Pediatric Otolaryngology – ENTs Just For Kids!

A Division of Sound Health Services, P.C.
621 S. New Ballas Road – 622A
St. Louis, MO 63141
314.872.8338 Office **314.872.8399 Fax**

☐ Dr. Randall Clary
☐ Dr. James Forsen

☐ New Patient
☐ Updated Info

PATIENT INFORMATION

Child's Last Name:_____ Child's First Name:_____ MI:_____
Street Address:_____ City:_____ State:_____ Zip:_____
☐ Cell ☐ Home Primary Phone #:_____ ☐ Cell ☐ Home Secondary Phone #:_____ Date of Birth:_____ Sex: M F
Parent 1 Name:_____ Parent 2 Name:_____
Mother / Father / Guardian DOB_____ Mother / Father / Guardian DOB_____
Email:_____ Email:_____
Employer:_____ Employer:_____
Occupation:_____ Occupation:_____
Employment Status: ☐ Full ☐ Part ☐ Student ☐ Other_____ Employment Status: ☐ Full Time ☐ Part Time ☐ Student ☐ Other_____
Primary Care Doctor:_____ Referral Doctor (if different):_____ Reason for referral:_____
Emergency Contact Name and Number:_____
Pharmacy Name, Address, & Phone #:_____
Other family members that are Sound Health Patients:_____
Race (Optional) ☐ Black/African American ☐ Caucasian ☐ Hispanic ☐ Asian/Pacific Islander ☐ More than 1 race ☐ Other
Language: ☐ English ☐ Spanish ☐ Other

INSURANCE INFORMATION

Primary Insurance:_____ Insurance Address:_____
Insured #:_____ Group #:_____ Co-pay $_____
Subscriber's Name: ☐ Same as Parent 1 ☐ Same as Parent 2 ☐ Other_____
Subscriber's Address:_____ City:_____ State:_____ Zip:_____
Home #:_____ Cell #:_____ Work #:_____
Subscriber's Date of Birth:_____ Subscriber's SS #:_____ Sex: M F
Relationship to Patient:_____ Employment Status: ☐ Full Time ☐ Part Time ☐ Student ☐ Other_____
Employer Name & Address:_____
Secondary Insurance:_____ Insurance Address:_____
Insured #:_____ Group #:_____ Co-pay $_____
Subscriber's Name: ☐ Same as Parent 1 ☐ Same as Parent 2 ☐ Other_____
Subscriber's Address:_____ City:_____ State:_____ Zip:_____
Home #:_____ Cell #:_____ Work #:_____
Subscriber's Date of Birth:_____ Subscriber's SS #:_____ Sex: M F
Relationship to Patient:_____ Employment Status: ☐ Full Time ☐ Part Time ☐ Student ☐ Other_____
Employer Name & Address:_____

Responsible Party Information (Person bringing the child into the office)

Name: ☐ Same as Parent 1 ☐ Same as Parent 2 ☐ Other_____
Street Address:_____ City:_____ State:_____ Zip:_____
Home #:_____ Cell #:_____ Work #:_____
Date of Birth:_____ SS #:_____ Relationship to Patient:_____ Sex: M F

I will be paying by: ☐ Cash ☐ Check ☐ Credit Card

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes to the above information. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to the physician unless my account has been paid in full. **I have received Sound Health Services, P.C. notice of privacy practice.**

Responsible Party Signature:_____ **Circle** **Mother / Father** **Date:**_____
Responsible Party Signature:_____ **Mother / Father** **Date:**_____
Responsible Party Signature:_____ **Guardian / Other** **Date:**_____

SOUND HEALTH SERVICES, P.C. | *One Group. Sound Health. Complete ENT Care.*

FINANCIAL AGREEMENT

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. WE WILL REQUEST TO PHOTOCOPY YOUR INSURANCE CARD(S) AND A PHOTO I.D. FOR YOUR FILE.

- **APPOINTMENTS –** 24 hours notice must be provided in the event you cannot keep an appointment. Should you not provide this notice, a cancellation fee up to $35 may then be added to your account. Cancellations for Ancillary Services will have a higher fee.

- **REFERRALS –** If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. It is then your responsibility to provide us with the referral within 48 hours or you will be personally responsible for that day's services.

- **CO-PAYMENTS –** By law we MUST collect your carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit. Should you not pay at the time of service, and we subsequently send you a statement, an administrative fee of $5 may be added to your account. Any procedure performed in this office could be deemed surgical by your insurance company and all copays and deductibles will apply.

