Carolina Ear & Hearing Clinic, PC

For Ofc Use:					MR #:

Patient Name:

Address: **City:** **State:** **Zip:**	**Maiden/Other Name:** **Sex:** **Date of Birth:** **Age:** **Social Security #:**
Please check box for preferred communication: ❑ **Home #:** ❑ **Work #:** ❑ **Cell #:** ❑ **Email:**	Language: Ethnicity: ❑ Hispanic/Latino ❑ Unreported/Refused ❑ Not Hispanic/Not Latino Race: ❑ American Indian/Alaskan ❑ Other Pac Islander ❑ Asian ❑ White ❑ Black/African American ❑ More than 1 Race ❑ Native Hawaiian ❑ Unreported/Refused
Employer: Address: City: State: Zip:	
Emergency Contact: Home #: Cell #: Work #: Relationship:	**Preferred Pharmacy:** Phone #: City:
Referring Dr:	**PCP Name:**

Guarantor Information *(if different from patient)*:

Guarantor Name:	Relationship:
Address: **City:** **State:** **Zip:** **Home Phone#:** **Work Phone#:** **Cell Phone#:**	Date of Birth: Social Security #: Employer: Address: City: State: Zip:

Insurance Information

Primary Insurance Carrier:	**Secondary Insurance Carrier:**
Certificate/ID #:	**Certificate/ID #:**
Group Number:	**Group Number:**
Group Name:	Group Name:
Copay:	Copay:
Subscriber Information *(If Different From Patient)*	
Name:	Name:
Date of Birth:	Date of Birth:
Social Security #:	Social Security #:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Carolina Ear and Hearing Clinic, P.C. or insurance company to release any information required to process my claims.

Patient/Resp. Party signature **Print name** **Date** **Witness/Staff Initials**

Patient Medical Questionnaire

Carolina Ear & Hearing Clinic, PC

Patient Name:	Date:

1. What is the reason for your visit today?

2. What treatment have you received for this condition?

3. Please list your other health care providers (primary care, ENT, cardiologist, etc.):

Medical History/Review of Systems

4. How would you rate your general health?

5. The following is a list of common symptoms and health problems. Please review the list and check the box if you are currently experiencing or have ever had/been diagnosed with any of these symptoms and/or health problems.

- ☐ Allergies/Hay Fever
- ☐ Anemia/Bleeding Disorder
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma/Chronic Lung Disease
- ☐ Bloody Nose
- ☐ Blurry/Double Vision
- ☐ Bowel Irregularity
- ☐ Cancer/Tumors
- ☐ Cataracts
- ☐ Chest Pain
- ☐ Chronic Fatigue Syndrome
- ☐ Daytime Sleepiness
- ☐ Decreased Energy
- ☐ Depression
- ☐ Diabetes
- ☐ Difficulty Swallowing
- ☐ Ear Infections/Chronic
- ☐ Eye Pain
- ☐ Facial Pain Fevers/Chills
- ☐ Fibromyalgia
- ☐ Gallbladder Disease
- ☐ Gastritis
- ☐ Glaucoma
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Hearing Loss
- ☐ Heart Disease
- ☐ Hoarseness/Voice Problems
- ☐ Immunodeficiency
- ☐ Kidney Disease
- ☐ Meningitis/Encephalitis
- ☐ Migraine Headache
- ☐ Mitral Valve Prolapse
- ☐ Muscle Aches
- ☐ Muscle/Skeletal Problems
- ☐ Nausea/Vomiting
- ☐ Numbness
- ☐ Peptic Ulcer Disease
- ☐ Peripheral Vascular Disease
- ☐ Prostate Problems
- ☐ Radiation Therapy
- ☐ Ringing in the Ears
- ☐ Runny Nose
- ☐ Seizures/Epilepsy
- ☐ Sinus/Nasal Pain/Disease
- ☐ Skin Problems/Rashes
- ☐ Sore Throat
- ☐ Stroke
- ☐ Syncope/Fainting Spells
- ☐ Thyroid Disease
- ☐ Tuberculosis (TB)
- ☐ Ulcers
- ☐ Weight Gain/Loss

6. Please list your previous surgical procedures.

- ☐ Did you experience any difficulty with anesthesia?
- ☐ Did you experience any bleeding problems following surgery?

7. Please list your previous injuries or accidents:
- ☐ To the ear and/or head
- ☐ Noise Exposure
- ☐ Other

8. Are you disabled in any way or have any birth defects?
- ☐ Yes
- ☐ No

If yes, please describe.

9. Are you allergic to any medications?
- ☐ Yes
- ☐ No

If yes, please list and explain your reaction to this medication

10. Please list your current medications (or attach a complete list that we may keep). Please include all prescription and over-the-counter medications, vitamins, herbal supplements, etc. Use the back of this page if necessary.

11. Have you received/taken any of the following:
- ☐ Prolonged use of IV antibiotics (given by vein)
- ☐ Chemotherapy agents for cancer
- ☐ High doses of aspirin (more than 8 per day)
- ☐ Quinine for malaria
- ☐ Diuretics (water pills)
- ☐ Cortisone

If yes to any of these, please explain usage.

