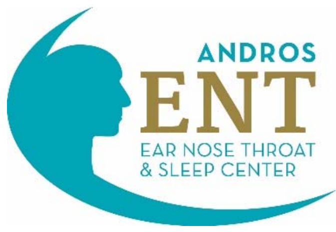


Andros ENT & Sleep Center

MINOR PATIENT REGISTRATION FORM

PLEASE PRINT

PATIENT INFORMATION				
Last Name First Name M.I.	DOB: / /	Age:	Sex: ☐ M ☐ F	
Social Security #:	Are Parents Divorced? ☐ YES ☐ NO	Patient's primary residence is with: ☐ Mother ☐ Father ☐ Both ☐ Other: ________________	If divorced, shared custody? ☐ YES ☐ NO ☐ N/A	
If NO, describe limitations:				

PRIMARY PARENT/GUARDIAN INFORMATION			
Last Name First Name M.I.	DOB: / /	Relationship to Patient:	
Street Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone:	
Email Address:	Employer Name & Address:		

SECONDARY PARENT/GUARDIAN INFORMATION			
Last Name First Name M.I.	DOB: / /	Relationship to Patient:	
Street Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone:	
Email Address:	Employer Name & Address:		

INSURANCE INFORMATION		
Name of Policy Holder:	DOB: / /	Address of Policy Holder:
Relationship to Patient: ☐ Self ☐ Parent ☐ Other: ____		
Insurance Company: ☐ Aetna ☐ Blue Cross ☐ Cigna ☐ Medicare ☐ Tricare ☐ United Health Care ☐ Other: ________________		
Group Number:	Policy ID Number:	

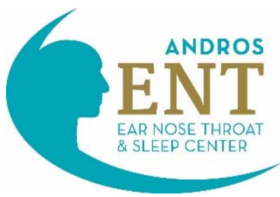
SECONDARY INSURANCE INFORMATION		
Name of Policy Holder:	DOB: / /	Address of Policy Holder:
Relationship to Patient: ☐ Self ☐ Parent ☐ Other: ____		
Insurance Company: ☐ Aetna ☐ Blue Cross ☐ Cigna ☐ Medicare ☐ Tricare ☐ United Health Care ☐ Other: ________________		
Group Number:	Policy ID Number:	

EMERGENCY CONTACT (CANNOT BE A PERSON LISTED ABOVE)		
Name:	Relationship:	Phone:

I certify that the above information is true to the best of my knowledge.

____ ________________________________

Parent/Guardian Signature Date



Pediatric Visit

Patient Name:	**Today's Date:**

Doctor who referred you: ______________________________ Clinic: ____

Reason for Today's Visit: ____

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: _______________________________________

Person completing form: ____

Legal guardian: ____ Date: ________________________________

Power of attorney: ____ Date: _______________________________

Past Medical History/Birth History

Method of delivery: _____Normal vaginal _____Cesarean section Intubated: Yes/No

Was born premature? Yes/No If yes, list gestational age at delivery: __________ weeks

Birth weight: _____ lbs. _____oz. Current weight: ________ lbs. Current height: ________ in.

Has child passed newborn hearing screening? Yes/No/Unsure

Please indicate any therapy child is receiving: _____ PT _____ OT _____Speech _____ Other (list): _____________

Immunization up to date: Yes/No, if no explain: ____

Please circle Yes or No to indicate if patient has any of the following illnesses; for YES please explain

Infections during pregnancy: Yes/No, if so: ____

Recurring/high fevers (>102): Yes/No, if so: ____

Complications during pregnancy: Yes/No

Hearing problems: Yes/ No

Nasal congestion: Yes/No

Vision problems: Yes/No

Large tonsils: Yes/No

Immune deficiency: Yes/No

Reflux/spit up: Yes/No

Attention problems: Yes/No

Walked at age: _____ months

Neurological problems: Yes/No

Bedwetting: Yes/No

Chronic runny nose: Yes/No

Respiratory problems/asthma: Yes/No

Easy bruising/bleeding/epistaxis: Yes/No

Heart problems: Yes/No

High fever/surgery: Yes/No

Circumcised: Yes/No

Speech problems: Yes/No ______ # of words easily understood

Ear infections: Yes/No if yes, ______ # past 6-12 months, Right/Left/Both

Chronic sore throat: Yes/No if yes, Strep: Yes/No, Mono: Yes/No

Please list all surgeries/operations

Type of Surgery	Date of Surgery

Social & Family History

1. Does child attend daycare? Yes/No
2. Are there pets in the house? Yes/No if yes, list number/types: ____
3. Is there smoke exposure? Yes/No
4. Who does the child live with? (including siblings): ____
5. School grade: ______________________ list any special schools/classes: ___________________________________

