CAMINO
EAR, NOSE & THROAT CLINIC

Patient Information

Patient Name _____ Date _____

Address _____

City, State, Zip _____ Sex ☐ Male ☐ Female

Home Phone _____ Work Phone _____

Mobile Phone _____ Email _____

Communication Preference ☐ E-Mail ☐ Home Phone ☐ Mobile Phone

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed Date of Birth _____ Age _____

Social Security # _____ Occupation _____ Employer _____

Insurance Information

Primary Insurance Provider _____

Name of Subscriber _____ Subscriber DOB _____

Subscriber ID _____ Group ID _____

Subscriber Social Security # _____

Secondary Insurance Provider _____

Name of Subscriber _____ Subscriber DOB _____

Subscriber ID _____ Group ID _____

Subscriber Social Security # _____

Primary Care Physician

Primary Care Physician _____

Address _____

City, State, Zip _____ Phone _____

Referral Information

Referring Physician _____

Address _____

City, State, Zip _____ Authorization # (if needed) _____

Emergency Contact Information

Name and Relationship of Emergency Contact _____

Address _____

City, State, Zip _____ Telephone _____

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Decline to Specify

Race ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Race ☐ Declined

Religion ☐ Do Not Wish to Specify ☐ Wish to Specify _____

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Adult Patient Health History

Date _____ /_____ /_____

Patient Name _____ DOB _____ Age _____

Occupation _____

Pharmacy Name and Address _____

Medical History

Do you have or have you ever had any of the following conditions? Please check:

Autoimmune Disease:
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Thyroid disease

Cardiovascular:
- ☐ Atrial fibrillation
- ☐ Heart attack
- ☐ Heart murmur
- ☐ Heart valve disease
- ☐ High blood pressure

Gastrointestinal:
- ☐ Colitis/diverticulitis
- ☐ Gastroesophageal reflux (GERD)
- ☐ Ulcers

Genito-urinary:
- ☐ Gender re-assignment
- ☐ Kidney stones
- ☐ Urinary tract infections (UTIs)

Hematologic/Metabolic:
- ☐ Anemia
- ☐ Bleeding disorder
- ☐ Bruising

Lungs:
- ☐ Asthma
- ☐ Bronchitis/pneumonia
- ☐ Emphysema/COPD
- ☐ Tuberculosis

Musculoskeletal/Neurological:
- ☐ Arthritis
- ☐ Headache/migraine
- ☐ Seizures

Other:
- ☐ Dementia/Alzheimer's
- ☐ Glaucoma
- ☐ High cholesterol
- ☐ HIV
- ☐ Neuropathy
- ☐ On CPAP for sleep apnea
- ☐ Stroke

Other medical conditions you may have:

_____

_____

_____

Previous Surgery

Have you had any surgeries? (include childhood surgery such as tonsillectomy)

☐ No ☐ Yes (please list below)

Surgery	Date

6060 Hellyer Avenue, Suite 150
San Jose, CA 95138
(408) 227-6300

2577 Samaritan Drive, Suite 765
San Jose, CA 95124
(408) 358-6163

Medications

Are you taking any prescribed or over-the-counter medicines?

☐ No ☐ Yes (please list below)

Medication	Dosage	Reason for Taking

Are you allergic to any medications?

☐ No ☐ Yes (please list below)

Medication	Type of Reaction

Family History

Do you have a family history (immediate family only) of medical problems? ☐ No ☐ Yes

- ☐ Alzheimer's
- ☐ Bleeding problems
- ☐ Cancer
- ☐ Diabetes
- ☐ Hearing loss
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Stroke
- ☐ Other: _____

Social History

Do you drink alcohol? ☐ No ☐ Yes If Yes, _____ drinks per week

Do you smoke cigarettes? ☐ No ☐ Yes If Yes, how much: _____

If you have quit smoking, when did you quit and how long did you smoke? _____

Do you do any illicit drugs? ☐ No ☐ Yes If Yes, what drug and how often? _____

Do you drink caffeine? ☐ No ☐ Yes If Yes _____ drinks per day

Have you had or been exposed to HIV (AIDS)? ☐ No ☐ Yes

Are you pregnant? ☐ No ☐ Yes

Review of Systems

Please check only those symptoms you have developed:

Constitutional:

- ☐ Anxiety
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Headache
- ☐ Weight gain How much _____
- ☐ Weight loss How much _____

Ear, Nose, Throat:

