nasal Hemorrhage, Posterior
- 31231 Diagnostic Nasal Endoscopy
- 31237 Nasal Endoscopy Surgical with Debridement (Unilateral or Bilateral)
- 31238 Nasal Endoscopy surgical with Control of Nasal Hemorrhage
- 31575 Flexible Laryngoscopy
- 69210 Removal of Impacted Cerumen
- G0268 Removal of Impacted Cerumen
- 69420 Myringotomy
- 69433 Tympanostomy
- 92557 Audiogram
- 92567 Tympanogram

You will be responsible for any additional copayment, coinsurance and/or deductible your insurance plan applies to your claim.

I certify that I have read and fully understand the above.

_____
Patient's Signature or Responsible Party


**Richard Herman, MD**
2100 N. Broad Street
Suite 102
Lansdale, PA 19446
(215) 368-5290
(215) 368-4401 fax

**Stephen Mass, MD**
103 Progress Drive
Suite 200
Doylestown, PA 18901
(215) 348-1152
(215) 348-7416 fax

**Sean Smullen, MD**
920 Lawn Avenue
Suite 7
Sellersville, PA 18960
(215) 453-8900
(215) 453-9330 fax

**Sonya Wexler, MD**

Patient Name: _____ DOB: _____

RACE: (Please circle)
White
Black/African American
American Indian/Alaska Native
Asian
Native Hawaiian/Other Pacific Islander
Unknown

ETHNICITY: (Please circle)
Spanish/Hispanic Origin
Not of Spanish/Hispanic Origin
Unknown

LANGUAGE _____

ARE YOU A FULL-TIME STUDENT? ☐ Yes ☐ No

ARE YOU EMPLOYED? ☐ Yes ☐ No
EMPLOYER NAME _____

☐ CHECK IF HOSPICE

HOW DID YOU HEAR ABOUT US? _____

HAVE YOU OR ANY FAMILY MEMBERS BEEN PREVIOUSLY SEEN BY THE DOCTOR? _____

**ALLERGIES?** ☐Yes ☐ No

| | Type of Reaction | | Type of Reaction |
|---|---|---|---|
| | | | |
| | | | |

Have you ever had an allergy test? ☐Yes ☐ No
Have you ever taken allergy shots? ☐ Yes ☐ No If yes, are you still taking them? ☐ Yes ☐ No
How much relief from shots? ☐ Minimal ☐ Partial ☐ Significant
Latex Allergy? ☐ Yes ☐ No

**LIST ALL MEDICATIONS YOUA RE TAKING (Prescription, over-the-counter or herbal) ☐ None**

| Medication | Dosage | How often taken | Medication | Dosage | How often taken |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

## FAMILY HISTORY and relationship to patient - Mother/Father/Sister/Brother/Son/Daughter

| | |
|---|---|
| Allergies | ☐ Yes |
| Asthma | ☐ Yes |
| Blood Disease | ☐ Yes |
| Cancer Type: _____ | ☐ Yes |
| Diabetes | ☐ Yes |
| Eczema | ☐ Yes |
| Hearing deficiency | ☐ Yes |
| Migraines | ☐ Yes |
| Renal Disease | ☐ Yes |
| Seizure Disorder | ☐ Yes |

Other: _____

## SOCIAL HISTORY:

**Tobacco Use? ☐ Yes ☐ No ☐ Former**

| Type of Tobacco | Packs/Day | For? Years | Yr. Quit? |
|---|---|---|---|
| Cigarettes | | | |
| Other: (list type) | | | |

