Pacific ENT Medical Group
6010 Hidden Valley Road, Suite 210
Carlsbad, CA 92011
Phone: (858) 755-9343
Fax: (858) 792-1790

Primary Care Physician _____
Pharmacy _____

Last Name	First Name	MI	Birth Date	Today's Date
Address	City		State	Zip Code
Home Phone	Work Phone	Cell Phone	Sex	Marital Status
Employer's Name	Employers Address, Phone	E-mail		
Emergency Contact	Relationship to patient	Emergency Contact Phone		

Ethnic Classification – Check One: ☐ **Hispanic or Latino** ☐ **Non-Hispanic or Latino** ☐ **Declined** ☐ **Unknown**

Race –Check One: ☐ **American Indian or Alaska Native** ☐ **Asian** ☐ **Black or African American** ☐ **Native Hawaiian or Other Pacific Islander** ☐ **White** ☐ **Declined** ☐ **Unknown**

Language - Please Print Preferred Language:

PLEASE COMPLETE THE FOLLOWING SECTION IF GUARANTOR IS DIFFERENT FROM PATIENT

Guarantor's Last Name	Guarantor's First Name	MI	Relationship to Patient	
Guarantor's Address	City		State	Zip Code
Guarantor's Home Phone	Guarantor's Cell Phone		Birth Date	Gender

Primary Insurance		Secondary Insurance	
Claims Address		Claims Address	
City, State, Zip	Subscriber's DOB	City, State, Zip	Subscriber's DOB
Patient's Relation to Subscriber: Self ☐ Spouse ☐ Child ☐ Other ☐		Patient's Relation to Subscriber: Self ☐ Spouse ☐ Child ☐ Other ☐	

I authorize the release of any medical information necessary to process medical insurance claims for services rendered.

SIGNED_____ **DATE** ____/_____/____
I authorize and request medical insurance benefits to be paid directly to Pacific ENT Medical Group.
SIGNED_____ **DATE** ____/_____/_____

PACIFIC ENT MEDICAL GROUP
MEDICAL HISTORY RECORD
MOSES D. SALGADO, M.D.
HERNAN GOLDSZTEIN, M.D./ SUPRITI PAUL, M.D.

Date:_____ Referring Doctor:_____

Name:_____ Birthdate: _____Age:_____
Last First MI, Suffix Sex: _____Occupation:_____

Reason for present visit:_____

Medical/Surgical History

Please list any significant medical problems or illnesses, past (with dates) or present:
_____
_____
_____
Please list any allergies/reactions to medications (if none, please indicate):
_____
Please list all current medications (include over the counter medications and herbal supplements):
_____
_____
Please list any operations you have had:_____
_____
_____
Please list any serious accidents or injuries:_____

Social History

Do you or have you ever:

Smoked?	N	Y	_____ ppd for____yrs.. Still smoking? _____Quit____
Drink alcohol?	N	Y	Type/amount per week _____Still drinking? ___Quit____
Chewed tobacco?	N	Y	How often? _____Still using? _____Quit____
Abused drugs?	N	Y	Please describe _____Last use____

Family History

Please provide the following information with regard to your relatives:
If living, age, state of health/illnesses; If deceased, age and cause of death

Mother _____
Father _____
Siblings _____
_____
_____
Children _____
_____
_____
Other Family _____

Review of Systems

Please indicate if you recently or routinely experience any of the following symptoms:

If checked, please describe

General

- ☐ Fevers/Chills _____
- ☐ Weight Loss/Gain _____
- ☐ Headaches _____
- ☐ Visual trouble _____
- ☐ Seizures _____
- ☐ Loss of consciousness _____
- ☐ Wheezing _____
- ☐ Shortness of breath _____
- ☐ Cough _____
- ☐ Chest pain _____
- ☐ Abdominal Pain _____
- ☐ Nausea/Vomiting _____
- ☐ Heartburn/Indigestion _____
- ☐ Hepatitis _____
- ☐ Urinary dysfunction _____
- ☐ Psychiatric Disorder _____
- ☐ Muscle weakness _____
- ☐ Stiff joints _____
- ☐ Bleeding tendencies _____
- ☐ Rash or skin disorder _____
- ☐ Other _____

Ear, Nose & Throat

- ☐ Hearing loss _____
- ☐ Ringing in the ears _____
- ☐ Dizziness/Vertigo _____
- ☐ Pain in the Ears _____
- ☐ Ear Discharge _____
- ☐ Nasal Discharge _____
- ☐ Nasal Obstruction _____
- ☐ Nosebleeds _____
- ☐ Sinusitis _____
- ☐ Allergic symptoms (Sneezing/itchy eyes) _____
- ☐ Post Nasal Drip _____
- ☐ Difficulty Swallowing _____
- ☐ Vocal Changes _____
- ☐ Snoring _____

_____ _____

Patient Signature Date

(For internal use)

I have reviewed and confirmed the above with the patient_____

Pacific ENT Medical Group, Inc.

