BEACH CITIES ENTS MEDICAL HISTORY

In order for us to obtain a complete medical history, it is important to fill out this form as completely as possible. **Please fill out every item.** This information will be entered into the computer and you are welcome to a copy of the report if you wish.

Patient's Last Name_____ **First** _____ **MI** _____

Sex: Male Female **Ethnicity:** Hispanic or Not **Date of Birth:** _____

Race: *Please circle your choice:* Caucasian African American Declined
Asian Hawaiian/Pacific Islander
Hispanic/Latino American Indian

Please provide us your email for an alternative means to contact you: _____

Preferred Language:_____ **Name of Primary or Referring Physician:**_____

HAVE YOU EVER BEEN A PATIENT AT BEACH CITIES ENTS BEFORE? Yes No When? _____

WHAT IS YOUR REASON FOR TODAY'S VISIT: _____

DO YOU HAVE ANY OF THE FOLLOWING? *Circle Yes or No.*

Fatigue	Yes	No	**Snoring**	Yes	No
Hearing Loss	Yes	No	**Cough**	Yes	No
Nasal Congestion	Yes	No	**Facial Pain**	Yes	No

ARE YOU ALLERGIC TO ANY MEDICATIONS? ____ Yes ____ No.

If yes, please list below:

Name of Medication	Type of Reaction

Pharmacy Preference (include location):_____

Do you consent for us to obtain your medications from your pharmacy? Yes No

MEDICATIONS. Please provide us a written list of your medications or write ANY AND ALL MEDICATIONS YOU ARE CURRENTLY TAKING below including over the counter medications.

MEDICAL History: *Check if Yes.*

- ☐ Cataracts
- ☐ Anxiety
- ☐ Enlarged Prostate
- ☐ High Cholesterol
- ☐ Depression
- ☐ Epilepsy/Seizures
- ☐ HIV +
- ☐ Heart attacks
- ☐ Kidney stones
- ☐ Ulcers
- ☐ Inflammatory Bowel Disease (IBS)
- ☐ Asthma
- ☐ Breast Cancer
- ☐ Heart Failure (CHF)
- ☐ Dermatitis
- ☐ Reflux (GERD)
- ☐ Hepatitis
- ☐ Degenerative Arthritis
- ☐ Stroke
- ☐ Rheumatoid arthritis
- ☐ Atrial fibrillation (A fib)
- ☐ COPD (Emphysema)
- ☐ Coronary artery disease
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Hypertension (High BP)
- ☐ Osteoporosis
- ☐ Tuberculosis (Tb)
- ☐ Anemia
- ☐ Back Problems
- ☐ Cancer _____
- ☐ Dementia
- ☐ Eczema
- ☐ Gout
- ☐ Migraines
- ☐ Pneumonia
- ☐ Thyroid disease

Besides those checked above, please list any other medical problems or diagnoses you have:

_____

_____

_____

_____

Have you ever smoked? Yes No **What years did you smoke?** _____

Do you drink alcohol? Yes No **How much do you drink?** _____ **How often?** _____

Have you used cocaine? Yes No **How many years?** _____

PAST SURGERIES: *Check if Yes.*

- ☐ Appendectomy
- ☐ Cesarean Section
- ☐ Fracture
- ☐ Hip Fracture
- ☐ Knee surgery
- ☐ Myringotomy and tube
- ☐ Other surgeries below
- ☐ Thyroidectomy
- ☐ Vasectomy
- ☐ Breast Reduction
- ☐ Gallbladder
- ☐ Gastric Banding
- ☐ Hip surgery
- ☐ Spine surgery
- ☐ Nasal Septoplasty
- ☐ Prostate biopsy
- ☐ Tonsillectomy
- ☐ Carotid Endarterectomy
- ☐ CABG – Coronary bypass
- ☐ Heart valve surgery
- ☐ Hysterectomy
- ☐ Lasik
- ☐ Pacemaker
- ☐ Shoulder Arthroscopy
- ☐ Prostatectomy
- ☐ Cataract surgery
- ☐ Ectopic Pregnancy
- ☐ Hernia (abdominal)
- ☐ Knee Arthroscopy
- ☐ Mastectomy (Breast CA)
- ☐ Coronary angioplasty/stents
- ☐ Shoulder surgery
- ☐ Tubal Ligation

Besides those checked above, please list any surgeries you have had (including dates):

_____

_____

_____

_____

WHAT TESTS OR STUDIES HAVE BEEN DONE FOR THE PROBLEM TODAY?

_____

_____

_____

_____

_____

WHAT MEDICATIONS HAVE YOU TRIED OR BEEN GIVEN FOR THE PROBLEM TODAY?

_____

_____

_____

_____

_____

BEACH CITIES ENTS
EAR NOSE THROAT SURGEONS

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Name: _____ Date of Birth: _____
Last First Middle

Authorization for Use/Disclosure of Information: I voluntarily authorize and direct the health care provider named below to disclose my health information during the term of this Authorization to the recipient that I have identified below.

