Albany ENT & Allergy Services

Patient Health Care Survey

518 701 2000

Patient Name	Date of Birth	Nickname (How you would like to be addressed:

Street Address	City, State and Zip	Email Address

Home Phone	Work Phone	Cell Phone

Preferred Contact Number ◯ Home ◯ Work ◯ Cell

Appointment Reminders Preference ◯ Home ◯ Work ◯ Cell ◯ SMS Text ◯ Email ◯ Opt Out

Gender ◯ Male ◯ Female ◯ Undifferentiated | Birth Gender (If different)

Ethnicity ◯ Non Latino- Hispanic ◯ Latino -Hispanic ◯ Decline to Specify | Other

Marital Status ◯ Single ◯ Married ◯ Divorced ◯ Separated ◯ Widowed

Race ◯ American Indian or Alaskan Native ◯ Afghanistan ◯ Asian ◯ African American ◯ Black or African American ◯ Iraqi ◯ More than 1 Race ◯ Native Hawaiian or Other Pacific Island ◯ White ◯ Decline to Specify | Other

Preferred Language (if other than English)

Are you covered by Insurance? ☐ Yes ☐ No

Please list all medical coverage for which you are eligible below. Use back of page if needed).

Primary Insurance Name	Primary Insurance Policy #	Group #	Co-Pay Office

Primary Insurance Policy Holder	Policy Holder Date of Birth	Relation to Patient

Secondary Insurance Name	Secondary Insurance Policy #	Group #	Co-Pay Office

Secondary Insurance Policy Holder	Policy Holder Date of Birth	Relation to Patient

Please List other Medical Providers you are seeing currently:

Primary Care Physician Name	PCP Phone	Provider 2 Name	Provider 2 Phone
Provider 3 Name	Provider 3 Phone	Provider 4 Name	Provider 4 Phone

Preferred Pharmacies

Local Pharmacy Name and Address	Mail Order Pharmacy Name

Preferred Laboratory

◯ LabCorp ◯ Quest ◯ St. Peters | Other Lab

Were you referred to our office by: ☐ Emergency Room ☐ Primary Care ☐ Other

Is your visit today related to a No Fault, Worker's Compensation or Disability Injury? ☐ Yes ☐ No

If Yes | Employer

Assignment & Release:

I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to the physician unless my account has been paid in full. I acknowledge that I am financially responsible for appropriate deductibles, co-payments and non-covered items, including those charges which have been denied by my insurance carrier.

Signature of Patient or Responsible Party: ______________________ **Date:** ____________

Acknowledgement of Receipt of Privacy Policy

I have received a copy of the Notice of Privacy Practices of Albany ENT & Allergy Services and designate the following persons who may contact Albany ENT & Allergy regarding the care of:

Patient Name: ______________________________

Please Note:
Relationships below are provided for your convenience in completing this form.
Only fill in the names of the persons you authorize for this chart. Thank you.

Relationship	Name	Phone	Full Access	Billing Only	Medical Only
Mother					
Father					
Spouse					
Partner					
Guardian					
Son					
Daughter					
Brother					
Sister					
Grandparent					
Aunt / Uncle					

I understand that Albany ENT & Allergy Services will contact me at the phone number(s) and address provided today to:

- Leave messages to confirm appointments or to request that I call the practice.
- Mail routine correspondence such as billing statements.
- Mail test results.
- Share billing information with the person holding the insurance to secure payment.

If I choose to opt out of any of the above services, I will send my request to the office in writing.

I also agree to notify the practice in writing of any changes to this information.

Date _____ /_____ /_____ Signature ______________________________

Relationship to patient:
❑ Self ❑ Parent ❑ Spouse ❑ Guardian ❑ Other ____________

Modifications to this form should be sent in writing to:
Albany ENT & Allergy Services • 123 Everett Road • Albany, NY 12205

Albany ENT & Allergy Services

Financial Information

We are committed to providing you the best possible care and are pleased to discuss our financial policies with you at any time.

Insurance Cards

We ask that you have your insurance cards available at the time of your visit. The information on your card is needed to verify the insurance is active as well as details about your out of pocket expenses. If we are unable to verify this, you will be asked to sign a waiver agreeing that you will be financially responsible.

Out of Network Plans

We submit claims to most insurances though we recommend that you contact your insurance company to verify we are a participating provider and that there are no geographic limitations, for example coverage in NYC only. If there is a geographic limitation we may be considered a participating provider but out of network. If this is the case the amount the insurance will assign as your out of pocket amount will be significantly higher. In addition, Blue Cross plans that may be from out of state, i.e. Texas, etc. follow the NYS guidelines when care is provided in New York and your benefits in New York may be different so you may need to contact a local Blue Cross office. Our billing department can help to clarify this for you.