Consent for Diagnostic Tests/Procedures that may be Necessary to Fully Diagnose and Treat Your Condition

Patient Name:_____DOB:_____

Pacific ENT Medical Group physicians are pleased you have chosen them to assist in your care. Our physicians feel that a patient presenting to our office with sinus, allergy, throat, hearing or voice complaints requires a thorough examination of that specific area. In some cases, this can only be accomplished through the use of diagnostic tests/procedures, which your physicians may feel is medically necessary. The tests and/or procedures are separate from the physician's office consultation and thus have a separate charge. Insurance companies may consider the nasal endoscopy and laryngoscopy a "diagnostic procedure" and apply them to your deductible and/or co-insurance. The following lists are the test/procedures that our physicians feel is medically necessary to perform:

- Ear wax Removal
- Control of Nosebleed
- Nasal Endoscopy
- Sinus cleaning ("debridement") after sinus surgery
- Laryngoscopy
- Video Laryngostroboscopy
- Fiberoptic Endoscopic Evaluation of Swallowing(FEES)
- Minor Surgical procedures and/or biopsies
- Ultrasound examination or guided biopsy
- Tympanogram
- Removal of foreign body from ear or nose
- Audiology/Balance Testing

Please note that we collect all co-insurance and unmet deductibles at the time of the visit. Please sign below to acknowledge that you have read the above and understand your financial liability.

Signature:_____Date:_____

Pacific ENT Medical Group, Inc

Financial Policies

Name:_____ **Date of Birth:**_____

Pacific ENT Medical Group appreciates your confidence in choosing us to provide for your health care needs. Services rendered will be your financial responsibility you will assume an obligation to ensure payment in full of our fees. We would like to share our financial policies with you since a clear understanding of our financial policies is an important component of our professional relationship.

Methods of Payment

We will bill your insurance as a courtesy to you with a copy of your current insurance card, which must be presented at each visit. If you do not have your insurance card, payment is due at the time of service. For your convenience, we accept cash, check, and credit cards. Please note that there is a $35 charge for checks returned by the bank for insufficient funds.

Participation with Insurance and Medicare

Pacific ENT Medical Group participates with Medicare, as well as many PPO plans and one HMO plan, which means that we accept assignment of benefits. We do not participate in Medi-Cal (Medicaid). If payment is not received from your insurance carrier within our contract limits, any balance will be your responsibility. If we do not have a contract with your insurance company, you are responsible for payment in full and consider to be Self-Pay. Payment is due at the time of service; we will supply you with a superbill to submit to your insurance company for direct reimbursement.

Medicare: As a Medicare patient, you are responsible for your deductible and for the difference between the approved charge and the amount Medicare pays. If you have supplemental insurance with a company with whom we are contracted, we will bill your secondary insurance for you. Any remaining balance will be billed to you.

PPO Plans: As a component of our contracts, we collect co-payments for every visit. If you have not met your deductible, we collect a deposit toward your services. You will receive a statement for the remaining balance after your insurance plan processes your claim.

HMO Plans: If you are insured through an HMO (Scripps Coastal or Affiliates), a referral is required from your primary care physician. If we do not receive a referral, we will require payment at the time of service. Our Contracted Payers: Aetna, Blue Cross, Blue Shield, Humana, Cigna, Great West, Medicare, United Healthcare, Tricare, First Health, PHCS.

Self-Pay

We offer a 10% discount. All fees are due at the time of service.

No Show Fees

Please note that we may find it necessary to charge a No show fee of $75 if you cancel within 24 hours of your appointed time. We appreciate your calling so that your appointment time can be opened up to someone else in need.

Our Fees

We are committed to provide the best treatment possible for our patients and we charge what is usual and customary for our area. If we do not have a contract with your insurance company, you are responsible for payment in full regardless of any insurance company's arbitrary determination of rates. Co-payments, co-insurance, and deductibles, or unpaid balances are due at the time of serve.

Fees for Completion of Forms

There is a minimum charge of $35 to complete forms such as disability or FMLA forms.

I have read the Financial Policies of Pacific ENT Medical Group, Inc. I understand that it is my responsibility to provide current insurance information at each visit, as required by my insurance provided.

_____ _____

Signature of Patient or Guardian **Date**

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, on our website, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

This office strictly prohibits electronic recording or videotaping of any kind in consideration of the privacy and confidentiality of the physician-patient relationship. We sincerely appreciate your compliance with our request.