Name of Provider: _____

Address of Provider: _____

_____

Fax Number: _____

RECIPIENT FOR DELIVERY OF RECORDS:
BEACH CITIES ENTS
20911 Earl Street, Suite 340, Torrance, CA 90503
FAX: 310-944-9295

Purpose: I understand that the specific purpose of this Authorization is
_____

Information to be disclosed: This authorization permits the above named health care provider to disclose the following medical records:

_____ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me, including without limitation, x-rays, HIV/AIDS status, genetic testing, psychotherapy notes and other mental health information, drug, alcohol or other controlled substance information, billing information, correspondence, and records from my other health care providers that the above-named health care provider may hold.

____ All of my health information described above except for the following:
_____

____ Only the following records or types of health information: (Insert dates of treatment, types of treatment or other designation.)
_____

Term: This Authorization will remain in effect for one (1) year from the date this authorization is signed.

Redisclosure: I understand that once my health care provider discloses my health information to the recipient identified above, my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider.
Revocation: I understand that the Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my health care provider at my health care provider's regular office address. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.
Questions: I may contact my health care provider for answers to my questions about the privacy of my health information at my health care provider's regular office telephone number. I understand that I have right to receive a copy of this authorization from my health care provider.
Photocopy: A photocopy, fax or electronic copy of this authorization shall be considered as effective and as valid as the original.

_____ _____ _____
Signature Date Signature of Witness
Name: (Please Print) _____
If Individual is unable to sign this Authorization, please complete the information below.

_____ _____ _____
Signature of Personal Legal Relationship Date Witness Signature
Representative Name: (Please Print) _____

HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT
I hereby acknowledge that I was offered or received a copy of Beach Cities ENTS' Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted on their website and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

Patient Signature: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request that payment of authorized insurance benefits be made on my behalf to Beach Cities ENTS for any services that the doctors provide. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand that my signature requests that payment be made and authorizes release of medical information to pay the claim. I understand that I am financially responsible for the balance not covered by my insurance. If I fail to make payment and the balance of my account is placed for collection, I will be responsible for reasonable collection costs, including attorney's fees. If I submit a check which is returned by my bank, I understand that I will be charged an administrative fee for additional costs incurred by Beach Cities ENTS.

Patient Signature: _____ *Date:* _____

20911 Earl Street, Suite 340 Torrance, CA 90503 Tel (310) 540-2111 Fax (310) 944-9295 www.BeachCitiesENTS.com

BEACH CITIES ENTS

Adult and Pediatric Ear, Nose, Throat & Sinus

OFFICE FINANCIAL AND PAYMENT POLICY (Updated 07/01/2022)

If you have medical insurance, we will do our best to help you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance and understanding of our payment policy. You will be asked to update your demographic and insurance information periodically, including providing our office with copies of your insurance card(s). **If you provide us with different insurance from the date of your visit and we are not contracted with your correct updated insurance, the patient is responsible for services rendered.** We are required to obtain your signature for permission to release information to your insurance carrier annually.

NO SHOW POLICY: We ask for a 2-business days notice if you must cancel or reschedule an appointment to allow more availability for patients who desire to be seen. There will be a $50 charge for appointments made which you do not show or do not cancel with 2-business day notice. If you schedule surgery and need to cancel or reschedule, we ask for 2 weeks notice prior to the surgery date in order to allow other patients access to the limited operating room time. If this adequate notice is not given, a $250 deposit will be required to reschedule surgery and will be lost if surgery is cancelled a second time. *Please initial here:* _____

As a courtesy, we will gladly submit fees for your covered medical services to your insurance company. However, we expect payment of all services within 60 days. It may become necessary for you to pay your account in full if your insurance company fails to pay for services in an appropriate time period. **It is your responsibility to understand your coverage and benefits, including pre-certifications, referral and authorization requirements.** We will, however, assist you to ensure all plan requirements are met.

Payment for services, including **co-payment, co-insurance and deductible amounts, is due at the time services are rendered. We do not bill secondary insurance for co-pays. We expect copay payments for primary and secondary insurances at the time of visit.** Any non-covered services are your responsibility. Our failure to collect these amounts may be a violation of our contract with your insurance company and may result in civil and criminal penalties and/or expulsion from your insurance plan.

Returned checks, balances older than 60 days and failure to pay account balances as promised will be subject to an external collection service and a **collection fee of $100.** To cover the cost for returned checks, you will be charged an administrative fee of $100 and the cost of certified mailing in addition to the amount of your check. If we receive a bounced check from the bank, we will no longer be able to accept checks from you but will require cash or credit card payment. Also, there is a **$25 charge for any forms** that require completion by our office.

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. If there is a dispute with your insurance company, you will receive a letter from our billing service asking for your help by your contacting your insurance company to assist with processing and payment of the services provided to you. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to promptly contact Karmen or Silvia at our billing service, Med Pro Management, Inc. at 818-549-1713 for assistance in the management of your account. Thank you. Your signature below constitutes acknowledgement and acceptance of this policy.

Signature:_____ Date: _____

BEACH CITIES ENTS
EAR NOSE THROAT SURGEONS

Notice to Patients

"The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov."

For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.

Patient Signature: _____ Date: _____

El Segundo Office 2110 E. El Segundo Boulevard, Suite 110 El Segundo, CA 90245
Torrance Office 20911 Earl Street, Suite 340 Torrance, CA 90503
Tel (310) 540-2111 Fax (310) 944-9295 info@beachcitiesents.com BeachCitiesENTS.com