Greater Philadelphia
Ear Specialists, P.C.

Dear Patient:

We welcome you as a patient and appreciate the opportunity to provide you medical care. Enclosed you will find our financial policy and forms which must be completed prior to your arrival in our office. For your convenience, these forms may be completed electronically on our patient portal (*preferred method*), or downloaded from our website and completed by hand. **All new patient paperwork must be complete and submitted to the office at least 2 days prior to your visit**. This can be accomplished electronically (via patient portal), submitted by email to *info@GreaterPhillyEar.com*, faxed to *(215) 422-3818*, or dropped off at the reception desk in person.

Our office participates with most major healthcare insurance plans. If a referral is required for your visit, we recommend that you contact your Primary Care Physician (PCP) as soon as possible. If your referral has not been received in our office, you may be asked to reschedule. Co-Payment is due on the date of service.

We try our best to maintain an efficient office schedule and to avoid any unnecessary delays or the need to reschedule. We ask for your assistance in the following:

- Plan to arrive 15 minutes early
- Contact your insurance company to verify coverage for your visit
- Complete and submit the enclosed forms at least 2 days prior to your visit
- Bring copies of your medical records/x-ray films or disks if available
- Bring your current insurance card
- Bring your photo ID (driver's license) or other form of identification
- Name, address, phone, fax, for your Primary Care Physician and/or referring physician for correspondence
- Co-Payment due at the time of service (we accept cash, check, Mastercard, Visa, Discover, American Express)

We look forward to meeting you at your upcoming visit!

Office Location:
768 N. Bethlehem Pike, Suite 300
Ambler, PA 19002

Sincerely,

Sean P. Larner, D.O
and Staff

Greater Philadelphia Ear Specialists, P.C.

Date:
Patient Name:
Account Number:
DOB:

Name: _____ Date of Birth: _____Age: _____ Sex: _____

Address: _____

Cell Phone: _____Home Phone: _____ Primary Language_____

Email Address: _____ Race: _____ Ethnicity_____

Referring Doctor Name: _____ Referring Doctor Phone: _____

Primary Doctor Name: _____ Primary Doctor Phone: _____

Primary Pharmacy Name: _____Primary Pharmacy Phone: _____

Secondary Pharmacy Name: _____Secondary Pharmacy Phone: _____

Mail Order Pharmacy Name: _____ Mail Order Pharmacy Phone_____

Medical Insurance Information

(Please bring your health insurance cards and photo ID to your appointment)

Primary Insurance Company Name: _____

Policy Number: _____ Group Number: _____

Policy Holder/Subscriber Name: _____

Policy Holder/Subscriber Date of Birth: _____ Relationship to Policy Holder: _____

Secondary Insurance Company Name: _____

Policy Number: _____ Group Number: _____

Policy Holder/Subscriber Name: _____

Policy Holder/Subscriber Date of Birth: _____ Relationship to Policy Holder: _____

Is this a ☐Workman's Comp or ☐Motor Vehicle Accident Injury? (please check)

Date of Injury: _____ Claim Number: _____

Patient Name: _____ Insurance Carrier: _____

Adjustor Name: _____Adjustor Phone Number: _____

Insurance Address: _____

Insured's Name: _____ Date of Birth: _____ Relationship: _____

If Workman's Comp, Employer's Name: _____

Greater Philadelphia Ear Specialists, P.C.

Date:
Patient Name:
Account Number:
DOB:

Employer's Address: _____

Patient's Name: _____

Reason for Visit: (*please be specific*): _____

When did the complaint start: _____

Accident? ☐Yes ☐NoIf yes, please provide a summary: _____

Were studies done? ☐Yes☐ No If yes, when, and where_____

What studies were done? ☐X-Ray ☐CT scan ☐MRI ☐Other _____

Do you have any medication allergies? ☐Yes ☐ No

If yes, please list all medication allergies: _____

_____

Please list all environmental allergies: ex: Food? Seasonal? Animals?

_____

_____

Current Medications

If you are not taking any prescription medications, please check this box ☐

List all Prescription Medications you are taking – If you need more room, please list them on a separate sheet.

Drug Name	Dosage	Frequency/How it is Taken

Greater Philadelphia Ear Specialists, P.C.