- ☐ Ear drainage
- ☐ Ear pain
- ☐ Difficulty swallowing
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Post nasal drip
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Snoring
- ☐ TMJ

Eye:
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Vision-flashes

Gastrointestinal:
- ☐ Acid reflux
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Nausea
- ☐ Poor appetite
- ☐ Vomiting

Genito-urinary:
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control

Men Only:
- ☐ Breast lump
- ☐ Lump in testicles

Musculoskeletal:
- ☐ Joint pain
- ☐ Muscle pain
- ☐ Muscle weakness
- ☐ Neck stiffness
- ☐ Teeth grinding

Neurological:
- ☐ Balance problems/dizziness
- ☐ Fainting
- ☐ Fall asleep easily during the day
- ☐ Headaches
- ☐ Memory problems
- ☐ Seizure
- ☐ Tingling
- ☐ Tremors

Respiratory:
- ☐ Oxygen dependence
- ☐ Persistent cough
- ☐ Productive cough
- ☐ Shortness of breath
- ☐ Wheeze

Skin:
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Rash
- ☐ Scars
- ☐ Sores that won't heal

Women Only:
- ☐ Abnormal pap smear
- ☐ Breast lump
- ☐ Hot flashes

CAMINO
EAR, NOSE & THROAT CLINIC

HIPAA / NOTICE OF PRIVACY PRACTICES & CONSENT FORM

We are required by law to keep health information confidential. Authorization for the disclosure of health information to someone who is not legally required to keep it private may cause the information to no longer be protected by state and federal confidentiality laws. In accordance with state and federal patient privacy laws, including HIPPA (the Health Insurance Portability and Accountability Act of 1996), this Notice describes how your health information may be used or disclosed and how you, the patient, can get this information. Please review this Notice carefully.

PERMITTED USES & DISCLOSURES: The law permits us to use or disclose your health information to the following:

- Another specialist or physician who is involved in your care.
- Your insurance company, for the purpose of obtaining payment for our services.
- Our staff, for the purpose of entering your information into our computerized system.
- Other entities during the course of your treatment, in order to obtain authorizations, referral visits, scheduling of tests, etc. Much of this information is sent via fax, which is a permitted use allowed by law. We have on file with these sources verification for the confidentiality of the fax used and its limited access by authorized personnel.
- If this practice is sold, your health information will become the property of the new owner.
- We may release some or all of your health information when required by law. Except as described above, this practice will not use or disclose your health information without your prior written authorization.

Federal and state law allows us to use and disclose our patients' protected health information in order to provide health care services to them, to bill and collect payments for those services and in connection with our health care operations. We also use a shared Electronic Medical Record that allows both our physicians and staff access to our patients' health information. The purpose for this access is to expedite the referral of patients within the Camino Ear, Nose & Throat Clinic, other providers, and to assist in providing and managing their care in a coordinated way. Information in the Electronic Medical Record can be released outside the Camino Ear, Nose & Throat Clinic only with the patient's express authorization or as otherwise specifically permitted or required by law.

PATIENT RIGHTS: The law also establishes patient rights and our responsibility to inform you of those rights. These include:

- You have the right to request in writing any uses or disclosures we make with your health information beyond the normal uses referenced above.
- You have the right to limit the use or restrict the use disclosure of your health information. Our office will follow any restrictions notated by you on page 2 of this Form.
- You have the right to request in writing to inspect and receive a copy of your health information.* Our office may charge a reasonable fee to cover copying and mailing of these records to you. Some releases of your health information may require the completion and submission of a separate request or form from this one, as our Privacy Officer may determine.

6060 Hellyer Avenue, Suite 150
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(408) 227-6300

2577 Samaritan Drive, Suite 765
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- You have the right to request an alternate means or location to receive communications regarding your health information.* Otherwise, such communications will be mailed to the home address in your medical or billing record or sent to the alternative address or by the alternative means of communication(s) you designate below (e.g., via telephone text or email).
- You have the right to request in writing an amendment or change to your health information. Our office may agree or disagree with your written request, but we will be happy to include your statement as part of your records. If an agreement to amend or change is acceptable, please be advised that previous documentation is considered a legal document and cannot be deleted or removed. Our office will simply notate the amendment and the reason for it and add it to your records.

  *Conditions and limitations may apply; obtain additional information from our Privacy Officer.

