ENT

ear nose & throat center pc

Welcome to our Office

For_____ **Appt**_____

www.entcentergr.com

____ 655 Kenmoor Ave. SE
Grand Rapids, MI 49546
(616) 575-1212

_____ 2373 64th Street, SW Suite 2300
Byron Center, MI 49315
(616) 531-4464

Robert Daniels, M.D., F.A.C.S **Darryl Elzinga, M.D.** **John Kosta, M.D.**
Mark Winkle, M.D. **Amy Rogghe, PA-C**

We appreciate your selection of this office to serve your medical needs, and we will do the best we can to provide quality care. Please take a moment to read the following about our office and your upcoming appointment.

Your Appointment: If you have not already filled out your health history on our Patient Portal, please take a moment to fill out the enclosed **Registration** form and the **Medical History** form as completely as possible. Bring these forms with you, along with your **Health Insurance Cards and a picture ID, THESE FORMS WILL NEED TO BE COMPLETED PRIOR TO BEING SEEN BY THE PHYSICIAN. IF THEY ARE NOT COMPLETED AT THE TIME OF YOUR APPOINTMENT, IT COULD DELAY YOUR VISIT.** Also, if you have had any test performed **related** to your medical problem, please bring them with you. Please do not rely on your physician's office or the hospital to do so. Examples would be hearing tests, sleep studies, or sinus x-rays (written reports must be included). If you have had a CT scan or MRI done, it is important that you get the **actual films**, or a **CD** of your films, from the facility where it was performed and bring those to your appointment.

24 hour notice must be provided in the event you cannot keep an appointment. Should you not provide this notice, a cancellation fee of $25 may then be added to your account.

Both of our offices are barrier free, and a wheelchair is available. We prefer at least one parent to accompany a patient under the age of 18. Because of the nature of our treatment, especially when a procedure or hearing test needs to be performed, please plan on being here an hour or more. Occasionally emergencies delay us, but a sincere attempt will be made to see you in a timely fashion. .

Office Hours: Our office's are open from 8:00am to 4:45pm Monday through Friday, except during the lunch hour. Our telephones are answered from 8:15am to 12:00 pm and 1:00pm to 4:00pm Monday through Friday. If you have a question about your bill or insurance coverage, you can reach the **Insurance Department** directly at **(616) 575-1204.** Questions about our hearing aid services can be directed to **(616) 575-1213.**

Surgery: We perform surgery at the Spectrum Health facilities, Mercy Health Care facilities and Grand Valley Surgical Center. Our staff makes those arrangements and will provide you with necessary information. We encourage you to discuss all aspects of surgery in advance, including the surgical fee, so we both know what to expect. A specified period of office visits afterwards is usually included in the fee excluding tests, procedures, or services due to unanticipated changes in your medical condition.

Fees and Insurance: You will find that the fees charged by us are comparable to those in this area. They are set to help cover all the expenses of running a quality health care office. Please be prepared to pay on your account when you are here. **Visa, Mastercard, and Discover** credit/debit cards can be used. **If you do not have insurance, the fees for the visit will be expected at the time of service.** Health insurance is complicated today! We will do our best to be clear about what plans we do and do not have contracts with, but please understand that the information we are given is not always accurate.

We do participate with Medicare, Priority Health, Blue Care Network, all BCBS including MESSA, United Health Care, Cigna, Aetna, Grand Valley Health Plan, some Medicaid plans, Tricare/Champus, First Health, Preferred Choices, Cofinity, and the MMPC network. If your plan requires an authorization, it is your responsibility to obtain the authorization in advance by your primary care physician. Please have your PCP fax a written referral to (616)575-1219. You may check our website for the most up to date information on which insurance companies we participate with. **By law, we must collect insurance co-pays at the time of your visit. Please be prepared to pay to co-pay at each visit. If you are unable to pay your co-payment at the time of service, we will be happy to reschedule your appointment.**

Hearing Resources, our audiology department, does participate with several insurance providers for hearing aid coverage. Please contact **(616) 575-1213** if you have questions regarding that.

As a courtesy to you, we will bill your insurance for you. By the law, the insurance company is required to pay or reject the claim within 30 days. Any secondary insurance will be billed once we receive payment from your primary insurance. Your insurance will be billed as many times as necessary in a 60 day time frame. If we have not heard from your insurance within that time, the balance becomes your responsibility.

