

**Andros ENT & Sleep Center**

**ADULT PATIENT REGISTRATION FORM**

PLEASE PRINT

Today's Date:		Primary Doctor:			
<b>PATIENT INFORMATION</b>					
Last Name		First Name		M.I	DOB: / /
Age:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F			
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Social Security #:		Email Address:	
Street Address:			City:		State: Zip:
Home #:		Cell #:		Work #:	
Employer Name & Address:				Employer Phone Number:	

<b>INSURANCE INFORMATION</b>		
Please give your insurance card to the receptionist.		
Name of Policy Holder:		DOB: / /
Address of Policy Holder:		
Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other: _____		
Insurance Company: <input type="checkbox"/> Aetna <input type="checkbox"/> Blue Cross <input type="checkbox"/> Cigna <input type="checkbox"/> Medicare <input type="checkbox"/> Tricare <input type="checkbox"/> United Health Care <input type="checkbox"/> Other: _____		
Group Number:		Policy ID Number:

<b>SECONDARY INSURANCE INFORMATION</b>		
Name of Policy Holder:		DOB: / /
Address of Policy Holder:		
Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other: _____		
Insurance Company: <input type="checkbox"/> Aetna <input type="checkbox"/> Blue Cross <input type="checkbox"/> Cigna <input type="checkbox"/> Medicare <input type="checkbox"/> Tricare <input type="checkbox"/> United Health Care <input type="checkbox"/> Other: _____		
Group Number:		Policy ID Number:

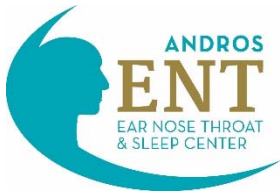
<b>EMERGENCY CONTACT</b>		
Name:		Relationship:
Phone:		

I attest that the above information is true to the best of my knowledge. I authorize Andros ENT & Sleep Center to charge my insurance based on the information I provided for services rendered. I acknowledge that I am responsible for all fees that are not covered by my insurance.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date





**Patient Name:** \_\_\_\_\_ **Birth Date:** \_\_\_/\_\_\_/\_\_\_ **Age:** \_\_\_\_\_

Primary care physician: \_\_\_\_\_ Clinic: \_\_\_\_\_

Doctor who referred you: \_\_\_\_\_ Clinic: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

May we contact you by email or direct mail with newsletters, updates, advertisements related to Andros ENT?

Yes/No if yes, email address: \_\_\_\_\_ Initial: \_\_\_\_\_

With whom would you like us to share info about your care at Andros ENT? (Please check all that apply)

\_\_\_\_ No one \_\_\_\_ Primary MD \_\_\_\_ Referring MD \_\_\_\_ Others: \_\_\_\_\_

Name: \_\_\_\_\_

Legal guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Power of attorney: \_\_\_\_\_ Date: \_\_\_\_\_

**History of Present Illness (Please answer as accurate as you can)**

Are you on disability because of your problem? Yes/No

When did your problem start? \_\_\_\_\_

What treatment(s) has been done so far? \_\_\_\_\_

\_\_\_\_\_

Are your symptoms improving or worsening? \_\_\_\_\_

\_\_\_\_\_

What makes your symptoms better/worse? \_\_\_\_\_

\_\_\_\_\_

**Past Medical History**

(Please list all medical problems such as; high blood pressure, diabetes, cholesterol)


**Social History**

How often do you drink alcohol? \_\_\_ # drinks per day/week/other: \_\_\_\_\_

Do you smoke? Yes/No if so, how much/how long? \_\_\_\_\_ Age when you started: \_\_\_\_\_

Are you employed? Yes/No if so, what is your occupation? \_\_\_\_\_

What is your marital status: \_\_\_\_\_

Do you drink caffeinated beverages? Yes/No if so, how many per day? \_\_\_\_\_ # of cups/cans per day/week

Do you drink coffee, tea, or soda? \_\_\_\_\_

Do you exercise? Yes/No if so, how often per week? \_\_\_\_\_ Do you use any recreational drugs? Yes/No





Patient Name:

**Review of Systems**

Circle any that applies to indicate whether you presently have any of the following symptoms. For any yes responses, please check if current.