12. Have you received any alternative treatments or medical care (acupuncture, chiropractic, etc.)?
- ☐ Yes
- ☐ No

If yes, please specify type of care and for what reason.

13. Do you or have you had any other medical problems not listed above:
- ☐ Yes
- ☐ No

If yes, please give details.

Family History

14. Do any of your family members have any of the following conditions?

☐ Allergies	☐ Cancer	☐ Heart Disease
☐ Asthma	☐ Cystic Fibrosis	☐ Immunodeficiency
☐ Anemia/Bleeding Disorder	☐ Ear Problems/Hearing Loss	☐ Other

Social History

15. What is your current or previous occupation?

16. Do you smoke?
- ☐ Yes
- ☐ No
- ☐ Previously

If yes, how much?
If previously, when did you quit?

17. Describe your diet:
- ☐ Regular
- ☐ Special

Please explain any special diet.

18. Do you drink alcoholic beverages?
- ☐ Yes
- ☐ No

If yes, what type and how much?

19. Do you exercise?
- ☐ Yes
- ☐ No

If yes, what type and how often?

20. Do you drink caffeine (coffee, tea, soda)?
- ☐ Yes
- ☐ No

If yes, what type and how much?

21. Have you had any recent changes in your home or work environment?
- ☐ Yes
- ☐ No

If yes, please give details.

Carolina Ear & Hearing Clinic Financial Policy *(eff. 12/1/13)*

Thank you for choosing CEHC as your health care provider. Our providers are committed to providing you with the best medical care available at a cost that is both fair and reasonable. Please read this Financial Policy carefully and indicate your understanding and agreement with your signature and the date.

1. CURRENT INSURANCE CARD – Patients cannot be seen if we do not have a CURRENT insurance card. You will be asked for your CURRENT insurance card at each visit. If a CURRENT insurance card cannot be provided, you will have the opportunity to pay for the visit or reschedule. If your insurance changes and we are not notified, you will be responsible for all charges.
2. CO-PAYS, DEDUCTIBLES, CO-INSURANCE – All co-pays, deductibles and co-insurance amounts are collected at the time of service. This includes any amount due for surgery or in-office procedures. Our contract with your insurance requires us to collect these fees; we are unable to waive or write-off any co-pay, deductible or co-insurance.
3. OUT OF POCKET EXPENSES – Insurance companies do not cover miscellaneous supplies or administrative work, nor do we contract with insurance companies for coverage of hearing aids and related services/supplies.
    a. SUPPLIES – Any supplies you receive from our office must be paid in full at the time of service.
    b. HEARING AIDS – We will not bill for services related to a hearing aid consultation or purchase. We will provide you with a copy of the encounter detailing your visit to submit for reimbursement.
    c. TESTING – Specialized testing performed by our audiologists may not be covered by your insurance. This includes some balance and vestibular testing that may be recommended by your doctor. For example, an SOT will require a payment of $100 at the time of service.
    d. OUTSIDE FORMS – Disability forms, CMLA forms, leave of absence forms and/or any requested correspondence that is not associated with reimbursement of a claim will be charged to you prior to completion of the form and will be based on time and volume.
    e. MEDICAL RECORDS – We will be happy to furnish you with a copy of your medical records. You will need to request the records in writing and a charge will be assessed based on time and volume. There is a two-week turnaround for all medical records requests.
4. PLEASE REMEMBER – **Your insurance is a contract between you and your insurance company.** CEHC contracts with most major insurance plans; however, it is your responsibility to understand your coverage and benefits and to determine if our providers are in-network with your insurance.
    a. BILLING INSURANCE – As a courtesy to you, we will file charges with your PRIMARY insurance company. We do not file charges with secondary or tertiary insurance; however, some claims may bill automatically if we have accurate secondary information. Charges not paid by your insurance company after 90 days will be billed directly to you.
    b. AUTHORIZATION – If your insurance requires an authorization for an appointment with a specialist, it is your responsibility to obtain that authorization prior to your appointment. If you do not have an authorization, you will be responsible for charges at the time of service.
    c. THIRD PARTY INSURANCE – We will not bill third party insurance. If your visits are being covered by Workman's Comp or disability insurance, you will be responsible for all charges at the time of service. We will provide you with a copy of the encounter detailing your visit to submit for reimbursement.
    d. NON-COVERED SERVICES – In the event your insurance determines a service to be "not covered," you will be responsible for payment.
5. NO-SHOW FEES – We require a 48 hour notice for proper cancellation or rescheduling of an appointment, surgery or in-office procedure. Failure to provide such notice will result in a $50 charge for an appointment and a $250 charge for a surgery or office procedure.
6. SELF-PAY – If you do not have health insurance, or we are not contracted with your insurance plan, you will be considered a self-pay patient and will be required to pay all charges, in full, at the time of service.
7. DIVORCED/SEPARATED PARENTS of a minor patient – The responsibility for payment of services rendered to dependent children whose parents are divorces/separated rests with the parent who brings the minor to the office visit. Any court ordered responsibility judgment must be determined between the individuals involved and cannot be considered by this office.