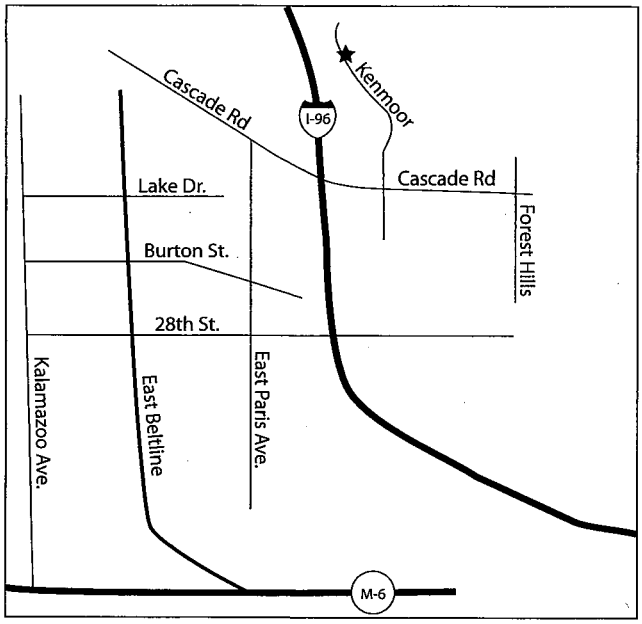
Insurance we DO NOT participate with: We will be happy to bill your insurance for you. You will be responsible for any balance left after your insurance pays us. If your insurance is not one we participate with, you will be responsible for your bill at the time of service, and it may be collected before you are seen.

Blue Cross Blue Shield: We will bill BCBS for you, including your initial consult. Please BE AWARE that under many BCBSM plans, consults are NOT a covered benefit. Please call BCBSM if you have any questions about what is covered under your plan. You are responsible for any balance not paid by BCBSM.

Self-Pay Patients: Payment is expected at the time of service unless financial arrangements have been made prior to you visit.

Any Questions? Please do not hesitate to ask! The best medical care is based on understanding and trust.

KENMOOR OFFICE
(Take Cascade Rd. East, exit 40, 1st light past overpass)



SOUTHWEST OFFICE
(M-6 and Byron Center Rd. area)

Welcome to Our Practice

ENT Center

Patient Legal Name: _____ Social Security #: _____-_____-_____

Marital Status: Single Married Divorced Widow / Widower

Date of Birth: _____/_____/_____ Age_____ Sex: (Please Circle One) Male Female

Race: _____ Ethnicity: _____ Primary Language Spoken: _____

Parent Name: (If patient is a minor) _____

Legal Guardian of Patient: (Please specify relationship) _____

Residence Address: _____ City: _____ State: ____ Zip: _____

Mailing Address: _____ City: _____ State: ____ Zip: _____

** How did you hear about us?: _____

CONTACT NUMBERS

* Please check the box beside the number(s) that are best to reach you Monday through Friday from 8am to 5pm.

☐ Home Telephone: (_____)_____-_____ Employer's Name:_____

☐ Work Telephone: (_____)_____-_____ Occupation: _____

☐ Mobile Telephone:(_____)_____-_____ Referring Physician: _____

E-Mail Address: _____ Primary Care Physician: _____

Individual to contact in case of an emergency: Physician Telephone: (_____)_____-_____

Name: _____DOB:_____ **Pharmacy**: _____

Relationship to Patient: _____ Pharmacy Address: _____

Contact Telephone #1: (_____)_____-_____ City: _____ State: ____ Zip: _____

Contact Telephone #2: (_____)_____-_____ Pharmacy Telephone: (_____)_____-_____

BILLING INFORMATION

Person responsible for paying bill: (Please circle one) Patient Parent Spouse Other_____

Name _____DOB:_____ Mobile Telephone: (_____)_____-_____

Home Telephone:(_____)_____-_____ Work Telephone: (_____)_____-_____

Residence Address: _____ City: _____ State: ____ Zip: _____

Mailing Address: _____ City: _____ State: ____ Zip: _____

INSURANCE INFORMATION (Please present your insurance cards to the receptionist upon check-in)

Primary Insurance

Insurance Company Name: _____

Name of Policyholder (subscriber): _____

Date of Birth of Policyholder: _____/_____/_____

Social Security #: _____-_____-_____

Patient's relationship to insured: Self / Spouse / Child / Other

Secondary Insurance

Insurance Company Name: _____

Name of Policyholder (subscriber): _____

Date of Birth of Policyholder: _____/_____/_____

Social Security #: _____-_____-_____

Patient's relationship to insured: Self / Spouse / Child / Other

I AGREE THAT THE INFORMATION CONTAINED ON THIS FORM IS UP TO DATE AND ACCURATE, TO THE BEST OF MY KNOWLEDGE.

