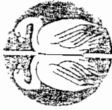

Head & Neck Specialty Group of New Hampshire

John M. O'Day, M.D., F.A.C.S.
Marjorie K. Stock, M.D., F.A.C.S.

361 High Street
Somersworth, NH 03878-1407
Phone: 603-692-4500
Fax: 603-692-4520

Otolaryngology
Head and Neck Surgery
Facial Plastic and Reconstructive Surgery
Allergy
Audiology
Hearing Aids

I. Patient Information

Appointment Date:________

Name: Last ____________________First ____________________Middle Initial____

Birthdate: ____________Physician you are seeing today: ______________________

Address: Street ____

City__________________________State______________Zip_________

Home phone: ___________________________Work phone: ___________________

E-Mail Address_________________________ (For updates regarding new services)

May we call you at work? __Y, __N Can we leave a message for you at work? __Y, __N

Social Security#: ____________________________

Employer: ____

Referred by: _______________________Primary Doctor: ____________________

Preferred Pharmacy (please list town): ______________________________________

Primary Care Physician's Hospital: ____

II. Insurance Information

Name of Primary Insurance Policy Holder:_______________________________

Name of Primary Insurance:____

ID#________________________________Group #: _______________________

Birthdate:___________________________Home Phone:______________________

Social Security #:_____________________Work Phone:______________________

Address:____

Employer:____

Name of Secondary Insurance Policy Holder:_____________________________

Name of Secondary Insurance:_______________________________________

ID#:________________________________Group#:________________________

Birthdate:_____________________________

Social Security:_________________________

Relationship of person bringing patient in today:_______________________________

Contact in case of an emergency: ____

Phone #: ______________________Relationship: ___________________________

Please list BELOW any family member or other person who may call and request information regarding the above patient.

PERSONAL DATA SHEET

Name: ______________________________________ Appointment Date: ____________
Date of Birth: _________________________________ Occupation: __________________
Married: __Y, __N Children: __Y, __N
Alcohol use: __never, __less than one a week, __1-2 drinks a week, __daily drink or two, __more than 2 drinks a day
Tobacco use: __Y, __N If yes, how much? ____, how many years? _____

Allergies: __pollen, __food __animal, __latex, __chemicals (please list)

____

____

Medication allergies: ____

Do you have any bleeding problems or take any of the following medications: Aspirin, Motrin, Advil, Ibuprofen, Aleve, Ticlid, Coumadin, Warfarin, any prescription arthritis medication? __Y, __N If yes, what? ______________________________________

Hospitalizations and Surgeries (please list hospital, date, and doctor): _______________

____

____

____

____

Active Medical Problems (anything you see a doctor for regularly or take medication for): ____

____

Do you have, or have you ever had:

__heart disease	__liver disease	__kidney disease	__diabetes
__bleeding problem	__stroke	__seizure	__thyroid disease
__mono	__eczema	__yellow jaundice	__rheumatic fever
__pneumonia	__emphysema	__measles	__German measles
__tuberculosis	__mumps	__chicken pox	__syphilis
__Zoster/shingles	__Bell's Palsy	__ear surgery	__cancer
__asthma	__glaucoma	__hypertension	__heartburn
__prostate enlargement	__anesthesia problems		__HIV disease

Please list all medications you currently take with the dose and times per day: ***This includes herbal, vitamins and all non-prescription products and supplements.**

____

____

____

____

____

Medical problems that run in your family (refer to the list above): __________________

____

____

What are you seeing the doctor for today? ____

Patient's Name: ______________________ Today's Date: ______________

EAR, NOSE, THROAT AND ALLERGY QUESTIONNAIRE

Do you have any of the following problems:

EARS:	Yes:______	No:_______
Hearing difficulty:	Right side: ______	Left side: ______
Ringing in ears:	Right side: ______	Left side: ______
Discharge:	Right side: ______	Left side: ______
Pain:	Right side: ______	Left side: ______
Dizziness:	Yes: ______	No: ______

NOSE:	Yes: ______	No: ______
Unable to breathe through:	Right side: ______	Left side: ______
Bleeding:	Right side: ______	Left side: ______
Discharge:	Right side: ______	Left side: ______
Previously broken:	Yes: ______	No: ______
Problems occur in different seasons:	Yes: ______	No: ______
Snore:	Yes: ______	No: ______
Stops breathing at night:	Yes: ______	No: ______

THROAT:	Yes: ______	No: ______
Hoarseness:	Yes: ______	No: ______
Difficulty swallowing:	Yes: ______	No: ______
Coughing up or spitting up blood	Yes: ______	No: ______
A lump in the throat:	Yes: ______	No: ______
A lump in the neck:	Yes: ______	No: ______
Painful throat or neck:	Yes: ______	No: ______

HEAD & NECK SPECIALTY GROUP – OFFICE FINANCIAL POLICY

If you have medical insurance, we will be happy to bill most insurance companies if you provide our office with all the necessary information. Any balance, however, is ultimately your responsibility. Your co-payment or co-insurance is due at the time of your visit. If you have no insurance, payment in full is expected at the time of your visit. We accept cash, checks, MasterCard, Visa and Discover.

