

**OTOLARYNGOLOGY ASSOCIATES PATIENT PROFILE**

Patient ID #: \_\_\_\_\_

Oto MD: \_\_\_\_\_ Refer MD: \_\_\_\_\_ Primary MD: \_\_\_\_\_

**PATIENT INFORMATION**

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

Sex: ( )Male ( )Female

Address: \_\_\_\_\_

SSN: \_\_\_\_\_

\_\_\_\_\_

Birth Date: \_\_\_\_\_

City, State: \_\_\_\_\_ Zip: \_\_\_\_\_

Marital Status: ( )Married ( )Divorced  
( )Single ( )Widowed

Phone #1: \_\_\_\_\_

( )Home ( )Work ( )Other

**CONTACTS**

Phone #2: \_\_\_\_\_

( )Home ( )Work ( )Other

**PATIENT EMPLOYMENT**

( )Employed ( )Retired Employer: \_\_\_\_\_

( )Student ( )Other Occupation: \_\_\_\_\_

**GUARANTOR/RESPONSIBLE PARTY INFORMATION**

( ) Same as Patient

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

SSN: \_\_\_\_\_

Address: \_\_\_\_\_

Birth Date: \_\_\_\_\_

\_\_\_\_\_

Employer: \_\_\_\_\_

City, State: \_\_\_\_\_ Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_

Phone #1: \_\_\_\_\_

( )Home ( )Work ( )Other

Phone #2: \_\_\_\_\_

( )Home ( )Work ( )Other

**PRIMARY INSURANCE**

Insured Party: \_\_\_\_\_ Insured Same as: ( )Other ( )Patient ( )Guarantor

Insured SSN: \_\_\_\_\_ Insurance Co: \_\_\_\_\_

Insured Birth Date: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Insured Phone: \_\_\_\_\_ Insured ID#: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_ Policy Group #: \_\_\_\_\_

**SECONDARY INSURANCE**

Insured Party: \_\_\_\_\_ Insured Same as: ( )Other ( )Patient ( )Guarantor

Insured SSN: \_\_\_\_\_ Insurance Co: \_\_\_\_\_

Insured Birth Date: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Insured Phone: \_\_\_\_\_ Insured ID#: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_ Policy Group #: \_\_\_\_\_

## OTOLARYNGOLOGY ASSOCIATES, PC

Mark I. Rubinstein, MD, FACS  
Deborah J. Doyle, MD, FACS  
Mark A. Soltany, MD  
Patty Lee, MD, FACS

Robert S. Bahadori, MD, FACS  
Bryan A. McKenzie, MD, FACS  
Belinda A. Mantle, MD  
James S. Batti, MD, FACS

### SUMMARY OF PRIVACY PRACTICES

This document summarizes the privacy practices of Otolaryngology Associates, PC as required by the privacy regulation created under the Health Insurance Portability and Accountability Act of 1996. You may request a complete copy of our Notice of Privacy Practices at any time and one will be provided to you free of charge.

Medical information about you may be used and/or disclosed by our practice. The following information summarizes how we may use and/or disclose your protected health information (PHI), your privacy rights regarding your PHI and our obligations concerning the use and disclosure of your PHI.

**Uses and Disclosures:** We will use and disclose elements of your PHI in the following ways.

**Without your signed authorization in routine situations:**

- ◆ For treatment purposes (e.g. writing prescriptions, ordering lab tests);
- ◆ For billing and payment purposes (e.g. contacting insurance companies, sending out bills);
- ◆ For internal purposes (e.g. conducting quality of care reviews);
- ◆ To contact you about appointment reminders, treatment alternatives and other health related benefits and services;
- ◆ To family/friends that participate in your care;
- ◆ For disclosures required by federal, state or local law.

**Without your signed authorization in special circumstances:**

- ◆ To public health authorities regarding public health risks;
- ◆ To health oversight regulatory agencies as required by law;
- ◆ In response to a court or administrative order;
- ◆ To law enforcement officials;
- ◆ To organizations handling organ, eye or tissue procurement;
- ◆ In emergency situations or to avert serious health/safety situations;
- ◆ To the military if required by the appropriate authorities;
- ◆ To federal officials for intelligence activities if required by law;
- ◆ To correctional institutions or law enforcement officials if you are an inmate;
- ◆ To workmen's compensation or similar programs.

All other uses and disclosures will require us to obtain from you written authorization.

You have the following rights concerning your PHI.

**Your Rights:**

- ◆ **Confidential Communications:** To request that our practice communicate with you about your PHI in a particular manner or at a certain location.
- ◆ **Restrictions:** To request restricted access to all or part of your PHI. Request must be submitted in writing. We are not required to grant your request.
- ◆ **Access:** To inspect or receive copies of your PHI.
- ◆ **Amendments:** To request changes be made to your PHI. We are not required to grant your request.
- ◆ **Accounting:** To receive an accounting of the non-routine disclosures by us of your PHI in the six years prior to your request (but not before 4/14/03).
- ◆ **This Notice:** To get updates or reissues of this notice, at your request.
- ◆ **Complaints:** To complain to us or to the US Dept. of Health & Human Services if you feel your privacy rights have been violated. The law forbids us from taking retaliatory action against you if you complain.
- ◆ **Authorization for other Uses and Disclosures:** To obtain your written authorization for uses and disclosures not permitted by applicable law.

For your convenience, we have developed simple forms for you to document your requests. These forms are available upon request and must be submitted to **Otolaryngology Associates, PC, ATTN: Privacy Officer, 8316 Arlington Blvd, Suite 300, Fairfax, VA 22031.**

**Our Duties:** We are required by law to maintain the privacy of your PHI. We must abide by the terms of this notice or any update of this notice.