/ /

Signature of Patient or Legal Guardian **Date: Month / Day / Year**

_____Robert Daniels, MD,FACS _____Darryl Elzinga, MD _____John Kosta, MD _____ Mark Winkle, MD _____ Amy Rogghe,PA-C

Date_____Referring Physician_____Height_____ Weight_____

Name_____Date of birth_____Age_____

REASON FOR TODAY"S VISIT:

_____

_____

PAST MEDICAL HISTORY

Do you have any of the following conditions?

High Blood Pressure	yes	no	COPD/Emphysema	yes	no	Thyroid Problems	yes	no
Heart Disease	yes	no	Asthma	yes	no	Stomach Problems	yes	no
Heart Attack	yes	no	Liver Problems	yes	no	Neurologic Problems	yes	no
Diabetes	yes	no	Kidney Problems	yes	no	Cancer type_____		

Other chronic illnesses or past illness/injuries?_____

_____

CURRENT MEDICATIONS: (please include prescription and over the counter medications and amount of each):

_____

_____

_____

DRUG ALLERGIES (please list drug allergy and reaction):

_____

PAST SURGICAL HISTORY-Please list all past surgeries and year:

_____

_____

ANESTHESIA COMPLICATIONS? YES NO

FAMILY HISTORY Please complete the following regarding your immediate family.

HAS ANY FAMILY MEMBER HAD ANY PROBLEMS WITH THE FOLLOWING:

	Family member (list who)		Family member (list who)
Ear disease	_____	Thyroid disease	_____
Hearing loss	_____	Allergies	_____
Cancer	_____	Musculoskeletal disease	_____
High Blood Pressure	_____	Bleeding	_____
Heart Disease	_____	Hematologic/lymphatic	_____
Stroke	_____	Neurological disease	_____
Anesthesia problems	_____	Diabetes	_____
Other:	_____		

OVER->

PERSONAL HISTORY:

Are you presently working? _____ Occupation:_____

Marital Status ☐Single ☐Married ☐Divorced/Separated ☐Widowed

Do you drink alcohol? _____ Amount consumed per WEEK: _____ Do you drink caffeine? _____Amount consumed per DAY: _____

Have you ever used tobacco? ☐Yes ☐No, not currently ☐Never
started (year): _____ quit (year): _____
how many/how much per day? _____

Do you currently or have you ever used illicit drugs (marijuana, cocaine, meth)? _____

REVIEW OF SYSTEMS Please circle yes or no if you are experiencing any of these problems:

CONSTITUTIONAL			CARDIOVASCULAR			ENDROCINE			RESPIRATORY		
Fever/Chills	yes	no	Chest pain	yes	no	Increased Appetite	yes	no	Wheeze	yes	no
Weight loss/Gain	yes	no	Irregular Pulse	yes	no	Decreased Appetite	yes	no	Cough	yes	no
Excessive Fatigue	yes	no	Tightness in chest	yes	no	Excessive thirst	yes	no	Coughing Blood	yes	no
Night sweats	yes	no	Swelling in Feet/Hands	yes	no	Hormone Problems	yes	no	Shortness of Breath	yes	no
EARS			NOSE			THROAT			MUSCULOSKELETAL		
Drainage from Ears	yes	no	Nosebleeds	yes	no	Sore Throats	yes	no	Joint Pain or Swelling	yes	no
Hearing loss	yes	no	Nasal Congestion	yes	no	Hoarseness	yes	no	Arm or leg weakness	yes	no
Ear Pain	yes	no	Nasal Drainage	yes	no	Difficulty swallowing	yes	no	Back Pain	yes	no
Ringing in Ears	yes	no	Sinus Headaches	yes	no	Mouth Sores	yes	no	Muscle Aches	yes	no
GASTROINTESTINAL			EYES			NEUROLOGICAL			HEMATOLOGIC/LYMPHATIC		
Indigestion	yes	no	Glaucoma	yes	no	Seizures	yes	no	Bleeding tendencies	yes	no
Nausea/Vomiting	yes	no	Cataracts	yes	no	Memory Problems	yes	no	Persistent swollen glands	yes	no
Diarrhea	yes	no	Double/Blurred Vision	yes	no	Speech Problems	yes	no	Night Sweats	yes	no
Constipation	yes	no	Vision Change	yes	no	Headache	yes	no	Easy Bruising	yes	no
Abdominal Pain	yes	no	Watery/Itchy Eyes	yes	no	Facial weakness	yes	no	Anemia	yes	no
PSYCHIATRIC			GENITOURINARY			INTEGUMENTARY			ALLERGIC/IMMUNOLOGIC		
Anxiety	yes	no	Difficulty Urinating	yes	no	Skin Rash	yes	no	Food Allergies	yes	no
Depression	yes	no	Painful Urination	yes	no	Sores	yes	no	Nasal Allergies	yes	no
Insomnia	yes	no	Blood in Urine	yes	no	Skin cancer	yes	no	Autoimmune Disease	yes	no