Referrals

Some insurances require that you have a referral submitted by your primary care physician before you can be seen in our office. This is your responsibility. If your plan requires this please contact your primary care physician. It must be available on the date of your appointment or you will be asked to sign a financial waiver agreeing to be responsible for all costs associated with your visit.

Procedures – Possible Additional Copays and Deductible Payments

Some times in order to fully evaluate you and set up an appropriate treatment plan your medical provider (physician or physician's assistant) may need to perform certain in – office procedures. The most common procedures performed during an evaluation in our office are removal of ear wax, nasal endoscopy, nasopharyngoscopy, flexible laryngoscopy and videostroboscopy. These procedures represent an additional charge and subsequently may have additional copays or deductible payments depending on your insurance plan. Although these are diagnostic tools designed to help guide your treatment, you may see them listed as surgical on your explanation of benefits.

Allergy Testing and Treatment

If you are considering allergy testing as well as allergy shots, it is important that you understand the financial obligation as it relates to your insurance plan. The Allergy Department will review this with you in detail including any out of pocket expenses prior to making your vials. However, after your consent is given to make these vials, you are financially responsible for them. Please consider this carefully. Allergy serum is a prescription customized to you and cannot be used for any other patients so you are responsible for the payment.

Patient Responsibility: Copays, Co-Insurance and Deductible

By submitting our claims to your insurance, we agree to abide with their determination of the payment amounts they assign. We must bill you as indicated on your Explanation of Benefits and we are not allowed to apply any discounts to the amounts listed as your responsibility. Below are some of the amounts that may be assigned to you depending on your plan.

Deductible

A deductible is the amount you pay for health care services before your health insurance begins to pay. The allowed amount for services in our office will be billed to you.

Coinsurance

Coinsurance is your share of the costs of a health care service. This is often a percentage of the amount allowed for services. When you go to the doctor, instead of paying all costs, you and your plan share the cost. For example, your plan pays 70 percent. The 30 percent you pay is your coinsurance. This portion will be billed to you.

Copay

A copay is a fixed amount you pay for a health care service. This must be paid on the date of your appointment. The amount can vary by the type of service and depending on the testing or procedures performed you may have more than one copay for an appointment. Your insurance may charge different copays for some tests depending on where these are done so it's a good idea with check with your plan.

If for any reason your insurance claim is denied you are responsible for the amount due on your account.

Parents of Minor Patients
The parent who consents to the treatment of a minor child will be held responsible for all payments. We cannot bill other persons based on custody documents.

Self Pay Policy
Self payments are due on the day of visit. Payment or the first installment on a payment plan are due on the day of the visit.

Payment Plans
Payment plans are available as recurring credit card or debit card transactions. We accept Cash, Check, Visa, Master Card, American Express and Discover as well as personal checks with proper identification.

Past Due Accounts
You are responsible for the timely payment of your account. Should you fall behind in payment for your allergy, speech or other treatments in our office you will be required to authorize a payment plan of a monthly charge until this is brought up to date in order to continue allergy treatment.

Patients who have not made an effort to make payment arrangements and have not expressed an interest in meeting their financial obligations may be turned over to a collection agency. Patients who have allowed their account to reach this state will be expected to make this payment or make arrangements for a payment plan before the scheduling of any future appointments.

Returned Checks
There will be a $40 charge for a check returned by the bank. Checks will not be presented to the bank twice.

Notice to Patients of Financial Interest
Although CT imaging and audiology tests are provided as part of our practice for your convenience, we also want to make you aware that upon request we will schedule this testing elsewhere, if you prefer another site for testing or if there are insurance requirements for this.

Policies for Late or No-Show Patient Appointments

Cancellation/No Show Policy for Provider Appointment
We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. A "no show" is someone who misses an appointment without canceling it within a 24-hour working day in advance. No-shows inconvenience those individuals who need access to medical care in a timely manner. A **no-show fee of $25.00 will be charged to those patients who do not cancel or reschedule their appointment in advance**.

Late Arrival for Provider Appointment
We understand that delays can happen, however, we must try to keep the other patients and doctors on time. If you are running late, please notify the office. If a patient is **20 minutes past their scheduled time, we may have to reschedule your appointment**.

Scheduled Procedures
We understand that emergencies or obligations arise that may impact your ability to proceed with an elective in-office procedure. However, these procedures often require a significant amount of reserved time and therefore late cancellations or “no shows” significantly limit the ability to provide care for other patients. If you need to reschedule or cancel your in-office procedure, we require that you call one working week in advance to do so. A **cancellation fee of $100.00 will be charged to those patients who do not cancel their procedure one week in advance**.