Date:
Patient Name:
Account Number:
DOB:

Personal and Family Health History

If you or an immediate family member has any of the following medical problems, please put S= Self, M=Mother, F=Father, SI = Sister, B=Brother, D=Daughter, SO= Son. If no history, leave the space(s) blank.

Medical Problem	S= Self, M=Mother, F=Father, SI = Sister, B=Brother, D=Daughter, SO= Son
Mellitus	
Type 1 – Insulin Dependent	
Type 2 – Non-Insulin	
High Blood Pressure	
Heart Attack	
Heart Disease	
Stents	
Cancer (Type)	
Asthma	
Emphysema	
Other Lung Disease	
Neuromuscular	
MS	
Reflux	
Hernia (type)	
Glaucoma	
Seizures	
Aids/HIV	
Clotting Procedures	
Hepatitis	
Cirrhosis	
Arthritis	
Sarcoidosis	
Lupus	
Gout	
High Cholesterol	
Overactive Thyroid	
Underactive Thyroid	
Other: Please List all other medical problems	

Social History

Current Tobacco User ☐ Yes ☐ No If yes, how many? # Per day: _____ # per week: _____

If former Tobacco User – How long? _____

Alcohol Intake ☐ Never ☐ Occasionally ☐ Daily How Much? _____

Greater Philadelphia Ear Specialists, P.C.

Date:
Patient Name:
Account Number:
DOB:

Surgical History

Please list any surgeries (Dates and Procedures): _____

_____

_____

_____

_____

Greater Philadelphia Ear Specialists, P.C.

Date:
Patient Name:
Account Number:
DOB:

Patient Financial Policy • Consent to Treatment • Assignment of Benefits

Thank you for choosing Greater Philadelphia Ear Specialists for your care. Our priority is to ensure that you receive the highest quality treatment for your health needs. Therefore, if you have questions or concerns about our policies, please ask us during your visit or contact us at 215-383-1333.

Insurance Information
We participate with most insurance providers. If we do not participate with your insurance company, payment is due in full at the time of service, or we may recommend that you contact your insurance company for a participating provider. All insured patients are required to sign the assignment of benefits statement for payment from the insurance company. We will submit your claim to participating insurance companies on your behalf. Patients are responsible for informing us of any changes to their insurance coverage. In some cases, benefits cannot be confirmed until the insurance company processes the claim.

After your insurance company has settled the claim, you will be billed for any noncovered services, copays, deductibles and/or coinsurance. You will receive a statement for any outstanding balance if you are no longer covered by your insurance plan. Accounts not paid within 90 days will be considered delinquent and may be referred to a collection agency or attorney. In the event your account is turned over for collection, you will be responsible for all reasonable collection and court costs at the time the account is considered delinquent.

Certain insurance plans require a referral, precertification or prior authorization for services. Please check with your plan prior to your visit. If a required referral, precertification or authorization is not on file at the time of the visit, the appointment could be rescheduled, or you may be responsible for all charges incurred on this date.

It is your responsibility to know your plan benefits. Contact your insurance company directly with any questions about coverage. Workers' compensation or auto insurance may require additional documentation. We will make reasonable efforts to bill these carriers; however, if the required information is not provided, or if coverage is exhausted or disputed, you will be responsible for payment at the time of service.

Payments at Time of Service
All copays and out-of-pocket charges are due at time of service. We accept most major credit cards, cash, checks, and money orders. Returned checks will incur a $25 fee, and repayment must be made with cash or credit card.

Specialty Services
Greater Philadelphia Ear Specialists is a medical and surgical subspecialty practice dedicated to the treatment of ear disease, hearing loss and vestibular disorders. We offer in-depth testing to better evaluate, diagnose, and treat these conditions. One or more of the following procedures may be performed at your appointment. Insurance companies consider these tests a surgical procedure, and are billed in addition to your office visit. Your insurance may apply additional charges in the form of copay, coinsurance, and/or deductible.