**Privacy Contact:** For more information about our privacy practices or to file a complaint about our privacy practices, please contact:

**Otolaryngology Associates, PC  
ATTN: Privacy Officer  
8316 Arlington Blvd, Suite 300  
Fairfax, VA 22031  
(703) 573-7600**

**Effective Date:** This notice is effective April 14, 2003.

Rev. 02/25/10

HIPAAsum.doc

**OTOLARYNGOLOGY ASSOCIATES  
FINANCIAL POLICY**

This is an agreement between Otolaryngology Associates, as creditor, and the Patient/Debtor named on this form.

**Payment Options:** All previous balances are due at the time of service unless previous arrangements have been made with our Business Office. You may pay your out-of-pocket costs at the time of service by check, cash or credit card. Failure to make appropriate copayments at the time of service may result in a service charge of \$10. If you are unable to pay your full out-of-pocket costs at the time of service, you may make payment arrangements through our Business Office by calling 703-573-5979. These options include a payment plan not to exceed three months on amounts less than \$250.00 and six months on amounts over \$250.00. Automatic payments can be arranged via credit card.

**Past Due Accounts:** If at any time you have a balance due which is more than 90 days old and have not made appropriate payment arrangements with our Business Office, your account may be referred to an outside collection agency. If you have established a payment plan and default on the agreed upon plan, your account may be referred to an outside collection agency. If we have to refer your account to a collection agency, you agree to pay for all collection costs and attorney fees incurred. Further, you understand that if your account is submitted to a collection agency, or if your past due status is reported to a credit reporting agency, the fact that you receive treatment at our office may become a matter of public record. We will also notify your insurance carrier.

**Pre-Authorization:** Many insurance companies, including worker's compensation carriers, require pre-authorization and/or referrals prior to obtaining specialty care. It is your responsibility to contact your insurer AND/OR Primary Care Physician to determine the need for a referral and/or pre-authorization. Failure to obtain a referral and/or preauthorization may result in lower reimbursement or claim denial from the insurance company.

**Divorce:** The parent authorizing treatment for a child will be the parent responsible for the charges related to that care. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

**Forms & Medical Records:** From time to time, various forms, including but not limited to, disability or FMLA forms need to be completed. There is a \$10 fee to complete each form. There are also fees associated with the copying of medical records. Please inquire at the Front Desk by requesting a Medical Record Release Form.

**Returned Check Fee:** There is a fee of \$25 for any checks returned by your bank.

**Prescription Refills:** Annual office visits are required for annual prescription refills. Prescription refills not obtained during office visits may be subject to a \$20 service charge.

**Missed Appointment Fee:** The second time a patient does not arrive on time for an appointment, or cancels with less than 24 hours notice, a missed appointment fee of \$25 may be charged. This fee must be paid before a new appointment is scheduled. Patients with four or more missed appointments may be asked to transfer their records to another physician.

**Effective Date:** Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient's Name: \_\_\_\_\_

Responsible Party: \_\_\_\_\_  
(If not the patient)

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

FinanPolicy0210.doc

**OTOLARYNGOLOGY ASSOCIATES, PC  
RELEASE OF INFORMATION**

I, the undersigned, authorize Otolaryngology Associates, PC to speak with the persons listed below regarding my medical care. I understand that with my signature I am authorizing the release of written or oral communication by Otolaryngology Associates, PC to the listed persons and thereby release Otolaryngology Associates, PC and their staff from all legal responsibility that may arise from the act hereby authorized.

_____ Authorized Person	_____ Relationship to Patient	_____ Phone Number
_____ Authorized Person	_____ Relationship to Patient	_____ Phone Number
_____ Signature of Patient / Responsible Party		_____ Date

**ASSIGNMENT OF BENEFITS**

I, \_\_\_\_\_(Please print your name) hereby authorize Otolaryngology Associates, PC to apply for benefits for covered services rendered by Otolaryngology Associates, PC, and to request that the payments from Medicare, Medicaid, Blue Cross/Blue Shield and/or \_\_\_\_\_ (other insurance company) be made directly to Otolaryngology Associates, PC if they choose to accept assignment, or to myself or to the party who accepts assignment.

I certify that the information I have reported with regards to my insurance is correct and further authorize the release of any necessary information, including medical information for this or any related claim to Medicare, Medicaid, Blue Cross/Blue Shield and/or \_\_\_\_\_ (other insurance as listed above).

I request that payment of authorized Medigap benefits be made either to me or on my behalf to the above-named provider for any services provided to me by that physician/supplier. I authorize any holder of medical information about me to release to \_\_\_\_\_ (name of Medigap Carrier) any information needed to determine these benefits payable for related services.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked at anytime in writing.

_____ Subscriber or Policy Holder Signature	_____ Insurance I.D. Number	_____ Date
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**RECEIPT OF PRIVACY PRACTICES WITH WRITTEN ACKNOWLEDGEMENT FORM**

I, \_\_\_\_\_, have received a written summary of Otolaryngology Associates, PC's Privacy Practices. I understand that a complete copy of the group's Notice of Privacy Practices is available, at no charge, upon request.

_____ Signature of Patient/Responsible Party	_____ Date
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Date \_\_\_\_\_

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

## Otolaryngology Associates

### Patient History

To be prepared for your upcoming evaluation at Otolaryngology Associates, please list the following:

List any allergic reactions you have had to any medications:

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List medications (prescription, over-the-counter, and health supplement)s you are taking:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If you or your child is being seen for a history of *Ears, Nose or Throat* infections, list the number of infections in the last 12 months and the treatments you (they) received:

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Have you had an X-Ray, CT scan, MRI, blood work, or other studies that are related to your visit? Please hand-carry a copy of the report AND, if possible, the actual films (or CD) to the visit.

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(02/10)

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