



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 other forms which must be completed prior to your arrival in our office. For your convenience, these forms may be completed electronically via the **Pre-Check In** feature of our electronic medical record - MEDENT™ (*preferred method*). You should receive an email and/or text with a link to these forms after scheduling your appointment.

Alternatively, these forms may be downloaded from our website, printed, and completed on paper. *If completed on paper*, all documents must be submitted by email to info@GreaterPhillyEar.com, faxed to (215) 422-3818, or dropped off at the office reception desk **at least 2 days prior to your visit**.

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 all **Pre-Check In** forms 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
- Co-Payment is due at the time of service (we accept cash, check, Mastercard, Visa, Discover, and 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

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: _____

Does your visit relate to a Motor Vehicle Accident Injury? ☐ Yes ☐ NoIf yes, please provide:

Date of Injury: _____ Claim Number: _____

Patient Name: _____ Insurance Carrier: _____

Adjustor Name: _____ Adjustor Phone Number: _____

Insurance Address: _____

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



Date:
Patient Name:
Account Number:
DOB:

Does your visit involve a Workman's Comp claim? ☐ Yes ☐ No

If yes, please provide:

Employer's Name: _____

Employer's Address: _____

Patient's Name: _____

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

When did the complaint start: _____

Accident? ☐ Yes ☐ No If 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 _____

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

AllergiesDo you have any medication allergies? ☐ Yes ☐ NoIf yes, please list all medication allergies: _____
_____**Past Medical History****Do you have, or have you ever had...?**☐ Yes ☐ No Heart Disease (heart attack, angina, heart surgery, arrhythmia)☐ Yes ☐ No Diabetes☐ Yes ☐ No Lung Disease (Asthma, COPD, emphysema, etc.)☐ Yes ☐ No Hypertension (High Blood Pressure)☐ Yes ☐ No Hypothyroidism (Underactive Thyroid)☐ Yes ☐ No Hyperthyroidism (Overactive Thyroid)☐ Yes ☐ No Kidney Problems☐ Yes ☐ No Cancer☐ Yes ☐ No Liver Disease☐ Yes ☐ No Head Trauma☐ Yes ☐ No Stroke or TIA☐ Yes ☐ No Migraine Headaches☐ Yes ☐ No Seizure☐ Yes ☐ No Anxiety Disorder☐ Yes ☐ No Depression☐ Yes ☐ No Panic Attacks☐ Yes ☐ No Arthritis☐ Yes ☐ No Glaucoma☐ Yes ☐ No Macular Degeneration☐ Yes ☐ No Bleeding Disorder (Hemophilia, Platelet Disorder, etc.)☐ Yes ☐ No Other: _____



Family History

Have any immediate family members had any of the following medical problems...?

(Include relationship to you (i.e. Mother, Father, Sister, Brother, Daughter, Son))

- | | |
|--|---|
| ☐ Epilepsy (Seizures) _____ | ☐ Diabetes _____ |
| ☐ Heart Disease _____ | ☐ Cancer _____ |
| ☐ Migraine _____ | ☐ Thyroid Problems _____ |
| ☐ Stroke _____ | ☐ Hearing Loss _____ |
| ☐ Mental Illness _____ | ☐ Anemia _____ |
| ☐ High Blood Pressure _____ | ☐ Glaucoma _____ |
| ☐ Bleeding Disorder _____ | |

Social History

- Do you smoke? ☐ Yes ☐ No *If yes:* ☐ Cigarettes ☐ Cigars
- How many... Per day: _____ Per week: _____
- Former Smoker? ☐ Yes ☐ No *If yes, when did you quit?* _____
- Do you drink alcohol? ☐ Yes ☐ No
- If yes, how many drinks...* Per day: _____ Per week: _____

Surgical History

Have you had surgery in the past? ☐ Yes ☐ No

If yes, please list prior procedures: _____

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.

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 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 Name: _____

Date of Birth: _____

Patient's Signature: _____

Date: _____

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: _____