**Allergy:**

Sneezing      Environmental allergy      Post-nasal drip      Food allergies (list): \_\_\_\_\_

**ENT:**

Ear pain/itch      Ear drainage      Hearing loss      Ear noises/ringing  
Dizziness      Light-headedness      Nasal congestion      Throat pain  
Sense of smell      Snoring/apnea      Throat clearing      Vocal loss  
Hoarseness      Throat dryness      Throat itching  
Daytime naps      Difficulty swallowing      Sinus pressure/pain

**Respiratory:**

Cough      Wheezing      Coughing blood      Shortness of breath

**Eyes:**

Eye pain      Watery eyes      Itchy eyes

**GI/Gy:**

Upset stomach      Heartburn      Bedwetting      Difficulty passing urine

**Neurological:**

Migraines      Headache      Weakness      Numbness and tingling

**General:**

Chills      Fatigue      Weight loss/gain      Daytime sleepiness

**Endocrine:**

Feel warmer than others      Feel cooler than others

**Heme/Lym:**

Swollen glands      Bleeding problems      Night sweats      Easy bruising

**Cardio:**

Chest pain      Palpitations

**Muscular:**

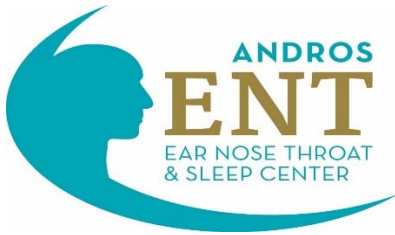
Joint aches      Muscle pain      Chronic back pain

**Skin:**

Rash      Itching      Hives      Skin changes

**Psych:**

Depression      Anxiety      Panic attack



Inell C. Rosario, MD  
Diplomate American Board of Otolaryngology  
Board Certified in Sleep Medicine

5565 Blaine Avenue  
Suite 225 & Suite 275  
Inver Grove Heights MN 55076

Josh G. Yorgason, MD  
Board Certified in Otolaryngology  
Adult and Pediatric Cochlear Implantation

(651) 888-7800 Clinic  
(651) 888-7801 Fax

## General Consent and Authorization Form

### Consent to Treat:

I consent to and authorize the physicians, nurses and other healthcare providers at Andros ENT & Sleep Center to perform appropriate healthcare examinations, treatment, and diagnostic testing or medication administration as deemed medically necessary by their professional judgment. I know that there are some risks with all medical treatments and procedures and I understand that no one can guarantee how well treatments or procedures will work.

### Assignment of Benefits/Payments for Services:

I authorize payment of any and all benefits to Andros ENT & Sleep Center. I know that I must pay for any charges for my care that are not covered by my insurance, health plan, or government programs. I realize I must cooperate with Andros ENT & Sleep Center to get payment for my care. If I am eligible for payment from more than one type of coverage, Andros ENT & Sleep Center will return any extra payments to the payor. If I have an unpaid bill at Andros ENT & Sleep Center, any refunds due to me will be put on my unpaid bill. If there is money left over after the bill is paid, I will get a refund from Andros ENT & Sleep Center.

### Release of Information

I consent to the release and use by Andros ENT & Sleep Center of my protected health information to the extent permitted by law to and for the following:

- To a healthcare provider being advised or consulted in connection with my treatment or care
- To a health plan, insurer, third party payer, third party administrator or other organization providing me with health benefits, for the purposes of claims payment and benefit determinations, fraud investigations, or quality of care studies or reviews,
- To a person or organization in connection with Andros ENT & Sleep Center's healthcare operations. These operations may include interdisciplinary care conferences, quality improvement activities, performance evaluations, business management and other related activities.
- To leave medical, billing or scheduling information on this voice mail/answering machine number:  
(     ) \_\_\_\_\_ - \_\_\_\_\_.

### Other Individuals Authorized to Release Information:

In addition to the myself (if minor any other legal guardians of the patient), the following persons are authorized to speak to my provider or have access to medical record.

- | <u>Name:</u> | <u>Relationship to patient:</u> |
|--------------|---------------------------------|
| • 1. _____   | _____                           |
| • 2. _____   | _____                           |
| • 3. _____   | _____                           |

**Release of Information for Research Purposes [Optional]**

I consent to and authorize the release of my protected health information for medical and scientific research purposes.  Agree  Disagree

**Patient Rights and Privacy Practices:**

You and your family’s rights and our privacy practices are posted in main areas within Andros ENT & Sleep Center. Your signature acknowledges receipt of our Notice of Privacy Practices. If you have any questions concerning your rights and/or our privacy practices, please contact your care provider of Andros ENT & Sleep Center’s Privacy Officer, Angel Grey-Swanstrom.

**Other Individuals Authorized to Consent to Treatment:**

In addition to the legal guardians of the patient, the following persons are authorized to consent to recommended medical care for me: name and relationship to patient (e.g., significant other, spouse, grandma, grandpa, daycare provider, etc.)