□ I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:

_____

Signed: _____ **Date**: _____

Print Name: _____ **Telephone**: _____

If not signed by the patient, please indicate relationship:

□ Parent or Guardian of minor patient

□ Guardian or conservator of an incompetent patient

□ Beneficiary or personal representative of deceased patient

Name of Patient: _____

Address of Patient: _____

Pacific ENT Medical Group, Inc.

6010 Hidden Valley Rd., Suite 210

Carlsbad, CA 92011

Privacy Officer: Jennifer Putman

Ph. 858-755-9343

Patient Contact Information Restriction

The HIPAA privacy rule gives you the right to request a restriction on uses and disclosures of your Protected Health Information.

I wish to be contacted in the following manner (**please check all that apply**):

□ **Home Phone** ( ) _____- _____
- □ Okay to leave message with detailed information
- □ Leave message with callback number only

□ **Cell Phone** ( ) _____- _____
- □ Okay to leave message with detailed information
- □ Leave message with callback number only

□ I hereby consent to the release of my medical information to the people listed below. This authorization will be in effect until I change it.

□ I hereby decline the release of my medical information to anybody. This authorization will be in effect until I change it.

Name	**Relationship**
_____	_____
_____	_____
_____	_____

_____ _____

Signature of Patient or Patients Representative **Date**

_____ _____

Print Patient's Name **Date of Birth**

Consent to Use Telemedicine

Patient's Name_____ My Doctor's Name_____

CONSENT TO USE TELEMEDICINE

I am physically located in California. At the beginning of each telemedicine session, I will help my doctor to complete a check-in to assess the suitability of using telemedicine services by verifying my full name, my current location, my readiness to proceed, and whether I am in a situation conducive to private, uninterrupted communication. By signing this consent, I understand and agree:

1. My doctor is located in and licensed by the State of California. My doctor may not be able to prescribe medications for me and/or may not be able to assist me in an emergency situation when I am located in any other state or country. If I require medication, I may contact my doctor. If I require emergency care, I may call 911 or proceed to the nearest hospital emergency room for help.

2. I submit to the exclusive jurisdiction of the California state superior courts and agree that any claim, lawsuit, or other legal proceeding arising out of or relating to the telemedicine services provided by my doctor and my doctor's staff will be brought solely and exclusively in California state superior courts. I also agree that the interpretation of this consent will be exclusively governed by and construed in accordance with the laws of California.

3. My doctor believes that telemedicine services are appropriate for my medical condition and that I would benefit from its use despite its risks and limitations. While I may expect anticipated benefits from the use of telemedicine, no specific results can be guaranteed or assured.

4. If my doctor believes at any time that another form of services (for example, a traditional in-person consultation) would be appropriate, my doctor may discontinue telemedicine services and schedule an in-person consultation with my doctor or refer me to a healthcare provider in my area who can provide such services.

5. I have the right to withdraw consent to the use of telemedicine services at any time and receive inperson healthcare services with my doctor.

6. I received an explanation of how the electronic communications technology will be used for the telemedicine services. I am comfortable with using electronic communications technology to communicate with my doctor and understand there are limitations to the technology which may require an in-person consultation.

7. I agree to have the necessary computer, equipment and internet access for my telemedicine communications. I also agree to arrange for a location with sufficient lighting and privacy and is free from distractions and intrusions during my telemedicine communications.

8. The laws that protect privacy and the confidentiality of my medical information also apply to telemedicine. The medical information that is transmitted electronically by my doctor to me will be encrypted during transmission and will be stored only by my doctor or a service provider selected by my doctor. I understand the dissemination of any personally-identifiable images or information from the telemedicine communication to researchers or other healthcare providers will not occur except as required by federal or California state law.

9. I understand my risks of a privacy violation increase substantially when I enter information on a public access computer, use a computer that is on a shared network, allow a computer to "autoremember" usernames and passwords, or use my work computer for personal communications. I also understand it is my responsibility to encrypt medical information I transmit electronically to my doctor and my failure to use technical safeguards, such as encryption, increases my risks of a privacy violation.

10. [I agree to be videotaped and recorded during the telemedicine services. I understand the resulting images and audio will become part of my medical record.] OR [No part of the encounter will be recorded without my written consent.]

11. I have the right to access my medical information and obtain copies of my medical records in accordance with California law.

12. I understand that the telemedicine services provided to me will be billed to my health insurance company and that I will be billed for any patient responsibility as per my insurance.

I read and understand the information provided in this Consent to Use of Telemedicine. I discussed any questions I had with my doctor and all of my questions were answered to my satisfaction.

_____ _____

Date Patient's Signature