Patient Name (print): ______________________ Date of Birth: ______________

EAR NOSE THROAT & FACIAL PLASTIC SURGERY SPECIALISTS, PC

723 Fitzwatertown Road, Willow Grove, PA 19090-1332
215-659-8805 Fax 215-784-9729

Last Name: ______________________ First Name: ______________ Acct#: __________

Address: ______________________ City/State/Zip: ______________________

Please circle the best way to reach you

Home Phone: ______________ ☐ OK to leave a message Cell Phone: ______________ ☐ Texts OK Work Phone: ______________

Date Of Birth: ______________ Age: ______________ Sex: **M / F** SS #: ______________

Email ______________________ Pharmacy # ______________________

Emergency Contact Name: ______________________ Relationship: ______________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

Primary Care Physician: ______________________________________

Address: ______________________________________

Phone #: ______________________ Fax #: ______________

For appointments not kept or cancelled less than 24 hours prior to your appointment date & time, the full charge of the visit, diagnositc testing, procedure, and or surgical procedure, will be charged to you

INSURANCE INFORMATION

If Insurance is held by someone other than this patient, please fill out the information below:

Name of Insured: ______________________

DOB: ______________________

Address: ______________________ **(COPY OF CARD)**

Relationship to Patient: ______________________

I AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO MANAGE MY CARE.

I UNDERSTAND AND AGREE THAT REGARDLESS OF MY INSURANCE STATUS, I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR ANY PROFESSIONAL SERVICE RENDERED. I HAVE COMPLETED THE ABOVE QUESTIONS AND CERTIFY THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY YOU OF ANY CHANGES IN MY INSURANCE STATUS OR ANY OF THE ABOVE INFORMATION. I AUTHORIZE THE STAFF TO PERFORM ALL NECESSARY SERVICES NEEDED DURING THE DIAGNOSIS AND TREATMENT. I ALSO AUTHORIZE THE PROVIDER TO RELEASE ALL INFORMATION REQUIRED TO PROCESS INSURANCE CLAIMS.

PLEASE SIGN AND DATE

______________________ ☐ **NONE (if none, please indicate)**
(Name of designated person)

SIGNATURE: ______________________ DATE: ______________

Patient Name (print): ______________________ Date of Birth: ______________________

EAR NOSE THROAT & FACIAL PLASTIC SURGERY SPECIALISTS PC

PATIENT FINANCIAL RESPONSIBILITY INFORMATION

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 DEPARTMENT.

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. MEDICARE PATIENTS ARE REQUIRED TO SIGN AN ABN.

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 AND FINANCE CHARGES.

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 PLANNED PROCEDURES ARE NOT FOLLOWED PRIOR TO YOUR APPOINTMENT, YOUR APPOINTMENT MAY BE RESCHEDULED.

DELINQUENT ACCOUNTS WILL BE TURNED OVER TO COLLECTION AGENCY WITH A 2 WEEK NOTICE UNLESS DEMOGRAPHIC INFORMATION HAS CHANGED AND RETURNED TO US BY THE UNITED STATES POSTAL SERVICE. ACCOUNTS WILL BE CONSIDERED DELINQUENT IF UNPAID AFTER 60 DAYS. IN THE EVENT YOUR ACCOUNT IS TURNED OVER TO 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 Name (print): ______________________ Date of Birth: ________________

EAR NOSE THROAT & FACIAL PLASTIC SURGERY SPECIALISTS PC

PATIENT FINANCIAL AND MEDICAL RESPONSIBILTY INFORMATION

THE OFFICE OR DR. GOLDBERG MAY HAVE ORDERED A STUDY, TEST, CONSULTATION AND/OR FOLLOWUP APPOINTMENT FOR YOU. WE WILL ASSUME IF YOU HAVE NOT SCHEDULED THE ADVISED ORDER THAT YOU DO NOT PLAN ON HAVING THE ABOVE PERFORMED. MISSING FOLLOWUP MAY BE SUBJECT TO MISDIAGNOSIS, DELAYED DIAGNOSIS AND MALTREATMENT.

PLEASE ADVISE US IF THERE HAS BEEN A CHANGE IN YOUR ADDRESS, PHONE NUMBER, OR INSURANCE COVERAGE SINCE YOUR LAST APPOINTMENT.

IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT WITH THE DOCTOR AND DO NOT GIVE 24 HOURS NOTICE A FEE MAY BE CHARGED.