<b><u>Name:</u></b>	<b><u>Relationship to patient:</u></b>
1. _____	_____
2. _____	_____
3. _____	_____

My signature here means I have read this information and understand it. This consent is valid until revoked in writing.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

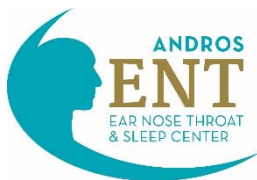
Signature: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Print name: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Interpreter (if used): \_\_\_\_\_

Interpreter Phone Number: \_\_\_\_\_





The Center for Medicare/Medicaid Services, the federal agency overseeing government-funded healthcare and its quality, has requested that we collect the following information on all patients seen in our clinic. This information will be used to help improve the quality and effectiveness of care for populations at risk for specific conditions, make available funding for crucial support services such as interpreters, and provide preventive screening for specific populations. The collection of this information is legal under Minnesota state law and is federally covered under Title VI of the Federal Civil Rights Act of 1964. In an effort to provide the best possible care for our patients, please check your race, ethnicity and your preferred language from the list below. This will help us to ensure the highest quality of service for you.

**Your answers will be confidential**

**Patient Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_  
(Please print)

**Please check the RACE that best describes you:**

- |   |  |
|---|--|
| <input type="checkbox"/> American Indian or Alaska Native         | <input type="checkbox"/> White or Caucasian              |
| <input type="checkbox"/> Asian                                    | <input type="checkbox"/> Multi-racial                    |
| <input type="checkbox"/> Black or African American                | <input type="checkbox"/> Choose not to disclose/ decline |
| <input type="checkbox"/> Native Hawaiian / Other Pacific Islander |  |

**Please check the ETHNICITY that best describes you:**

- Hispanic or Latino
- Not Hispanic or Latino
- Choose not to disclose/decline

**Please check your primary LANGUAGE:**

- |                                  |  |                                   |                                  |   |
|----------------------------------|--|-----------------------------------|----------------------------------|---|
| <input type="checkbox"/> Amharic | <input type="checkbox"/> Arabic        | <input type="checkbox"/> Bosnian  | <input type="checkbox"/> Burmese | <input type="checkbox"/> Cambodian      |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> English       | <input type="checkbox"/> French   | <input type="checkbox"/> German  | <input type="checkbox"/> Hindi          |
| <input type="checkbox"/> Hmong   | <input type="checkbox"/> Italian       | <input type="checkbox"/> Japanese | <input type="checkbox"/> Karen   | <input type="checkbox"/> Korean         |
| <input type="checkbox"/> Laotian | <input type="checkbox"/> Mandarin      | <input type="checkbox"/> Oromo    | <input type="checkbox"/> Polish  | <input type="checkbox"/> Romanian       |
| <input type="checkbox"/> Russian | <input type="checkbox"/> Sign Language | <input type="checkbox"/> Somali   | <input type="checkbox"/> Spanish | <input type="checkbox"/> Swahili        |
| <input type="checkbox"/> Tagalog | <input type="checkbox"/> Tibetan       | <input type="checkbox"/> Tigrinya | <input type="checkbox"/> Urdu    | <input type="checkbox"/> Vietnamese     |
| <input type="checkbox"/> Yorba   | <input type="checkbox"/> Other         | Specify _____                     |                                  | <input type="checkbox"/> Decline Answer |





## **Financial Policy**

Andros ENT & Sleep Center is privileged to provide medical and surgical treatment for our patients. We work diligently to maintain our high level of personalized service and strive to accommodate our patients' needs for office visits in a timely manner. We strive to render excellent medical care to you, your family, and all of our patients. We ask that you review our Financial Policy below that includes more information on the scheduling and cancellation of appointments in addition to your financial obligations when services are rendered to you. We look forward to caring for you!

### **Insurance**

- Andros ENT & Sleep Center accepts and is contracted with most insurance carriers, PPOs, and HMO's. Charges for the services billed to our contracted insurance carriers will be discounted to their allowed amount. You are responsible for any copays, deductibles, any non-covered services, and usual and customary amounts for non-contracted insurance.
- Please bring your current medical insurance card to every visit and notify us if there is a change in your insurance coverage.
- Contact your insurance company prior to your visit to clarify your covered benefits for your ENT & sleep services.
- If your insurance requires a referral, you must obtain one prior to your visit.
- Co-payments are due at the time of check-in along with any past amount due on account. If you are unsure of your copay, deductible, or coinsurance amount, please contact your insurance company for clarification prior to your appointment.
- You will be asked to sign an Authorization and Release of Information form which allows us to bill and receive payment from your insurance company.

### **Patients without Insurance**

- If you do not have insurance, or your insurance company does not cover your services, we will require you to pay your bill in full at the time of your appointment.

### **Cosmetic Services**

- Cosmetic Services are not covered by insurance and must be paid in full at the time of service.