Other: _____

The information provided in this form is accurate to the best of my knowledge.

_____

Patient Signature Date

_____

Parent signature if patient is minor Date

Patient HIPAA Acknowledgement and Consent Form

Patient Information:

First Name: _____ **Last Name:** _____ **DOB:** _____

Notice of Privacy Practices

_____ (Patient Initials) I acknowledge ENT Center, PLLC has provided, for my review, a copy of the Notice of Privacy for Protected Health Information. Copies of the HIPPA Policy are located in the lobby, as well as provided on the first visit. Additional copies can be obtained at any time by requesting them at the check-in or check-out desks. This notice describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

Release of Information

_____ (Patient Initials) I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior admission(s) may be made available to subsequent admitting facilities to coordinate patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf, in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors. In order for these individuals and entities to share my health information with one another to accomplish goals that may include, but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious disease including, but not limited to, blood-borne diseases, such as HIV and AIDS.

Pharmacy Benefit Management (PBM) Consent

Electronic Prescribing (E-Prescribing or E-Rx) is defined as a physician's ability to electronically send an accurate, error-free, and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. Your Medication History Transactions provide the physician with the information about the medications that the patient is already taking prescribed by any provider, to minimize the number of adverse drug events.

_____ (Patient Initials) I hereby permit practice and the physicians or other health professionals involved in my care to request and use my prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Please sign here if you wish to DENY this PBM consent: _____

Disclosures to Family Members and/or Friends

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?

_____ (Patient Initials) I hereby permit practice and the physicians or other health professionals involved in my care to disclose my Protected Health Information for the purposes of communicating results, findings and care decisions to the family members and others listed below:

Name: _____ Relationship: _____ Contact Number: _____

Name: _____ Relationship: _____ Contact Number: _____

Name: _____ Relationship: _____ Contact Number: _____

Patient may revoke or modify this specific authorization and that revocation or modification must be in writing.

Consent for Communications

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

_____ (Patient Initials) consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request will apply to all future appointment reminders/feedback/billing/health information unless I request a change in writing (see revocation section below)

( )_____-_____ This is the cell phone number that I authorize to receive the text message communications listed above.

_____ This is the email address that I authorize to receive the messaged communications listed above.

The practice does not charge for this service, but standard text messaging rates apply as provided in your wireless plan (contact your carrier for pricing plans and details)

Revocation
I hereby revoke my request for future communications via email and/or text.
_____ (Patient Initials) I hereby revoke my request to receive any future appointment reminders, feedback, billing and general health via text messages.
_____ (Patient Initials) I hereby revoke my request to receive any future appointment reminders, feedback, billing and general health via email
NOTE: This revocation only applies to communications from this Practice.

Patient Name: _____ Patient/Representative Signature: _____

Witness: _____ Date: _____ Time: _____
Please note that it may take up to 3 business days to process this request. Communications may occur during this time.

Patient Bill of Rights/Financial Responsibilities

_____ (Patient Initials) I acknowledge that ENT Center, PLLC, has provided, for my review, a copy of the Financial Agreement and the Patient Bill of Rights and Responsibilities. I understand that knowing what my insurance policy covers, or does not cover, is my responsibility. I further understand that I agree to pay for all services rendered by this office, as a result of the determined diagnosis and/or treatment plan.

Signature Acknowledgement

By my signature below, I acknowledge that I have initialed the sections above noting my agreement or disagreement with the policies described within.

Signature: _____ **Date:** _____

Relationship to Patient: _____

Name: (Please Print) _____