IF YOU ARE UNABLE TO KEEP YOUR PROCEDURE OR TESTING APPOINTMENT AND DO NOT GIVE 48 HOURS NOTICE A FEE MAY BE CHARGED.

PAYMENT IS EXPECTED AS SERVICES ARE RENDERED UNLESS PRIOR FINANCIAL ARRANGEMENTS HAVE BEEN MADE.

IF CO-PAY IS NOT PAID AT TIME OF VISIT, THERE WILL BE A CHARGE OF $11.50 FOR ADMINISTRATIVE COSTS.

A FEE OF $25.00 WILL BE CHARGED FOR ALL RETURNED CHECKS.

THERE WILL BE AN ADMINISTRATIVE FEE FOR THE COMPLETION OF ALL FORMS.

COMMUNICATION IS DOCUMNETED THROUGH PHONE CALLS DIRECTLY MADE TO OUR OFFICE. EMAILS, TEXTS & SOCIAL MEDIA IS NOT PART OF YOUR MEDICAL RECORD.

ALL REFILL REQUESTS MUST COME FROM THE PATIENT OR FAMILY; WE DO NOT ACCEPT REFILL REQUESTS OR FAX REFILL REQUESTS FROM PHARMACIES.

EAR NOSE THROAT & FACIAL PLASTIC SURGERY SPECIALISTS and/or Dr. Goldberg does not accept any portion or any content of a text message, any cell phone voice mail and/or email as valid communication. It will not be considered part of medical record.

SIGNATURE______________________________ DATE______________
(IF OVER 18 YEARS OF AGE)

Patient Name (print): ______________________ **Date of Birth:** ______________________

EAR NOSE THROAT & FACIAL PLASTIC SURGERY SPECIALISTS PC

NAME______________________ DATE OF BIRTH ______________ DATE ______________

HEIGHT ____________ WEIGHT ____________

It is your responsibility to provide accurate and current medical information below at your initial and subsequent visits. Any information not disclosed can result in misdiagnosis and maltreatment. ANY ITEMS LEFT BLANK OR NOT COMPLETED WILL BE NEGATIVE.

PAST MEDICAL HISTORY ☐ NONE ☐ NO CHANGE (existing patients only)

☐ anemia ☐ bronchitis ☐ emphysema ☐ heart murmur ☐ kidney disease ☐ MS
☐ arthritis ☐ cancer ☐ glaucoma ☐ hepatitis ☐ lung cancer ☐ reflux
☐ asthma ☐ cataracts ☐ hearing problem ☐ high blood pressure ☐ migraine headaches ☐ seizures
☐ bleeding disorder ☐ diabetes ☐ heart disease ☐ high cholesterol ☐ mono ☐ thyroid
☐ pulmonary disease

☐ Other illnesses: ______________________

PAST SURGICAL HISTORY ☐ NONE ☐ NO CHANGE (EXISTING PTS ONLY)

____

ALLERGIES ☐ NONE ☐ NO CHANGE (EXISTING PTS ONLY)

____

MEDICATIONS ☐ NONE ☐ NO CHANGE (EXISTING PTS ONLY)

____

OCCUPATIONAL HISTORY ☐ NONE ☐ NO CHANGE (EXISTING PTS ONLY)

____

SOCIAL HISTORY ☐ NONE ☐ NO CHANGE (EXISTING PTS ONLY)

TOBACCO ______________________

ALCOHOL ______________________

ILLICIT DRUGS ______________________

FAMILY HISTORY ☐ Grandparents ☐ Parents ☐ Siblings ☐ NONE ☐ NO CHANGE (EXISTING PTS ONLY)

☐ anemia ☐ bronchitis ☐ emphysema ☐ heart murmur ☐ kidney disease ☐ MS
☐ arthritis ☐ cancer ☐ glaucoma ☐ hepatitis ☐ lung cancer ☐ reflux
☐ asthma ☐ cataracts ☐ hearing problem ☐ high blood pressure ☐ migraine headaches ☐ seizures
☐ bleeding disorder ☐ diabetes ☐ heart disease ☐ high cholesterol ☐ mono ☐ thyroid

Other illnesses: ______________________

I am signing that I am responsible for providing all accurate and up to date medical information listed above.
ANY ITEMS LEFT BLANK OR NOT COMPLETED WILL BE NEGATIVE.

PATIENT/GUARDIAN SIGNATURE: ______________________ Date: ______________

Patient Name (print): ______________________________ **Date of Birth:** ______________________

It is your responsibility to provide accurate and current medical information below at your initial and subsequent visits. Any information not disclosed can result in misdiagnosis and maltreatment.