MEDICAL INSURANCES:

We participate with the following insurances: **Anthem BCBS/Matthew Thornton, Cigna HealthCare, EBPA, Heathcare Value Management, PHCS, Harvard Pilgrim, Martins Point. Tricare-(Standard only), Medicare, NH Medicaid.**

For other insurance companies that we do not participate with, we will make a reasonable effort to bill. However, there may not be any benefits or there may be limited benefits for services by our physicians. Please be advised that it is your (the patient's or insured's) responsibility to contact your insurance company to see what your plan covers prior to treatment. In cases of liability, we do not bill third party insurances or attorneys; payment in full is expected at the time of your visit.

If your insurance has not paid within 60 days, the balance will become your responsibility and we recommend that you contact your insurance company.

MANAGED CARE INSURANCES:

As a specialty practice, our physicians are not authorized to provide services for patients with managed care insurance without authorization from their primary care physician. The exception to this would be if your insurance includes a Point of Service or Option 2 plan, which allows you to choose treatment without a referral. In this case, you need to notify our office that you have chosen this option (if applicable). For all other HMOs, please be advised that it is your (the patient's or insured's) responsibility to make certain a referral authorization has been received in our office prior to your appointment or bring your referral with you at time of appointment. If you do not have the referral with you or the referral is not in our office the day of your appointment, you will be responsible for any charges denied by your insurance for no referral.

ADDITIONAL INFORMATION:

You will receive two separate bills for x-rays, one from Head & Neck Specialty Group for the technical component and one from Associates in Radiology for the reading of the x-ray.

If your insurance company requires that you provide them with a signed claim form or accident details, it is your responsibility to do so. Failure to respond to requests from your insurance company will result in the balance becoming your responsibility.

In cases of divorced or separated parents, our policy is that the parent bringing the child into our office for services must be responsible for any balance.

I hereby authorize **Head & Neck Specialty Group** to furnish my health information for purposes relating to treatment, payment, and health care operations, and I hereby assign to **Head & Neck Specialty Group** all payments for medical services rendered. I understand and agree that, regardless of my insurance status, I am ultimately responsible for my account for any professional services rendered. I have read the information in this OFFICE FINANCIAL POLICY and verify that all insurance information is true and correct to the best of my knowledge.

I hereby agree to consultation with Head & Neck Specialty Group and agreed-upon treatment. I understand that this signature is valid for any treatment for the duration of one year.

Patient Signature: ______________________________ Date: ____________________

Parent Signature (if patient is a minor): ______________________________ Date: ____________

Parent Social Security Number (if patient is a minor): ______________________________

HEAD & NECK SPECIALTY GROUP OF NH
SUMMARY JOINT NOTICE OF HEALTH INFORMATION PRACTICES

We are required by federal law to provide a Joint Notice of Privacy Practices that describes how health information that we maintain about you may be used or disclosed. The Joint Notice describes each use and disclosure that we are permitted to make, and provides a description of your rights and our obligations under federal and state privacy laws.

When this Summary Joint Notice refers to "we" or "us", it is referring to Head & Neck Specialty Group.

USES AND DISCLOSURES

We are permitted to use and disclose your health information under a variety of circumstances. Sometimes we must obtain your authorization before we use or disclose that information, but in other circumstances, we may use your information without your authorization and without informing you of the use or disclosure. Some of the reasons that we may use or disclose your information include:

- to provide information about your health condition to others who may treat you;
- to provide information about the treatment that we provided in order to obtain payment from your health plan
- to report a communicable disease, domestic violence or criminal activity; or
- to comply with a court order requiring the disclosure of your medical record.

These examples are merely illustrative. For a full description of the uses and disclosures that we are permitted to make, consult the Joint Notice of Privacy Practices.

YOUR RIGHTS

While the records that we maintain about you belong to us, under the federal privacy law you have a variety of rights with respect to the information maintained in those records. For instance, you have the right to access and receive a copy of the health information that we maintain about you and to request that we amend any of the information that you believe is incomplete or incorrect. Also, you may request that we provide you with a list of each disclosure that we have made of your health information. All of these rights are subject to some exceptions that are described fully in the Joint Notice.

OUR OBLIGATIONS

We are required to provide you with our Joint Notice of Privacy Practices and to abide by its terms. We may amend the Joint Notice from time to time. All amendments apply retroactively.
A copy of our full Joint Notice of Privacy Practices is available upon request. Please read it carefully. If you have any questions or require additional information, please contact:

Joyce M. O'Day RN, Office Manager
361 High Street
Somersworth, NH 03878
603-692-4500

ACKNOWLEDGMENT OF RECEIPT OF JOINT NOTICE OF PRIVACY PRACTICES

I have received a copy of the Joint Notice of Privacy Practices. The Joint Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Joint Notice may be changed at any time. I may obtain a revised copy of the Joint Notice by calling Laurie Seavey at 603-692-4500 or by requesting one at the office.

____
(Please Print your Full Name)

______________________________ ____/____/____
(Signature) (Date)

As the representative of the above individual, I acknowledge receipt of the Joint Notice on his or her behalf.

______________________________ ______________________________
(Please Print your Name) (Relationship)

______________________________ ____/____/____
(Signature) (Date)