Family History (check all that apply, if not applicable please write N/A)

	Mother	Father	Sister	Brother	Grandmother (m)	Grandfather (m)	Grandmother (f)	Grandfather (f)
Allergy								
Asthma								
Bleeding Disorder								
Cancer: Type								
Diabetes: Type								
Hearing problems								
Heart problems								
Malignant Hyperthermia								
Meniere's								
Migraines								
Narcolepsy								
Restless Legs								
Sleep Apnea								
Thyroid Problems								

Patient Medication Form

Do you have a preferred pharmacy? ______ Yes ______ No if yes, please list below.

Pharmacy:_____________________________________ Pharmacy fax: ___________________________________

Pharmacy phone:_________________________________

Pharmacy address: ____

Please list all medications you are currently taking including over-the-counter medications, herbals, vitamins, etc. Ask for additional sheets if necessary.

Medication Name	Dose/Strength	Reason for taking

Patient Allergy Information

1. Allergic to latex? Yes/No
2. Allergic to medical tape? Yes/No
3. Have any known drug allergies? Yes/No
4. If yes, please list all the medications below. Attach additional sheets as necessary.

Medication patient is allergic to	Reaction

Review of Systems

Circle any that applies to indicate whether you presently have any of the following symptoms. For any yes, responses please check current, if the symptoms relates to the reasons for your visit today and you would like to have it evaluated.

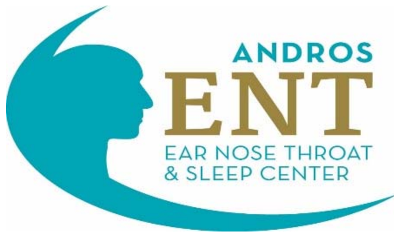
Allergy:

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

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

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

(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.

Name:	**Relationship to patient:**
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.)

Name:	**Relationship to patient:**
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: ______________________________

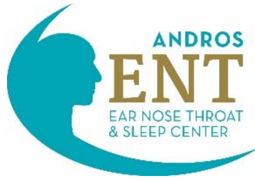
Signature: ______________________________ Relationship to patient: ____________________

Print name: ______________________________ Date: ______________________________

Name of Interpreter (if used): ____

Interpreter Phone Number: ______________________________________

Revised 12/29/2016



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:

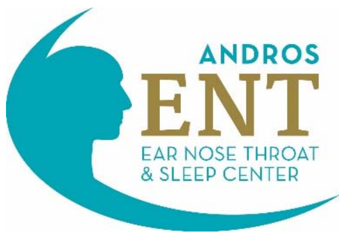
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian / Other Pacific Islander
- ☐ White or Caucasian
- ☐ Multi-racial
- ☐ Choose not to disclose/ decline

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:

☐ Amharic	☐ Arabic	☐ Bosnian	☐ Burmese	☐ Cambodian
☐ Chinese	☐ English	☐ French	☐ German	☐ Hindi
☐ Hmong	☐ Italian	☐ Japanese	☐ Karen	☐ Korean
☐ Laotian	☐ Mandarin	☐ Oromo	☐ Polish	☐ Romanian
☐ Russian	☐ Sign Language	☐ Somali	☐ Spanish	☐ Swahili
☐ Tagalog	☐ Tibetan	☐ Tigrinya	☐ Urdu	☐ Vietnamese
☐ Yorba	☐ Other	Specify_____________		☐ 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

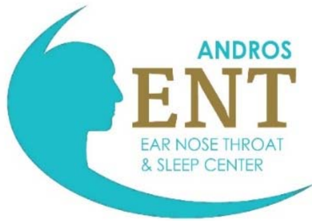
- You will receive an itemized statement monthly if there is a remaining patient balance on your account, and payment is due within 30 days of the statement date. If you are unable to pay the balance in full, please contact our business office immediately to preserve your credit. We accept cash, check, 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