- **FMLA AND/OR WORKMAN COMP –** There is a $25.00 charge for completion of Workman Comp or FMLA forms.

- **SURGERY DEPOSITS –** If you and your physician determine that your course of care requires surgery, a surgical deposit will be collected at time of scheduling. Our scheduling coordinators will work with you to determine estimated insurance payment and estimated patient responsibility.

- **OUT OF NETWORK PLANS –** You will be responsible for any balance your plan indicates as due on their explanation of benefits form. We will adjust the charges to coincide with your plan's UCR (Usual, Customary and Reasonable) charges. All patients will be responsible for their co-insurance and deductible. If we do not "participate" with your plan, we will send a courtesy bill to that carrier on your behalf. However, should they not pay your claim within 45 days, you will be responsible for the full amount due. Should you receive payment from your insurance carrier, please forward it to the physician's office.

  > Private Insurance Authorization for Assignment of Benefits/Information Release: I, the undersigned, authorize payment of medical benefits to Sound Health Services, P.C. for any services furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize any holder of medical information about me to release to my insurance company (or the agent) information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

- **SELF-PAY PATIENTS –** Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.

- **MEDICARE –** We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one.

  > Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits to be made on my behalf to Sound Health Services, P.C. for any services furnished to me. I authorize any holder of medical information about me to release to the CMS (and it agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluation and administering claims of benefits.

- **DIVORCED/SEPARATED PARENTS OF MINOR PATIENTS –** The parent who consents to the treatment of a minor child is responsible for payment of services rendered, Sound Health Services, P.C. will not be involved with separation or divorce disputes.

- **INSUFFICIENT FUND CHECKS –** A $25.00 fee will be charged to patient's account for checks returned due to non sufficient funds

- You are responsible for the timely payment of your account. Should it become necessary for us to use an outside agency to collect payment from you, you will be obligated to pay to us, to cover the costs of using a collection agency, an additional amount equal to 30% of your total unpaid balance at the time a collection agency is brought in to collect your account. WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, AMERICAN EXPRESS, DISCOVER OR CARE CREDIT. THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share with us special concerns.

Patient's Name: _____ DOB: _____

Responsible Party Signature:_____ Date:_____

Revised 03/01/2016

SOUND HEALTH SERVICES, P.C. | *One Group. Sound Health. Complete ENT Care.*

AUTHORIZATION FOR RELEASE OF INFORMATION
SOUND HEALTH SERVICES, P.C.

Patient Name: _____ Date Of Birth: _____

I understand that Sound Health Services, P.C. (the "Practice") has certain rights and obligations with regard to my protected health information (information regarding my health and treatment that the Practice may have in its possession). I also understand that I have certain rights with regard to my protected health information.

I authorize the Practice to provide informational reminders regarding upcoming appointments I or my child may have to me or anyone who may answer the telephone. Messages or reminders may be left on any voicemail or answering machine at the numbers I have provided EXCEPT my place of employment **or** at the following telephone numbers:

1. _____
2. _____
3. _____

I authorize the Practice to disclose my protected health information to any of the following persons:
(State name of person and relationship to you – ex. father, grandparent, step parent or other guardian):

1. _____ Relationship: _____
2. _____ Relationship: _____
3. _____ Relationship: _____
4. _____ Relationship: _____

I understand that I may revoke any authorization granted above by written notice signed by me delivered to the Practice's Privacy Official at the address stated below. My authorization remains valid until revoked by me in writing.

I acknowledge receipt of the Practice's Privacy Practices Notice effective September, 23, 2013 regarding the Practice's rights and obligations and my rights regarding my Protected Health Information. I acknowledge that I understand that I have the right to request and receive clarifications, explanations or further information with regard to The Practice's Privacy Practices through written request signed by me addressed to the Practice's Privacy Official.