### **Laboratory/Pathology Services**

- If you receive services such as cultures and biopsies, you may receive a bill from Quest Diagnostics Laboratories as they perform the analysis of the lab specimen.

### **Appointment Cancellation Policy**

- Your appointment is reserved especially for you. Should you need to cancel or change the date of your appointment, we would appreciate 48 hours' notice.

- A patient who fails to show up for a scheduled appointment without prior notice will be considered a “no show.”
  - A patient who is considered a “no show” for an overnight sleep study appointment will have a \$100 service fee charged to the credit/debit card on file that is not billable to insurance.
- A patient who no shows for three times or fails to give an adequate 24 hour notice for three appointments may be subject to a \$50 service fee at the next appointment in addition to deductible/coinsurance/copay for that visit that is not billable to insurance.
- As a courtesy, we will do our best to send a reminder via text, email, or telephone call for appointments. If you do not receive your reminder call or message, the cancellation policy will still remain in effect.

## **Billing**

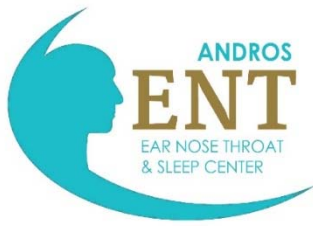
- You will receive an itemized statement monthly if there is a remaining patient balance on your account, and payment is due within 30 days of the statement date. If you are unable to pay the balance in full, please contact our business office immediately to preserve your credit. We accept cash, check, credit cards, and Care Credit.
- You are ultimately responsible for all fees relating to your care. Any balances that have been unpaid for a period of 60 days or longer may be sent a notice letter. This is the final opportunity that you have to resolve your account. If no contact is made to our office, your account may be sent to our legal collection agency. If your account is sent to an external collection agency, all contact regarding your account must then be made with the legal collection agency’s account representative. Any applicable collection fees billed by the collection agency will be the responsibility of the patient and are not billable to insurance. Any checks returned for insufficient funds will incur a \$25.00 fee that is not billable to insurance.
- Please report all address, insurance and/or telephone number changes promptly by calling our office.
- Responsibility for minor/dependent accounts rests with the legal guardian and we may ask for proof of guardianship. Any court ordered responsibility judgment must be determined between the individuals involved.
- If at any time you have any questions regarding your bill, please call our office at 651-888-7800 and we will be happy to assist you.

## **CPAP (Continuous Positive Airway Pressure Unit)**

- A CPAP unit is a potential treatment for a patient diagnosed with a sleep condition. Andros ENT & Sleep Center will bill the CPAP unit according to insurance guidelines that could be considered a rental or purchase agreement. The supplies that are sold with the CPAP unit are always purchased and nonrefundable. Insurance carriers have a variety of guidelines, so please inquire with your insurance carrier for more details.

## **Patient Satisfaction**

- Andros ENT & Sleep Center takes pride in the services that are rendered to our patients. It is important to us that our patients are the center of our practice. Our goal is to provide you with the highest quality of care in a courteous and professional setting. If at any time your experience with us did not meet your expectations, please contact our practice administrator, Shannon Storbeck, at any time to report your question, issue, or concern. You can reach her by calling 651-888-7803.



## **Notice of Privacy Practices**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

### Uses and Disclosures

**Treatment.** Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

**Payment.** Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

**Health care operations.** Your health information may be used as necessary to support the day-to-day activities and management of Andros ENT & Sleep Center. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

**Law enforcement.** Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated report.

**Public health reporting.** Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

**Other uses and disclosures require your authorization.** Disclosure of your health information or its use for any purpose other than those listed above require your specific written authorization. Examples include psychotherapy notes, marketing, and sale of your protected health information. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

### Additional uses of information

**Appointment reminders.** Your health information will be used by our staff to send you appointment reminders.

**Information about treatments.** Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health related products and services that we believe may interest you.

### Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information

- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to be notified of a breach of protected health information
- The right to restrict disclosures of protected health information to a health plan where the individual pays out-of-pocket in full for the item or service
- The right to receive a printed copy of this notice

### **Andros ENT & Sleep Center Duties**

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

### **Right to Revise Privacy Practices**

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

### **Requests to Inspect Protected Health Information**

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting Luis Rosario. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

### **Complaints**

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Luis Rosario  
5565 Blaine Ave, Suite 225 & 275  
Inver Grove Heights, MN 55076  
(651) 888-7800

If you believe your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

### **Contact Person**

The name and address of the person you can contact for further information concerning our privacy practices is:

Luis Rosario  
5565 Blaine Ave, Suite 225 & 275  
Inver Grove Heights, MN 55076  
(651) 888-7800

### **Effective Date**

This notice is effective on or after July 1, 2013