REVIEW OF SYSTEMS

ANY ITEMS LEFT BLANK OR NOT COMPLETED WILL BE NEGATIVE.

CONSTITUTIONAL: ❑NONE ❑FEVERS ❑CHILLS/SWEATS ❑WEIGHT LOSS ❑TIRED
❑LOSS of APPETITIE ❑RECENT TRAVEL ❑BLOOD TRANSFUSION

EYES: ❑NONE ❑PAIN ❑ITCHING ❑VISION CHANGE

EAR: ❑NONE ❑PAIN ❑DRAINAGE ❑HEARING LOSS ❑RINGING ❑DIZZINESS

NOSE: ❑NONE ❑PAIN ❑DRAINAGE ❑LOSS of SMELL ❑CONGESTION ❑NOSEBLEEDS

ORAL: ❑NONE ❑PAIN ❑LUMP/LESION ❑LOSS/CHANGE TASTE ❑CAVITIES

THROAT: ❑NONE ❑PAIN ❑LUMP/LESION ❑DRAINAGE ❑HOARSENESS ❑COUGH
❑TROUBLE SWALLOWING

NECK: ❑NONE ❑PAIN ❑SWELLING ❑NUMBNESS ❑LUMP/LESION

CARDIOVASCULAR: ❑NONE ❑CHEST PAIN ❑PALPITATIONS

RESPIRATORY: ❑NONE ❑SHORTNESS BREATH ❑WHEEZING ❑COUGH

GASTROINTESTINAL: ❑NONE ❑NAUSEA ❑VOMITING ❑DIARRHEA
❑CONSTIPATION ❑PAIN ❑BLOOD IN STOOL

GENITALURINARY: ❑NONE ❑PAIN/BURNING ❑URGENCY/FREQUENCY ❑BLOOD

NEUROLOGY: ❑NONE ❑HEADACHES ❑WEAKENESS ❑NUMBNESS ❑TREMOR

ENDOCRINE: ❑NONE ❑ALWAYS HOT OR COLD ❑HAIR OR NAIL CHANGES
❑HORMONE CHANGES

HEMATOLOGY/ONCOLOGY: ❑NONE ❑CANCER ❑EASY BLEEDING/BRUISING

MUSCULOSKELETAL: ❑NONE ❑ACHES/PAINS ❑JOINT SWELLING/STIFFNESS

ALLERGIC/IMMUNE: ❑NONE ❑SNEEZING/ITCHING ❑COLDS/INFECTIONS

SKINCARE: *❑ACNE ❑ROSACEA ❑WRINKLES ❑PIGMENTATION ❑SUN DAMAGE ❑SCARS*
❑I am interested in a complimentary skin care consult

I am signing that I am responsible for providing all accurate and up to date medical information listed above.
ANY ITEMS LEFT BLANK OR NOT COMPLETED WILL BE NEGATIVE.

SIGNATURE______________________________ DATE______________
(IF OVER 18 YEARS OF AGE)

SIGNATURE______________________________ DATE______________
(RESPONSIBLE INDIVIDUAL)

Patient Name (print): ______________________ Date of Birth: ______________________

EAR NOSE THROAT & FACIAL PLASTIC SURGERY SPECIALISTS PC

V QUESTIONS

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE PLEASE CONTACT OUR PRIVACY OFFICIAL AT THE OFFICE ADDRESS AND NUMBER.

VI PRIVACY OFFICIAL

YOU MAY CONTACT OUR PRIVACY OFFICIAL AT 723 FITZWATERTOWN ROAD, WILLOW GROVE, PA 19090, Ph: (215) 659-8805

HIPAA ACKNOWLEDGMENT

NAME: ____

I ACKNOWLEDGE THAT A COPY OF THE NOTICE OF PRIVACY PRACTICES FOR EAR NOSE THROAT & FACIAL PLASTIC SURGERY SPECIALISTS PC WAS MADE AVAILABLE TO ME.

IF I WISH TO ALLOW A FAMILY MEMBER OR FRIEND TO RECEIVE MY PERSONAL PROTECTED HEALTH INFORMATION, I MUST SIGN AN AUTHORIZATION FORM PROVIDED BY THE PRACTICE.

SIGNATURE: ______________________________ DATE: ______________
(if over 18 years of age)

WITNESS SIGNATURE: ______________________________________