Sound Health Services, P.C.
Attn: Privacy Official
3860 South Lindbergh
St. Louis, MO 63127

Patient's (or Patient's Parents) Name: _____ Date: _____

Basis of representative's authority to act for patient (ex. – mother, father, step mother, step father, grandparent)

_____

_____

Pediatric Otolaryngology- ENTs Just For Kids!
314.872.8338 Office 314.872.8399 Fax

Patient's Name _____ Patient's Date of Birth _____

WHAT IS **MAIN REASON** FOR YOUR CHILD'S VISIT TODAY? _____

HOW LONG HAS THIS PROBLEM EXISTED? _____

Current Height _____ Current Weight _____

PLEASE CHECK THE BOX BY YOUR CONCERNS

EAR PROBLEMS

- ☐ EAR INFECTION
  # in 6 mos ____
  # in 12 mos ____
- ☐ PROLONGED FLUID IN MIDDLE EAR
- ☐ EAR PAIN
- ☐ EAR WAX
- ☐ EAR DRAINAGE
- ☐ FAILED HEARING TEST
- ☐ HEARING LOSS
- ☐ OTHER_____

NOSE PROBLEMS

- ☐ NASAL BLOCKAGE
- ☐ NASAL DRAINAGE
- ☐ HEADACHE
- ☐ REPEATED SINUS INFECTIONS
- ☐ MOUTHBREATHING
- ☐ NOSEBLEEDING
- ☐ THROAT-CLEARING/COUGH
- ☐ OTHER_____

THROAT/MOUTH/NECK PROBLEMS

- ☐ SORE THROATS
  # in 12 mos _____
- ☐ HOARSENESS/VOICE PROBLEMS
- ☐ SPEECH DELAY
- ☐ TONGUE TIE
- ☐ SWALLOWING PROBLEMS/POOR FEEDING
- ☐ COUGH
- ☐ SNORING
- ☐ NOISY BREATHING
- ☐ MASS IN NECK
- ☐ OTHER_____

OTHER PROBLEMS: _____

_____

PAST MEDICAL PROBLEMS/HOSPITALIZATIONS: Include dates of admission: _____

_____

SURGICAL HISTORY: List procedure, dates, surgeon: _____

_____

PAST ENT HISTORY: List reasons and dates of admission: _____

_____

PAST ENT SURGERIES: List procedure, dates, surgeon: _____

_____

MEDICATIONS: Please list name, strength, how often taken.

Amoxicillin	Augmentin	Bactrim	Biaxin	Ceclor	Cedax
Ceftin	Cefzil	Cindamycin	Erythromycin	Omnicef	Pedizole
Rocephin	Sepira	Suprax	Vantin	Zithromax	Rocephin

CURRENT:_____

_____

PAST 6 MONTHS: _____

ALLERGIES TO MEDICATIONS: List drug name and reactions (rash, swelling, shock)

_____

Pediatric Otolaryngology- ENTs Just For Kids!
314.872.8338 Office 314.872.8399 Fax

OTHER ALLERGIES: List names and reactions (rash, swelling, shock)

_____

SOCIAL HISTORY: Check all that apply

Smokers in the house? (even if they do not smoke inside) ☐ Yes ☐ No

Who has legal custody of child? _____

Are they also responsible for 100% of medical decision making? ☐ Yes ☐ No ☐ Other_____

Child lives with: ☐ Both Parents ☐ Mom ☐ Dad ☐ Grandparents ☐ Other family/relatives ☐ Foster Family

Parents are: ☐ Married ☐ Not Married ☐ Separated ☐ Divorced

Does your child attend: ☐ Daycare ☐ Preschool Grade in School? _____

Number of brother/sisters:_____

Pets in the home? ☐ Yes ☐ No ☐ Dog ☐ Cat ☐ Other_____

FAMILY HISTORY: Check **ALL** that apply for brothers, sisters, parents, grandparents.

Unknown Family History—Child Adopted? ☐ Yes ☐ No

	Father	Mother	Brother	Sister	Paternal Grandparents	Maternal Grandparents
Problems with Anesthesia						
Problems with Bleeding						
Seizures						
Heart Disease (Specific)						
Kidney Disease						
Allergies						
Asthma						
Hearing Loss						
Sudden Death						

REVIEW OF OTHER CURRENT PROBLEMS: Please circle **YES** or **NO** for these problems.

Fever	**YES**	**NO**	Heart Murmur	**YES**	**NO**	Anxiety	**YES**	**NO**
Weight Loss	**YES**	**NO**	Wheeze	**YES**	**NO**	Increased Bleeding	**YES**	**NO**
Eye Drainage	**YES**	**NO**	Indigestion	**YES**	**NO**	Increased Infection	**YES**	**NO**
Headache	**YES**	**NO**	Rash	**YES**	**NO**			
Dental Problems	**YES**	**NO**	Depression	**YES**	**NO**			

ALERTS: Please circle **YES** or **NO** for these problems.

Allergy to Iodine	**YES**	**NO**
Allergy to Latex	**YES**	**NO**
Allergy to Adhesive	**YES**	**NO**

Other medical problems:_____