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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Pediatric Patient Health History

Patient Name _____ DOB _____ Age _____

School _____

Pharmacy Name and Address _____

Medical History/Birth History

Method of delivery? ☐ Normal Vaginal ☐ Cesarean Section

Were there any complications or infections during pregnancy? ☐ No ☐ Yes

If yes, please explain: _____

Was child born premature? ☐ No ☐ Yes If yes, list gestational age _____ weeks

Was child in the NICU? ☐ No ☐ Yes If yes, was child intubated? ☐ No ☐ Yes

Did child pass newborn hearing screening? ☐ No ☐ Yes ☐ Unsure

Was child breastfed? ☐ No ☐ Yes

Please indicate any therapy child is receiving: ☐ PT ☐ OT ☐ Speech ☐ Other _____

Are your child's immunizations up to date? ☐ No ☐ Yes

Have you refused or declined any immunizations? ☐ No ☐ Yes If yes, which one(s)? _____

Does your child have or ever had any of the following conditions? Please check:

☐ Behavior/developmental disorders:
_____

☐ Ear infections. If yes, how many in past 12 months:
_____

☐ Easy bruising/bleeding disorder:
_____

☐ Heart problems:
_____

☐ Stomach or intestinal problems:
_____

☐ Strep throat or tonsillitis. If yes, how many in past 12 months:
_____

☐ ADHD/ADD
☐ Asthma
☐ Bladder/urinary tract infections (UTIs)
☐ Bronchitis/pneumonia
☐ Cancer/leukemia
☐ CMV exposure
☐ Cystic fibrosis
☐ Diabetes
☐ Headache/migraine
☐ Jaundice
☐ Meningitis
☐ Seizures
☐ Thyroid disease
☐ Tuberculosis

Do you think your child hears normally? ☐ No ☐ Yes

Has anyone voiced concerns about your child's speech development? ☐ No ☐ Yes

Please list other medical conditions your child may have:

_____

_____

_____

Previous Surgery

Has your child had any surgeries?

☐ No ☐ Yes (please list below)

Surgery	Date

Medications

Is your child taking any prescribed or over-the-counter medicines?

☐ No ☐ Yes (please list below)

Medication	Dosage	Reason for Taking

Is your child allergic to any medications?

☐ No ☐ Yes (please list below)

Medication	Type of Reaction

Family History

Is there a family history (immediate family only) of medical problems? ☐ No ☐ Yes

- ☐ Hearing loss before age 50
- ☐ Bleeding problems
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Problems with anesthesia
- ☐ Stroke
- ☐ Other _____

Social History

Does your child attend daycare? ☐ No ☐ Yes

Are there pets in the house? ☐ No ☐ Yes If yes, number/types: _____

Is there smoke exposure? ☐ No ☐ Yes If yes, describe exposure: _____

Who does the child live with? (Include siblings): _____

School grade? _____ List any special schools or classes _____

Number of languages spoken at home: _____

Do the child's siblings have ear infections? ☐ No ☐ Yes

Does the child use a pacifier? ☐ No ☐ Yes Stopped using pacifier at age (if applicable): _____

Does the child have poor academic performance? ☐ No ☐ Yes

Review of Symptoms
Please check only those symptoms your child has developed:

Constitutional:

- ☐ Anxiety
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Headache
- ☐ Weight gain
- ☐ Weight loss

Ear, Nose, Throat:

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

Eye:

- ☐ Blurred vision
- ☐ Double vision

Gastrointestinal:

- ☐ Acid reflux
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Nausea
- ☐ Poor appetite
- ☐ Stomach pain
- ☐ Vomiting

Genito-urinary:

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control/wets bed

Musculoskeletal:

- ☐ Joint pain
- ☐ Muscle pain
- ☐ Muscle weakness
- ☐ Neck stiffness

Neurological:

- ☐ Balance problems/dizziness
- ☐ Fainting
- ☐ Memory problems
- ☐ Seizure
- ☐ Tremors

Respiratory:

- ☐ Hoarseness
- ☐ Mouth breathing
- ☐ Oxygen dependence
- ☐ Persistent cough
- ☐ Productive cough
- ☐ Shortness of breath
- ☐ Snoring or gasping at night
- ☐ Wheeze/asthma

Skin:

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

CAMINO
EAR, NOSE & THROAT CLINIC

Summary of Financial Policies

Will my insurance cover this visit?

In most cases, yes. Camino Ear, Nose & Throat Clinic accepts all PPO insurance and is in-network with several different HMOs as well. We do our best to help you know before you come in if your insurance will cover a visit with us. It is, however, ultimately your responsibility to know your plan, whether your insurance information is current (you will be asked) and to check with your carrier first to make sure we will be considered in-network for your visit. If you have an HMO, you are responsible for knowing whether an authorization has been issued for your visit. If we have reason to believe that your insurance will not cover something, we will have you sign an Advanced Beneficiary Notice beforehand, giving you notice. We do not accept Medi-Cal. If you have international medical insurance, we cannot submit those claims on your behalf. You will be treated as a "Cash Pay" patient and will be given the necessary documents so that you may file a claim with your carrier.

_____ Initial here if you do not have Medi-Cal, primary or secondary.

_____ Initial here if you have International Medical Insurance.

Why am I being asked for a credit card, and how will it be used?