How to Reschedule or Cancel Your Appointment
If it is necessary to reschedule or cancel your scheduled appointment, we require that you call **one working day in advance** (or **one week in advance for in-office procedures**). Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care. To cancel an appointment, please call our office Monday through Friday, 8:30 am through 4:30 pm at **(518) 701-2085 or email us at call@albanyentandallergy.com**

Consents

Authorization to Release Information
I hereby authorize Albany ENT & Allergy Services to release any medical information pertaining to the examination, treatment, history prescription of medications and medical expenses of myself to any physician, hospital, clinic, insurance company and all other agencies deemed necessary in order to process insurance claims. This authorization also includes the release of any pertinent medical information to any specialist or other medical facility, the physician may refer the patient to for medical treatment or evaluation.

Assignment of Benefits
I authorize payment of medical benefits to Albany ENT & Allergy Services for services rendered. I understand that I am financially responsible for any co pays, co- insurance or deductibles required by insurance company. I understand that it is my responsibility to verify with my insurance company that medical and testing services provided by Albany ENT & Allergy Services will be covered by my plan. I will notify you of any changes in the above information. I also understand that I am responsible for charges that are not covered by my insurance company.

General Consent for Care and Treatment
I hereby authorize the health care providers of Albany ENT & Allergy Services, to perform reasonable and necessary medical examination testing and treatment necessary for the diagnosis of the condition(s) which brought me to seek care at this practice. I understand that if additional invasive or interventional procedures are recommended for the treatment of these conditions, I will be asked to read and sign additional consent forms prior to these procedures.

Notice of Privacy
I have received a copy of the Albany ENT & Allergy Associates notice of privacy practice.

Medication History
I authorize Albany ENT & Allergy Services to access my medications electronically directly from my pharmacy.

I hereby agree that you may contact me for whatever reason concerning my account on any and all of the phone numbers I have provided to you including but not limited to home phone, work phone, cell hone or any other phone number.

____ Date of Birth: ___________________________________
Patient's Name

____ Date: ___________________________________
Responsible Party Signature

____ Relationship: ___________________________________
Print Responsible Party Name

Thank you for taking the time to review our financial policies. The Billing Department of Albany ENT & Allergy Services is available to assist you as needed. Please contact us at 518 701 2086 for assistance.

We are also happy to provide you with billing codes and other information you may need to call your insurance plan to determine your coverage and establish your out of pocket expenses for services to be provided at our office.

Hixny Electronic Data Access Consent Form
Albany ENT & Allergy Services, PC

In this Consent Form, you can choose whether to allow Albany ENT & Allergy Services, PC to obtain access to your medical records through a computer network operated by the Healthcare Information Xchange of New York (Hixny), doing business as Hixny, which is part of a statewide computer network. This can help collect the medical records you have in different places where you get health care, and make them available electronically to our office.

You may use this Consent Form to decide whether or not to allow Albany ENT & Allergy Services, PC to see and obtain access to your electronic health records in this way. You can give consent or deny consent, and this form may be filled out now or at a later date. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent may not be the basis for denial of health services.**

If you check the **"I GIVE CONSENT"** box below, you are saying "Yes, Albany ENT & Allergy Services, PC's staff involved in my care may see and get access to all of my medical records through Hixny."

If you check the **"I DENY CONSENT"** box below, you are saying "No, Albany ENT & Allergy Services, PC may not be given access to my medical records through Hixny for any purpose."

Hixny is a not-for-profit organization. It shares information about people's health electronically and securely to improve the quality of health care services. This kind of sharing is called ehealth or health information technology (health IT).

Please carefully read the information on the back of this form before making your decision. Your Consent Choices. You can fill out this form now or in the future.
You have two choices.

- ☐ **I GIVE CONSENT for Albany ENT & Allergy Services, PC to access ALL of** my electronic health information through Hixny in connection with providing me any health care services, including emergency care.

- ☐ **I DENY CONSENT for Albany ENT & Allergy Services, PC to access** my electronic health information through Hixny for any purpose, *even in a medical emergency*.

NOTE: UNLESS YOU CHECK THIS BOX, New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through Hixny.

______________________________ ____________ ____________
Print Name of Patient | Date of Birth | Date

______________________________ ______________________________
Signature of Patient or Patient's Legal Representative | Print Name of Legal Representative (if applicable)

____
Relationship of Legal Representative to Patient (if applicable)

Details about patient information in Hixny and the consent process:

How Your Information will be used

Your electronic health information will be used by Albany ENT & Allergy Services, PC only to:

- Provide you with medical treatment and related services
- Check whether you have health insurance and what it covers
- Evaluate and improve the quality of medical care provided to all patients

NOTE: The choice you make in this Consent Form does NOT allow health insurers to have access to your information for the purpose of deciding whether to give you health insurance or pay your bills. You can make that choice in a separate Consent Form that health insurers must use.