Financial Agreement / Patient Acknowledgment of Financial Responsibility

We require every patient to read the preceding Financial Policy and sign the following Financial Agreement prior to seeing one of our medical professionals. Your clear understanding of this Financial Policy is essential. Please ask to speak with any member of our billing/insurance team if you have questions.

FINANCIAL RESPONSIBILITY: Patient Name _____

I hereby guarantee payment of charges for the above named patient.

Print Name:

Signature:

Relationship to Patient:

Date:

ASSIGNMENT OF INSURANCE BENEFITS: I authorize the release of any medical information necessary to process the insurance claim for services rendered by Carolina Ear & Hearing Clinic and its providers. I also authorize payment of benefits directly to Carolina Ear & Hearing Clinic. I understand that I am financially responsible for charges not covered by this authorization.

Signature of Policy Holder
or Representative:

Date:

MEDICARE ASSIGNMENT (if applicable): I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the Carolina Ear & Hearing Clinic and the medical professional furnishing the service.

Signature of Policy Holder
or Representative:

Date:

Carolina Ear & Hearing Clinic, PC ★
5900 Six Forks Road, Suite 200
Raleigh, NC 27609
919-876-4327; Fax 919-876-6800

Acknowledgement of Receipt
of Notice of Privacy Practices

Patient Name
Address

A representative from Carolina Ear and Hearing Clinic, PC may:

Leave a message on my answering machine/voicemail	❑ YES	❑ NO
Speak with a family member in my home about my care	❑ YES	❑ NO
Speak with family member calling our office concerning my care	❑ YES	❑ NO

Your signature below is only an acknowledgement that you have received this Notice of Privacy Practices:

_____

Patient Signature Date

For Office Use Only	
We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because: ❑ An emergency existed & a signature was not possible at the time. ❑ The individual refused to sign. ❑ A copy was mailed with a request for a signature by return mail. ❑ Unable to communicate with the patient for the following reason:	
Prepared By:	
Signature:	Date:

Directions to Carolina Ear & Hearing Clinic, PC

5900 Six Forks Road, Suite 200
Raleigh, NC 27609-3838
919-876-4327

From Greensboro, Charlotte, Chapel Hill and other points West

- Take **I-40 East**
- Take **Exit 283** to merge onto **I-540 East** toward US-70
- Take **Exit 11** for **Six Forks Road** and **turn right** onto Six Forks Road
- Drive **3.6 miles** to our building is on your **left** immediately after the stoplight at Sandy Forks Road

From Sanford, Apex, Cary and other points Southwest

- Take **US 1 North** to **I-440 East** (US 1 will run into I-440)
- Take **Exit 8B** for **Six Forks Road North** towards North Hills
- Merge onto Six Forks Road North
- **Drive 2.1 miles** to our building on your **right**

From Lumberton, Fayetteville and other points South

- Take **I-95 North**
- Take **Exit 81** to merge onto **I-40 West** toward Raleigh
- Take **Exit 301** for **I-440/US-64 East**
- Take **Exit 8B** for **Six Forks Road North** toward North Hills and turn right onto Six Forks Road
- **Drive 1.9 miles** to our building on your **right**

From Wilmington, Warsaw, Clayton and other points Southeast

- Take **I-40 West**
- Take **Exit 301** for **I-440/US-64 East**
- Take **Exit 8B** for **Six Forks Road North** toward North Hills and turn right onto Six Forks Road
- **Drive 1.9 miles** to our building on your **right**

From New Bern, Goldsboro and other points Southeast

- Take **US-70 West** towards **Raleigh**
- Take the **I-40 West/US 70 West Exit** towards **Garner/Raleigh**
- Take **Exit 301** for **I-440/US-64 East**
- Take **Exit 8B** for **Six Forks Road North** toward North Hills and turn right onto Six Forks Road
- **Drive 1.9 miles** to our building on your **right**

From Greenville, Wilson and other points East

- Take **US-264 West**
- Take **Exit 419** for **I-440 West** towards **US 1/Wake Forest**
- Take **Exit 8B** for **Six Forks Road North** toward North Hills and turn right onto Six Forks Road
- **Drive 1.9 miles** to our building on your **right**

From Roanoke Rapids, Rocky Mount and other points Northeast

- Take **I-95 South**
- Take **Exit 138** to merge onto **US-64 West** towards **Nashville**
- Take **Exit 419** for **I-440 West** toward **US 1/Wake Forest**
- Take **Exit 8B** for **Six Forks Road North** toward North Hills and turn right onto Six Forks Road
- **Drive 1.9 miles** to our building on your **right**

From Henderson, Wake Forest and other points North

- Take **US 1 South**
- Merge onto I**-440 West/US 1 South** via the ramp to **Sanford**
- Take **Exit 8B** for **Six Forks Road North** toward North Hills and turn right onto Six Forks Road
- **Drive 1.9 miles** to our building on your **right**