COLORADO SPRINGS EAR ASSOCIATES

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Otology, Neurotology & Skull Base Surgery

THESE FORMS CAN BE COMPLETED IN A PDF READER APPLICATION

PATIENT PROFILE

PERSONAL INFORMATION

First Name:	**Last Name:**	**DOB:**	**Age:**	**Sex:**
Phone Number:	**Email Address:**			**SSN:**
Mailing Address:		**City:**		**State/Zip:** ,

PROVIDER INFORMATION

Referring Provider:	**Primary Care Physician:**

EMPLOYMENT INFORMATION

Employer:	**Employer Address:**

FINANCIAL INFORMATION **Current Balance:**

Patient is financially responsible for their care: Yes____ No____ If No, please provide Guarantor information:

Name:	**DOB:**	**Relationship:**
Phone Number:	**Email Address:**	**SSN:**
Mailing Address:	**City:**	**State/Zip:**

INSURANCE INFORMATION **Copay:** **Deductible:**

Primary Insurance Company:		**Priority:**
Insured Person:	**Member ID:**	**Group ID:**
Name:	**DOB:**	**Relationship:**
Plan Name:	**Employer:**	
Secondary Insurance Company:		**Priority:**
Insured Person:	**Member ID:**	**Group ID:**
Insured Person DOB:	**Insured Person Phone Number:**	**Relationship:**
Plan Name:	**Employer:**	

CONSENT

I hereby authorize treatment of the above named patient and agree to pay all charges for treatment regardless of insurance coverage or the pendency of insurance claims. I authorize the release of all medical information pertinent to my medical care and necessary to process my insurance claims. I will assign all medical benefits to Colorado Springs Ear Associates, Prof. LLC. A photocopy of this form shall be as valid as the original. I understand that I can withdraw this medical consent at any time by notifying this office in writing. I HAVE READ THIS INFORMATION THOROUGHLY AND UNDERSTAND IT.

Signature:_____ Today's Date: _____

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FINANCIAL POLICIES

1. Private Insurance: You are responsible for deductibles, copays, coinsurance, any non-covered services including out-of-network charges specific to your plan, and items considered not medically necessary by your insurance company. Copays and deductible amounts are due at time of service. Balances are due 30 days after receipt of payment from your insurance company. If you or your insurance carrier makes payment exceeding your balance, reimbursement will be remitted.
2. Private Pay: Please make payment for your care at each patient visit.
3. Medicare: Our office will submit your Medicare charges to Medicare and your secondary insurance, if applicable. You are responsible for co-insurance, co-pays, and any non-covered services.
4. Balances Due: Invoices are emailed immediately after your claim has been processed. Payment is due within 30 days of the invoice email date. Reminder emails will be sent 30 and 60 days after the invoice email date. A 5% late fee will be added to all invoices that are 60 days overdue. Unpaid invoice balances will be transferred to a debt collection service 90 days after the initial invoice email date. We can no longer accept payment for balances after an account has been transferred to a debt collection service.
5. Paperless Billing: Our offices do not mail paper invoices; we email invoices when balances are due. Patients may also log in to the Invoice Portal on our web sites to view their invoices and statements. Patients who choose to opt out of paperless billing will be charged a processing fee for each paper invoice mailed to them.

GUARANTEE OF PAYMENT

1. I understand that I am responsible for payment of all fees and services rendered, irrespective of insurance coverage or other responsibilities. **NOTE:** We will bill your primary insurance. If insurance does not pay in a timely manner (within 90 days from the date of service and insurance filing), the insured will be expected to pay the balance and then pursue reimbursement from the insurance company. I understand there is a $50 fee for any returned check for NSF (non-sufficient funds). **The guarantor of each account is ultimately responsible for payment in full of the account.**
2. I have been advised that if my commercial insurance carrier/HMO/Medicare plan claims that the services I receive from Colorado Springs Ear Associates, PLLC, hereafter known as CSEA, are not considered reasonable and medically necessary for my care, I will be responsible for payment of these services.
3. I understand that my insurance plan may require my primary care physician to obtain an **authorization number** for the services that I receive from Dr. Hegarty. I have been advised that if I did not request a referral and authorization from my PCP in advance, my insurance plan may deny payment for services and I will be responsible for payment of all services.
4. I understand that it is my responsibility to determine if Joseph Hegarty, M.D. is a network physician for my **specific insurance plan** even if I have been advised that he is contracted with most commercial insurance companies. I understand that I may be responsible for paying out-of-network fees if relevant.