What Types of Information about You Are Included

If you give consent, Albany ENT & Allergy Services, PC may access ALL of your electronic health information available through Hixny. This includes information created before and after the date of this Consent Form. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may relate to sensitive health conditions, including but not limited to:

- Alcohol or drug use problems
- Birth control and abortion (family planning)
- Genetic (inherited) diseases or tests
- HIV/AIDS
- Mental health conditions
- Sexually transmitted diseases

Where Health Information about You Comes From

Information about you comes from places that have provided you with medical care or health insurance ("Information Sources"). These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other ehealth organizations that exchange health information electronically. A complete list of current Information Sources is available from Albany ENT & Allergy Services. You can obtain an updated list of Information Sources at any time by checking the Hixny website: www.hixny.org.

Who May Access Information about You, If You Give Consent

Only these people may access information about you: doctors and other health care providers who serve on Albany ENT & Allergy Services, PC's medical staff who are involved in your medical care; health care providers who are covering or on call for Albany ENT & Allergy Services, PC's doctors; and staff members who carry out activities permitted by this Consent Form as described above in paragraph one.

Penalties for Improper Access to or Use of Your Information

There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call Albany ENT & Allergy Services, PC at: 518-701-2000; or call Hixny at (518) 640-0021; or call the NYS Department of Health at (877) 690-2211.

Re-disclosure of Information

Any electronic health information about you may be re-disclosed by Albany ENT & Allergy Services, PC to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. Some state and federal laws provide special protections for some kinds of sensitive health information, including HIV/AIDS and drug and alcohol treatment. Their special requirements must be followed whenever people receive these kinds of sensitive health information. Hixny and persons who access this information through the Hixny must comply with these requirements.

Effective Period

This Consent Form will remain in effect until the day you withdraw your consent or until such time Hixny ceases operation.

Withdrawing Your Consent

You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to Albany ENT & Allergy Services, PC. You can also change your consent choices by signing a new Consent Form at any time. You can get these forms from any Hixny provider, from the Hixny website at www.hixny.org, or by calling (518) 640-0021.

NOTE: Organizations that access your health information through Hixny while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.

Copy of Form

You are entitled to get a copy of this Consent Form after you sign it.

ENT & Allergy Care for Adults & Children

400 Patroon Creek Boulevard - Suite 205
Albany, New York 12206
518.701.2000

Maggie West-Bump PA-C
Robyn Smith PA-C
Michael Rizzuto PA-C
Andrew Larsen PA-C
Donna Silvernail PA-C
Susan Hare MS CCC-SLP
Deanna Ross AuD
Marcia Perretta AuD
Dana Wilhite AuD
Janelle Westbrook AuD
Tricia Doyle AuD

Pediatric ENT • Nasal & Sinus Disorders Center • Allergy Testing & Treatment • Facial Plastic Surgery • Snoring & Sleep Disorders
Voice, Speech & Swallowing • Hearing Loss, Tinnitus & Balance • Cochlear Implants • Head & Neck Surgery • Skull Base Surgery
Thyroid & Parathyroid Surgery • CT Scan Imaging Services

Nasal Endoscopy and Laryngoscopy

Please be aware that in order to provide you with a comprehensive ENT exam for your medical condition, certain in-office procedures (nasal endoscopy, laryngoscopy) may be necessary for diagnosis and treatment that are not included in the specialty head and neck exam office visit. These are performed, when necessary, in the best interest of patient care, and are billed separately and may be subject to copay, coinsurance or deductibles applied by your insurance plan. A comprehensive ENT exam may include:

Nasal Endoscopy: This procedure uses the flexible or rigid scope attached to a light source to view areas of the nasal cavities that cannot be viewed by speculum.

Flexible Fiberoptic Laryngoscopy: This procedure involves passing a long, thin flexible scope through the nasal cavity into the throat. This enables the physician to see areas of the throat unable to be visualized by mirror.

Flexible and Rigid Endoscopes

If you have questions regarding the billing of these procedures, please contact our Billing Department at (518) 701 2086 or ask to speak with someone at the time of your visit.

I acknowledge that in-office procedures are separate from the exam and I understand that I am responsible for any balance that my Insurance Company applies to the deductible, copay or coinsurance.

☐ I Accept ☐ I Decline Signature: ______________________________