The following list is not all-encompassing, but includes the most commonly encountered otology, audiology, and vestibular office procedures:

Otology

- 92504: Microscopic ear examination
- 69210: Removal of impacted cerumen
- 69433: Tympanostomy requiring insertion of ventilation tube (topical or local anesthesia)
- 69801: Labyrinthotomy, with perfusion of vestibuloactive drug(s), transcanal
- 31231: Nasal endoscopy; diagnostic (unilateral or bilateral)
- 31575: Laryngoscopy, flexible fiberoptic; diagnostic

Audiology

- 92557: Comprehensive audiometry threshold and speech recognition
- 92550: Tympanometry and acoustic reflex threshold testing

- 92587 or 92588: Distortion product evoked otoacoustic emissions (limited or comprehensive)

Vestibular

- 92540: Videonystagmography (VNG) testing
- 92537: Caloric vestibular testing (bilateral, bithermal)
- 92584: Electrocochleography (ECoG)
- **92517:** *Vestibular evoked myogenic potential (VEMP) testing; cervical (cVEMP)*

Consent to Call, Email and Text
I understand and agree that Greater Philadelphia Ear Specialists, P.C. may contact me using automated calls, emails and/or text messaging. These communications may notify me of appointment reminders, preventative care, test results, treatment recommendations, outstanding balances or any other communications from Greater Philadelphia Ear Specialists, P.C. I understand that I may opt out of receiving such communications by informing my providers front desk or scheduling staff. This consent and authorization will remain fully effective until it is revoked in writing. You have the right to discontinue services at any time. I certify that I have read and understand the above statements.

General Consent to Care
I, the undersigned, for myself, a minor child or another person for whom I have the authority to sign, hereby consent to medical treatment, as ordered by a provider, for which such medical treatment is provided through Greater Philadelphia Ear Specialists, P.C. This consent includes my consent for all medical services rendered under the general or specific instructions given by, the physicians/providers who treat me while I am a patient. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations.
You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any tests ordered for you. If you have concerns regarding any test or treatment recommended by your provider, we encourage you to ask questions.

Patient Acceptance
I have read and understand the above policies and have had the opportunity to ask questions. This acknowledgment will be in force unless revoked in writing.

Patient Signature: _____ Date: _____

Assignment of Benefits
I hereby guarantee payment of all charges incurred at the office of Greater Philadelphia Ear Specialists, P.C. I hereby assign and direct to pay all benefits for medical services under this claim directly to Greater Philadelphia Ear Specialists, P.C. I hereby authorize the release of any medical information requested by the insurance companies. I give permission to Greater Philadelphia Ear Specialists, P.C. to appeal on my behalf. I also understand and agree this Assignment of Benefits will continue for as long as I am being treated or cared for by the organization and will constitute a continuing authorization, maintained on file, which will authorize and allow for direct payment to the organization of all applicable and eligible coverage benefits for all subsequent and continuing treatment, services, supplies and/or care provided. I also realize that I am responsible for paying any noncovered services, copayments, deductibles or coinsurance amounts due.

Patient Name: _____ Date of Birth: _____

Patient's Signature: _____ Date: _____

Greater Philadelphia Ear Specialists, P.C.

Date:
Patient Name:
Account Number:
DOB:

HIPAA Release Authorization

I, _____, acknowledge that as part of my medical care, this practice creates and maintains health records that include my medical history, symptoms, examination results, diagnostic findings, treatments, and future care plans. I understand that these records are maintained for the following purposes:

- Coordinating and planning my care and treatment
- Supporting communication among the healthcare professionals involved in my care
- Providing information needed for accurate billing of my medical services
- Confirming to third parties that services billed were actually provided
- Assisting with quality review and evaluation of healthcare provider performance

A Summary of the Notice of Privacy Practices is posted on the Greater Philadelphia Ear Specialists website. The complete Notice of Privacy Practices is also available in the main lobby for review. I understand that if a copy of the Summary or complete Notice is requested, these are available and may be obtained at the front desk.

I acknowledge that Greater Philadelphia Ear Specialists, P.C. has made its Notice of Privacy Practices available to me for review, which explains in detail how my health information may be used or disclosed. I also understand that this practice does not use health information for directory purposes.