ASSIGNMENT

1. I assign the benefits from my insurance carriers to this office for the medical/surgical benefits to which I am entitled.
2. I request that payment of authorized Medicare benefits be made on my behalf to CSEA for any service furnished to me by these providers.

RELEASE OF INFORMATION

1. I authorize CSEA to release to my insurance carrier(s) any information needed to determine benefits payable for services.
2. I authorize CSEA to release any information regarding my evaluation and treatment to my Referring/PC Providers.
3. I authorize any physician, hospital, laboratory or x-ray facility to release to CSEA any and all medical information, hospital records, laboratory studies or x-rays that may be requested. A copy of this authorization is as binding as the original.

CASTLE ROCK
EAR ASSOCIATES

COLORADO SPRINGS
EAR ASSOCIATES

ACKNOWLEDGMENT OF RECEIPT OF FINANCIAL AND PRIVACY PRACTICES

_____ (initial) **I have read and understand the CSEA Financial & Privacy Policies.**

I authorize Colorado Springs/Castle Rock Ear Associates to discuss my private health information with the following persons:

Name: _____ Relationship:_____ Phone:_____

Name: _____ Relationship:_____ Phone:_____

_____ _____ _____
Signature Email Address Today's Date (valid for one year)

_____ _____
Printed Name of Patient's Representative Relationship

CASTLE ROCK
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Name _____ Age _____ Date of Birth _____ Date _____

MEDICAL HISTORY: Please mark any medical problems you have been or are being treated for.

☐ High Blood Pressure	☐ Heart stents/bypass	☐ Joint Replacements	☐ Sleep apnea
☐ Heart Disease	☐ Blood clots/DVT	☐ Arthritis	☐ Migraines
☐ Heart Attack	☐ Parkinsons	☐ Thyroid problems	☐ Anxiety
☐ Atrial Fibrillation	☐ Acid reflux/ulcers	☐ Use Oxygen	☐ TMJ
☐ Pacemaker	☐ Diabetes	☐ Asthma/COPD	☐
☐ Stroke/TIA	☐ Brain tumors	☐ Allergies/Sinusitis	☐

How would you rate your overall health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

SURGICAL HISTORY: Please note all the ear surgeries & procedures you have had in the past.

☐ Ear Tubes ☐ Stapedectomy ☐ Tympanoplasty ☐ Mastoidectomy

OTOLOGIC HISTORY: Please mark if you have had exposure to any of these below (include year of exposure).

☐ Unprotected noise exposure	☐ Ear injury	☐ Chemotherapy	☐ Gun shooting
☐ Gentamycin	☐ Vancomycin	☐ Meningitis	☐ Ear infections

SOCIAL HISTORY:

What is your current occupation? _____

Do you smoke or vap? ☐ No ☐ Yes Use Marijuana? ☐ No ☐ Yes
Do you drink alcohol? ☐ No ☐ Yes _____ drinks/week
Do you use caffeine? ☐ No ☐ Yes _____ cups/day

Currently disabled? ☐ No ☐ Yes Reason for disability _____

ALLERGIES TO MEDICATIONS: Please list the reactions you have had to each medicine. If nothing is listed, no allergies known.

1.	3.
2.	4.

MEDICATIONS: Please list of all the medicines you take (include strength and how often they are taken).

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

FAMILY HISTORY: Mark if any blood relative has had any of the following conditions. Please indicate which relative.

☐ Congenital deafness	☐ Premature hearing loss	☐ Otosclerosis	☐ Bleeding/Blood clots
☐ Cochlear implant	☐ Migraines	☐ Meniere's	☐ Anesthesia reactions

(continue to next page)

HEARING & BALANCE QUESTIONNAIRE

I. DIZZINESS: Please describe in your own words the sensation you feel regarding your balance. Skip if you are not feeling dizziness.

_____

_____

Please mark all that apply:

Feels like:	☐ lightheadness	☐ spinning	☐ motion-sickness	☐ drunk	☐ floating	☐ head bobbling
Lasts for:	☐ seconds	☐ minutes	☐ hours	☐ days	☐ weeks	☐ constant
Worse when:	☐ rolling in bed	☐ head moving	☐ looking up/down	☐ walking	☐ getting up	☐ in the dark
I've been dizzy:	☐ days	☐ weeks	☐ months	☐ years	☐ decades	
Better when:	☐ not moving	☐ physical therapy	☐ meclizine			

II. HEARING LOSS: Please describe in your own words the problem you are having with your hearing. Skip if you do not have hearing loss.