- We may use your information to contact you. For example, we may use the U.S. Mail, the telephone, a text message or email to remind you of an appointment or call you with information regarding your care. If you are not at home, this information may be left on your answering machine or voicemail, sent via text or email or left with the person who answered the phone. In an emergency, we may disclose your health information to a family member or another person designated responsible for your care.
- MINORS: We take patient privacy laws very seriously. The State of California limits what type of health information we can share with the parents or legal guardians of minor teenage children between the ages of 12 and 17. Accordingly, we will maintain an exclusive phone number and email address for minors in this age range, as they may designate.

IF PATIENT IS A MINOR, PLEASE STATE AGE: _____ **AND DATE OF BIRTH:** _____

- **WHOM I DESIGNATE: Please designate whom our offices CAN disclose your health information to, including, but not limited to, correspondence, test results, prescriptions, medical records or billing information, who are 18 years or older, by checking the boxes below and signing below:**

This authorization to Release Health Information is voluntary.

☐ **OK to Spouse: Please list name, alternative address, phone number and email address of Spouse, as applicable:** _____

☐ **OK to Family Members: Please list name(s), alternative address, phone numbers and email addresses of Family Member(s), as applicable:** _____

_____

☐ **OK to Other (e.g., Attorney, Accountant, Financial Advisor, Legal Guardian, Conservator, or other legally authorized agent or representative). Please list name(s), alternative address, phone numbers, and email addresses of authorized person(s) or entities:**

_____

_____

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HIPAA / NOTICE OF PRIVACY PRACTICES & CONSENT FORM

☐ **OK to leave health information on answering machine, voicemail, telephone text or email.**

☐ **DO NOT RELEASE AND SEND ANY INFORMATION to anyone other than myself (the Patient). Please send my information to my home address or the alternative address, phone number and email address I list here:**

Address: _____ **Phone:** _____

Email Address: _____

IF PATIENT IS A MINOR, PLEASE STATE AGE: _____ **AND DATE OF BIRTH:** _____

☐ **DO NOT RELEASE TO:** _____
[Please list names, as applicable.]

We reserve the right to change our privacy practices and the conditions of this notice at any time and without prior notice. In the event of changes, an updated notice will be posted, and our office will notify you of the changes in writing. You have the right to file a complaint with the Department of Health and Human Services, 200 Independent Avenue, S.W., Room 509F, Washington, DC 20201. Our office will not retaliate against you for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer at (925) 627-3424.

ACKNOWLEDGEMENT, AUTHORIZATION & CONSENT

This acknowledges that you have received and read a copy of our Privacy Practices Notice and Consent to the disclosure of your health information to the person(s) or entities you have designated above. This document will remain as part of your medical and billing record.

Signature: _____ Date: _____

Patient's Name: _____ Date of Birth: _____

If the person signing is not the patient, please provide your/their name and identify the relationship to the patient and in what capacity you/they are signing (e.g., parent, guardian, conservator):

Name: _____

Capacity and/or Relationship to Patient: _____

This authorization/consent may be revoked at any time prior to the release of the requested information. The revocation must be in writing, signed by the patient or their authorized representative and delivered to Camino Ear, Nose & Throat Clinic at their address referenced below.

Patient's authorized representative is entitled to receive a copy of this Authorization.

EXPIRATION OF AUTHORIZATION/CONSENT: Unless otherwise revoked, rescinded, revised, updated or changed by you in a writing signed by you, this Authorization & Consent shall not expire and will last indefinitely.

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Summary of Financial Policies for Camino Ear, Nose & Throat Clinic

Insurance and Insurance Payment

If you are unable to present an insurance card at the time of service, or if you are covered by an insurance company with which we are not contracted, we require that you pay for services at the time of service. If we are able to collect from your insurance company after you have fully paid, we will issue a refund.

Know Your Insurance Plan

All insurance plans, including Medicare, have different plans, each with different benefits. Because your health insurance is an agreement between you and your insurer, you should understand what services are covered under your specific plan. Your insurer can assist you with any questions you have relative to your own benefits. All co-payments, co-insurance and/or deductibles are your responsibility. Co-payments are due at the time of service. This is a requirement of your insurer.

HMO plans do require a referral from your plan and/or medical group. You should obtain an authorization before being seen at our office. It is your responsibility to verify that they properly authorize your care and treatment in advance.

Secondary insurance does not necessarily mean that your service will be covered at 100%. Depending on your plan's benefits, the secondary may pay a fraction of what the primary insurer paid. We will bill your secondary as a courtesy, but you are responsible for any balances after your insurers have processed your claims.