**Do you consume alcohol? ☐ Yes ☐ No ☐ Former**
**_____# Drinks ☐ per day ☐ per week**

**Caffeine Consumption?**
**☐ No ☐ Yes Amount per Day? _____**
**What? _____**

**What is the reason you are here today?**

**PHARMACY NAME (include phone number and address if known)**

***MEDICAL/SURGICAL CURRENT PROBLEM AND HISTORY*: HAVE YOU EVER BEEN *DIAGNOSED* WITH ANY OF THE FOLLOWING?**

**Surgery/Management**

**Cardiovascular:**

Coronary Artery Disease ☐ **Yes** _____

☐ **Heart Attack**

Elevated cholesterol (hyperlipidemia) ☐ **Yes** _____

High Blood Pressure (hypertension) ☐ **Yes** _____

☐ **Stroke**

**Gastrointestinal:**

Hepatitis ☐ **Yes** _____

Gastroesophageal reflux ☐ **Yes** _____

**Genitourinary:**

Renal Failure (acute) ☐ **Yes** _____

**Ear/Nose/Throat: (HEENT)**

Cataracts ☐ **Yes** _____

Glaucoma ☐ **Yes** _____

Chronic ear infections (otitis media) ☐ **Yes** _____

Hearing loss ☐ **Right** ☐ **Left** ☐ **Both**

☐ **Current Hearing Aid**

Sinus Problems (chronic sinusitis) ☐ **Yes** _____

Nasal polyps ☐ **Yes** _____

Nasal Allergies ☐ **Yes** _____

Recurrent tonsillitis ☐ **Yes** _____

Tinnitus ☐ **Yes** _____

Vertigo ☐ **Yes** _____

☐ **History of Falls**

**Hematologic:**

Anemia ☐ **Yes** _____

Bleeding Disorder ☐ **Yes** _____

**Immunologic:**

Season Allergies Type: _____ ☐ **Yes** _____

Food Allergies Type: _____ ☐ **Yes** _____

HIV/AIDS ☐ **Yes** _____

Multiple Sclerosis ☐ **Yes** _____

**Integumentary**

Eczema/Psoriasis ☐ **Yes** _____

**Infectious Disease:**

Mononucleosis ☐ **Yes** _____

**Metabolic/endocrine:**

Diabetes Type: _____ ☐ **Yes** _____

Thyroid deficiency (hypothyroidism) ☐ **Yes** _____

Thyroid excess (hyperthyroidism) ☐ **Yes** _____

**Musculoskeletal:**

Arthritis ☐ **Yes** _____

**Neoplastic:**

Cancer Type: _____ ☐ **Yes** _____

**Neurologic:**

Migraine ☐ **Yes** _____

Parkinson's ☐ **Yes** _____

Seizure Disorder ☐ **Yes** _____

**Obstetric:**

Currently Pregnant ☐ **Yes Due Date** _____

**Psychiatric:**

Depression (major) ☐ **Yes** _____

Drug Addiction ☐ **Yes** _____

**Pulmonary:**

Asthma ☐ **Yes** _____

COPD/Emphysema ☐ **Yes** _____

Sleep Apnea ☐ **Yes** _____

Tuberculosis ☐ **Yes** _____

**Other:** _____

_____

**Injury** **Date of accident** _____

Head ☐ **Yes** _____

Facial Fracture ☐ **Yes** _____

Injury Due to ☐ MVA ☐ Work Injury

If YES to any of the above – was surgery performed?

Where/When/By Whom?

**REVIEW OF SYSTEMS:** **Check any of the following problems you have recently had:**

**General health problems**
☐fatigue ☐fever ☐night sweats ☐unintentional weight loss ☐sleeping problems ☐weight gain
**Eye problems**
☐double vision ☐itchy eyes ☐swelling ☐redness
**Ear problems**
☐ear drainage ☐hearing loss ☐ear infections ☐dizziness ☐itchy ☐noise exposure ☐ringing /noise in ears ☐ear pain ☐ tinnitus
**Nose & Sinus problems**
☐chronic congestion ☐mouth breathing ☐nosebleeds ☐frequent sneezing ☐runny nose ☐post-nasal drip
**Mouth & Throat problems**
☐difficulty swallowing ☐snoring ☐sore throat ☐hoarseness ☐sores in mouth ☐ulcers
**Heart or circulation problems**
☐heart murmur ☐leg cramping ☐swelling of ankles ☐chest pain ☐blacking out ☐irregular heartbeat
**Lung or respiratory problems**
☐shortness of breath ☐wheezing ☐ cough
**Stomach problems**
☐abdominal pain ☐diarrhea ☐heartburn ☐nausea ☐vomiting
**Brain or Nervous system problems**
☐headache ☐seizures ☐weakness ☐numbness ☐facial pain
**Glands & Hormone problems**
☐intolerance to heat ☐increased appetite ☐neck enlargement ☐intolerance to cold
**Blood or Lymph nodes problems**
☐bleeds excessively after injury ☐bruises easily
**Allergy problems**
☐food intolerances ☐insect bites
**Skin**
☐rash ☐itchy ☐latex allergies ☐swelling ☐urticaria / hives

## Previous Examination

**If you have had any of these tests performed in the past year, please fill out.**
***Please bring results to visit if recent tests were not performed at our participating hospitals (Grand View Hospital, Doylestown Hospital) since we will not be able to access and will need all current information for a thorough visit.**

☐ **Previous ENT consults**

- ○ Hearing test — Where and Date: _____
- ○ ENG or VNG — Where and Date: _____

☐ **Cardiovascular**

- ○ EKG — Where and Date: _____
- ○ Stress test — Where and Date: _____
- ○ Holter monitor — Where and Date: _____
- ○ Tilt table test — Where and Date: _____
- ○ Cardiac echo — Where and Date: _____

☐ **Imaging**

- ○ Head or neck CT scan — Where and Date: _____
- ○ Head or neck MRI — Where and Date: _____
- ○ Head MRA — Where and Date: _____
- ○ Sinus CT scan (films & results) — Where and Date: _____

☐ **Neurological**

- ○ Carotid ultrasound/Doppler — Where and Date: _____
- ○ EEG — Where and Date: _____
- ○ Lumbar puncture — Where and Date: _____

☐ **Labs**

- ○ CBC with differential — Where and Date _____
- ○ Chemistry complete
  - ☐ Electrolytes
  - ☐ Fasting blood sugar
  - ☐ Liver function
- ☐ Cholesterol/triglyceride or cardiac profile
- ☐ Thyroid function: TSH
- ☐ FTA-ABS and VDRL

***PLEASE PROVIDE PLACE OF SERVICE AND DATE**