_____

_____

Please mark all that apply:

Hearing loss present:	☐ days	☐ weeks	☐ months	☐ years	☐ born with it
Most difficulty with:	☐ women	☐ men	☐ telephone	☐ crowds	☐ restaurants
Hearing aids:	☐ I don't have	☐ they help	☐ they don't help	☐ they squeal	☐ they hurt
Trauma history:	☐ gun shooting	☐ military noise	☐ ear infections	☐ ear tubes	☐ ear surgery

III. EAR RINGING: Please describe in your own words the problem you are having with tinnitus. Skip if you do not have tinnitus (ringing).

_____

_____

Please mark all that apply:

Tinnitus present:	☐ days	☐ weeks	☐ months	☐ years	☐ lifelong
Risk factors:	☐ noise exposure	☐ TMJ	☐ neck problems	☐ caffeine use	☐ salt use
Location:	☐ left ear	☐ right ear	☐ head	☐ ear & head	☐ can't tell
Sounds like:	☐ air leaking	☐ motor hum	☐ crickets	☐ ocean	☐ clicking
	☐ hissing	☐ paper crinkling	☐ heartbeat	☐ static	☐ crackling

Loudness scale: (0-barely hear it, 10-fire engine) Right ear 0 ——————— 10 Left ear 0 ——————— 10 ("**X**" the loudness level on the scale above)

SYSTEMS REVIEW

Please mark all conditions that apply to your **current** health.

GENERAL:

N	Y	
☐	☐	Fevers
☐	☐	Weight Loss
☐	☐	Chills
☐	☐	Night sweats

EYES:

N	Y	
☐	☐	Macular Degen
☐	☐	Double vision
☐	☐	Retinoblastoma
☐	☐	Detached retina

ENT:

N	Y	
☐	☐	TMJ
☐	☐	Allergies
☐	☐	Loss of smell
☐	☐	Nasal polyps

HEART:

N	Y	
☐	☐	High blood pressure
☐	☐	Palpitations
☐	☐	Recent heart attack
☐	☐	Passing out

LUNGS:

N	Y	
☐	☐	Asthma
☐	☐	COPD
☐	☐	Cough
☐	☐	On oxygen

HEME/LYMPH:

N	Y	
☐	☐	HIV/AIDS
☐	☐	Hemophilia
☐	☐	Blood clots/DVT
☐	☐	Easy bruising

MUSCULOSKELETAL:

N	Y	
☐	☐	Neck surgery
☐	☐	Back surgery
☐	☐	Numb feet
☐	☐	Fibromyalgia

SKIN:

N	Y	
☐	☐	Psoriasis
☐	☐	Face cancer
☐	☐	Rashes
☐	☐	Ear lesions

NEUROLOGICAL:

N	Y	
☐	☐	Migraines
☐	☐	Multiple sclerosis
☐	☐	Stroke
☐	☐	Parkinsons

GI:

N	Y	
☐	☐	Vomiting
☐	☐	Heartburn
☐	☐	GERD
☐	☐	Ulcers

GU:

N	Y	
☐	☐	STDs
☐	☐	Incontinence
☐	☐	Kidney stones
☐	☐	Kidney failure

ALLERGY/IMMUNO:

N	Y	
☐	☐	Seasonal allergies
☐	☐	Food allergies
☐	☐	Slow wound healing
☐	☐	Anaphylaxis

ENDOCRINE:

N	Y	
☐	☐	Hot/Cold Intolerance
☐	☐	Use birth control
☐	☐	Thyroid lump
☐	☐	Recent hair loss

PSYCHIATRIC:

N	Y	
☐	☐	Mania
☐	☐	Paranoia
☐	☐	Insomnia
☐	☐	Depression

☐ Unless at **Y** box is filled, these Systems are Negative **N**

Patient Signature _____ Date _____ Physician Signature Joseph Hegarty MD

Adult & Pediatric Ear Care • Hearing Aid & Cochlear Implant Center • Balance Disorders Center • Skull Base Surgery Center

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