We cannot see you if you do not have a credit card on file with our office. Our policy is to inform patients when they make the appointment. If you were not told, please let us know. Over the last several years, we have seen patient copays/coinsurance/deductibles go from approximately 10% of our income to 35%. We are sure you also have noticed that your bills from physicians' offices have increased as well. The costs of healthcare shared by carriers and patients are increasingly being allocated to patients (lower premium, higher deductible plans), and we are being instructed, per your carriers, to send the bill to you. When you are in our office, you will be asked verbally if you would like to use your credit card on file for your standard copay or for any unpaid balance. You will be given a receipt. If there is an outstanding bill for which you have received more than two statements and have not called with a question or have not mailed in an alternate form of payment, the outstanding balance will be charged in full.

What does it mean to be in a specialist's office?

Specialists' offices bill very differently from General Practitioners and Pediatricians. We do not have a global office visit code available to us to bill under that covers everything that happens in our office. Specialists must separately document and code every procedure and exam they conduct. Each code may generate a separate charge. So you may get a bill from our office if your carrier indicates that is what your plan requires. Our providers do not know your individual situation and nor do they know the wide variety of policies of various insurers regarding different charges, so please don't ask them in the exam room. Let them focus on you, and let our billing department help you understand and manage any charges that arise as a result of your visit.

How much will this visit cost me?

Short answer: we don't know beforehand (see the section above as to why). If you have insurance, you may have a copay, coinsurance and/or a deductible. Every patient and plan is different.

Do you accept non-insured ("Cash Pay") patients?

Yes. We offer non-insured patients rates that are comparable to the average reimbursement from an insurance company. We do not charge more than the average, and we may not, per our contracts with insurance companies, charge less. If the balance is large, a "Cash Pay" patient should discuss their payment options with our billing specialist, so a plan can be made and care is not delayed. We do not want patients to avoid seeing a provider out of concern over a charge. We cannot accept cash payment if you are enrolled in Medi-Cal (Medicaid).

How and when do I pay?

For our insured patients, we ask that you pay your copay at the time of your visit. For our non-insured patients, your charges will be determined at the end of your visit, and we ask that you pay the outstanding charges, unless an alternate arrangement is made. All charges may be settled using cash, checks, Visa, Mastercard, American Express or Discover. You will receive a statement from our office showing what remittance advice, if any, we received from your insurance company. All undisputed amounts owed should be paid within 30 days of you receiving your first statement. After two statements are sent, the credit card on file will be charged.

Do you offer payment plans?

Yes. We offer 0% interest payment plans. The most important thing is that you call and speak with our billing specialist to arrange a plan as soon as you are aware that you need some assistance in managing the payment. The credit card that is kept on file with our office will be used to collect the agreed-upon amounts at the agreed-upon dates.

Am I able to negotiate my balance with Camino Ear, Nose & Throat Clinic?

Not really. If you are an insured patient, your agreement with your insurance company dictates how your charges are to be shared between you and your insurance carrier. We send the charges to your carrier; they tell us how to allocate the charges. Our agreement with them is very clear—we must collect what is owed or we can be dropped as a provider. For non-insured patients, our insurance contracts still dictate that our minimum charges cannot be less than they reimburse. If you are under financial hardship, and even an interest-free payment plan will not suffice, there is a process by which you can document your hardship to the satisfaction of your insurance company (it involves pay stubs and bills) so that we will be allowed to reduce somewhat the amount you owe.

Do you send patients to collections?

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

Is there a fee for not showing up or showing up late for a scheduled appointment?

A "No-Show" is defined as a patient who fails to reschedule more than 24 hours before their scheduled visit. For Monday appointments, this means by the prior Thursday by 5 p.m. (one business day). If you call our office more than 24 hours before your visit to let us know you cannot make it, there is no charge. The fee for the first "No-Show" is $50. The second is $75. If there is a third no-show, the provider with whom you're scheduled with may decide to discharge you from their clinic or, another $75 charge will be incurred. We really dislike having to do this, but we really need some 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're open to discussing them.

Is there a fee for a late cancellation or not showing up to a surgery?

Yes. A "No-Show" for surgery is a person who fails to cancel or reschedule more than 5 business days prior to their scheduled surgery. If you communicate with the surgeon's medical assistant more than 5 business days prior to your scheduled surgery and cancel or reschedule, there will be no charge. The fee for a surgery that is not cancelled or rescheduled within the allowed timeframe will be $250. We really dislike having to charge this fee, but we need the notice to allow other patients to be able to be put on the surgery schedule. A lot of time from the medical and surgical staff goes into planning the surgery and coordinating the people and equipment that are needed. Like with our office visits, we do understand that extenuating circumstances can arise. We're open to discussing those on a case-by case-basis.

Acknowledgment of financial policies and guarantee of payment

By signing my name below,

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 pay Camino Ear, Nose & Throat Clinic, Margaret Carter, M.D., Michael T. Murray, M.D., Lionel Nelson, M.D., Hussein A. Samji, M.D., Christina Biondolillo, N.P., Meagan Bergeron, Au.D., Kelly Brennan, Au.D., Jennifer A. Tucker, Au.D., Nicole Ulen, Au.D., Shaun Frost, PA-C and/or Ken Trulson PA-C, on my behalf for any services furnished to me or my dependent. 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-pay 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.

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
San Jose, CA 95138
(408) 227-6300

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

16130 Juan Hernandez Drive, Suite 108
Morgan Hill, CA 95037
(669) 258-5454

HIPAA / NOTICE OF PRIVACY PRACTICES & CONSENT FORM

- 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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