I understand that I have the following rights:

- To review the Notice of Privacy Practices before signing this authorization
- To request limitations on how my health information is used or disclosed for treatment, payment, or healthcare operations (although Greater Philadelphia Ear Specialists, P.C. is not obligated to accept such limitations)
- To revoke this authorization in writing at any time, except where Greater Philadelphia Ear Specialists, P.C. has already acted in reliance on it

I also understand that Greater Philadelphia Ear Specialists, P.C. reserves the right to amend their Notice of Privacy Practices. If this Notice is changed, a revised copy may be obtained by contacting the office.

I request the following restrictions on the use or disclosure of my health information:

_____

I authorize the following individuals to access my medical records/information:

1. _____ Relationship: _____
   (FIRST & LAST NAME) (Date of Birth)

2. _____ Relationship: _____
   (FIRST & LAST NAME) (Date of Birth)

3. _____ Relationship: _____
   (FIRST & LAST NAME) (Date of Birth)

By signing below, I confirm that I understand and agree to the terms of this authorization:

Signature: _____ Date: _____

Greater Philadelphia Ear Specialists, P.C.

Date:
Patient Name:
Account Number:
DOB:

Dizziness Handicap Inventory (DHI) – Short Form

Please answer 'Yes', 'Sometimes', or 'No' for each item below.

1. Does looking up increase your problem?
   ☐ Yes ☐ Sometimes ☐ No

2. Because of your problem, do you feel frustrated?
   ☐ Yes ☐ Sometimes ☐ No

3. Does walking down the aisle of a supermarket increase your problem?
   ☐ Yes ☐ Sometimes ☐ No

4. Because of your problem, do you have difficulty getting into or out of bed?
   ☐ Yes ☐ Sometimes ☐ No

5. Does your problem significantly restrict your participation in social activities?
   ☐ Yes ☐ Sometimes ☐ No

6. Because of your problem, do you have difficulty reading?
   ☐ Yes ☐ Sometimes ☐ No

7. Does performing more ambitious activities such as sports or household chores increase your problem?
   ☐ Yes ☐ Sometimes ☐ No

8. Because of your problem, are you afraid people may think you are intoxicated?
   ☐ Yes ☐ Sometimes ☐ No

9. Because of your problem, is it difficult for you to concentrate?
   ☐ Yes ☐ Sometimes ☐ No

10. Because of your problem, do you feel handicapped?
    ☐ Yes ☐ Sometimes ☐ No

Greater Philadelphia Ear Specialists, P.C.

Date:
Patient Name:
Account Number:
DOB:

Hearing Handicap Inventory (HHI) – Short Form

Please answer 'Yes', 'Sometimes', or 'No' for each item below.

1. Does a hearing problem cause you to feel embarrassed when meeting new people?
   ☐ Yes ☐ Sometimes ☐ No

2. Does a hearing problem cause you to feel frustrated when talking to family members?
   ☐ Yes ☐ Sometimes ☐ No

3. Do you feel handicapped by a hearing problem?
   ☐ Yes ☐ Sometimes ☐ No

4. Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?
   ☐ Yes ☐ Sometimes ☐ No

5. Does a hearing problem cause you difficulty in the movies or theater?
   ☐ Yes ☐ Sometimes ☐ No

6. Does a hearing problem cause you to feel frustrated when listening to TV or radio?
   ☐ Yes ☐ Sometimes ☐ No

7. Does a hearing problem cause you to have arguments with family members?
   ☐ Yes ☐ Sometimes ☐ No

8. Does a hearing problem make you feel left out during social activities?
   ☐ Yes ☐ Sometimes ☐ No

9. Does a hearing problem cause you to feel stressed when talking to strangers?
   ☐ Yes ☐ Sometimes ☐ No

10. Does a hearing problem cause you to feel limited in personal/social life?
    ☐ Yes ☐ Sometimes ☐ No

Greater Philadelphia Ear Specialists, P.C.

Date:
Patient Name:
Account Number:
DOB:

Fall Risk Screening Questionnaire

Please answer the following questions to help us assess your risk of falling.

1. Have you fallen in the past year? ☐Yes ☐No
2. If yes, how many times? _____
3. Were you injured in any of your falls? ☐Yes ☐No
4. Do you feel unsteady when standing or walking? ☐Yes ☐No
5. Do you worry about falling? ☐Yes ☐No