Specialists' offices bill very differently from general practitioners and pediatricians. We do not have a global office visit billing code that covers every service that may happen in our office. Specialists must separately document and code every procedure and exam they conduct. Each code may generate a separate charge. You may get a bill from our office if directed by your service carrier. The bill and/or explanation of benefits may classify these codes as "Surgery" but, in fact, is not surgery. It's a procedure that can be done in a surgical and office setting.

Credit Card on File

We require that all patients provide a credit card to keep on file before their first visit. This card will be used for new patients who do not show up to their visit or do not cancel prior to 24 business hours. If there is an outstanding bill for which you have received more than 2 statements and have not called with a question or have not mailed in an alternative form of payment, the outstanding balance will be charged in full to the card on file.

Missed Appointments

There is a fee of $100 for New Patients and $75 for Established Patients for appointments that are not canceled or rescheduled prior to 24 business hours, or if you arrive more than 15 minutes late to your appointment. Appointments must be canceled during business hours with the office directly and not the call service. Any cancellations made outside of business hours may be subject to the fee. Please do not rely on our automated appointment reminders system as your only reminder to keep your scheduled appointment. We cannot guarantee this service or that the phone number provided is accurate or functional for this purpose. We dislike having to do this, but we need the notice to allow other patients to schedule. We turn away other people needing care in order to hold a place for a patient. If there are extenuating circumstances, we are open to discussing them. You will have 45 business days to contact our office, after that, we will not discuss any no-show fees. We reserve the right to discharge patients from our office with three or more no-shows.

Surgery Cancellation

There is a fee of $500 for any individual who does not cancel or reschedule their surgery within 7 business days prior to their scheduled surgery. Again, we hate to charge this fee, but we need the notice to allow other patients to be able to be put on the surgery schedule. Significant time and effort goes into planning the surgery and coordinating the people and equipment that are needed. Like with our office visits, we understand that extenuating circumstances can arise. We are open to discussing those on a case-by-case basis.

Collections

Any balances that remain unpaid for more than 90 days from the final determination by your carrier as to the correct charges will be sent to collections. The company we use is Professional Credit.

Request for Medical Records

A signed release of records form is required at the time of your request. You will be charged a clerical fee of $25 for any request over 5 pages. The medical records will not be released to you until the fee is paid in full. These fees are set by the State of California (Health & Safety Code section 123110), not Camino ENT.

Medical Forms

There will be a $50 fee for our staff to fill out any medical forms. This includes, but is not limited to, disability and FMLA. This fee must be paid prior to the forms being processed. The turnaround time is 5–7 business days.

Good Faith Estimate

The federal "No Surprise Act" grants consumers the right to receive a "Good Faith Estimate" explaining how much their medical and mental health care will cost. Under the law, health care providers, including psychotherapists, must give clients who don't have insurance or who are not using insurance an estimate of the expected charges for treatment of services. You can ask all of your health care providers, including your therapist and other providers from whom you seek treatment, for a Good Faith Estimate before you schedule a service. If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill. Make sure to save a copy or picture of your Good Faith Estimate.

Assembly Bill (AB) 1278-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.

Acknowledgment of Financial Policies and Guarantee of Payment

By signing my name below, I acknowledge that I have read and understood the above financial policy. I hereby guarantee payment in full within ninety (90) days of all charges established by Camino Ear, Nose & Throat Clinic for service(s) rendered to me or my dependent unless other arrangements satisfactory to Camino Ear, Nose & Throat Clinic have been made. This includes any charges that a third-party payer may determine to exceed usual and customary limits. I authorize Medicare, Medicaid and all relevant commercial payers to Camino Ear, Nose & Throat Clinic, including but not limited to Margaret Carter, M.D., Michael T. Murray, M.D., Hussein Samji, M.D., Lionel Nelson, M.D., Katrina Chaung, M.D., Danielle Ourada, Au.D., Cynthia Atchoukeu, Au.D., and/or Shaun Frost, PA-C., on my behalf for any services furnished to me or my dependents. I certify that I have read this assignment of benefits, that the information given by me is correct and that I agree to all the provisions contained in it. The insurance information I have provided is current and correct. If I sign this form and the insurance card is found later to be outdated or invalid, I understand that I am responsible for paying for the services in full and will need to file with the insurance carrier myself. My insurance co-payment is due at the time of service, per my insurance company.

Print Name: _____ Signature: _____ Date: _____

BASS MEDICAL GROUP

Camino Ear, Nose & Throat Clinic
is a division of BASS Medical Group.

Updated August 2025