Medical History Form

Patient Name: _____ M/F DOB: _____

DRUG ALLERGIES/REACTIONS: _____

MEDICATIONS CURRENTLY TAKING: _____

_____

PHARMACY NAME: _____ **CROSS STREETS/LOCATION:** _____

Patient Medical History

☐ **No significant Medical History**

Yes	☐	Acute Myocardial Infarction (Heart Attack)	Yes	☐	Hearing Loss
Yes	☐	Allergic rhinitis	Yes	☐	Hypercholesterolemia (High Cholesterol)
Yes	☐	Alzheimer's Dementia	Yes	☐	HIV
Yes	☐	Anemia	Yes	☐	Hypertension (High Blood Pressure)
Yes	☐	Arthritis	Yes	☐	Migraine Headache
Yes	☐	Cataract	Yes	☐	Osteoporosis
Yes	☐	**Cancer**	Yes	☐	Psychiatric Disorders
Yes	☐	Breast Cancer	Yes	☐	**Respiratory Disorders**
Yes	☐	Lung Cancer	Yes	☐	Asthma
Yes	☐	Prostate Cancer	Yes	☐	Tuberculosis
Yes	☐	Thyroid Cancer	Yes	☐	COPD
Yes	☐	Coronary Artery Disease	Yes	☐	Seizure Disorder
Yes	☐	Diabetes Mellitus	Yes	☐	Sleep Apnea
Yes	☐	GERD	Yes	☐	Stroke
Yes	☐	Glaucoma	Yes	☐	Thyroid Disorders
Yes	☐	Gout	Other:		
Yes	☐	**Hepatic Disorder**			
Yes	☐	Hepatitis A			
Yes	☐	Hepatitis B			
Yes	☐	Hepatitis C			

***** Please have your medication list ready for the medical staff. Thank you!**

Boulder Valley Ear Nose and Throt Assoc., P.C.

EMR Entered _____

Surgical History

☐ No Surgical History

Yes ☐ Adverse reaction to Anesthesia

Yes ☐ Easy Bruising Tendency

Yes ☐ Easy Bleeding

ENT Surgeries

Yes ☐ Tonsillectomy

Yes ☐ Adenoidectomy

Yes ☐ Thyroid Surgery

Yes ☐ Tubes

Yes ☐ Mastoidectomy

Yes ☐ Tympanoplasty

Yes ☐ Sinus Surgery

Yes ☐ Septoplasty

Yes ☐ Turbinate Reduction

Yes ☐ Polypectomy

Yes ☐ UPPP

Other _____

OTHER Surgeries

Yes ☐ Appendectomy (Appendix Surgery)

Yes ☐ Breast Surgery

Yes ☐ Cardiovascular Surgery (Heart Surgery)

Yes ☐ C-section Delivery

Yes ☐ Cholecystectomy (Gall Bladder Surgery)

Yes ☐ Hernia Repair

Yes ☐ Hysterectomy

Yes ☐ Lung Surgery

Yes ☐ Oral Surgery

Yes ☐ Orthopedic Surgery

Yes ☐ Renal Surgery (Kidney Surgery)

Other _____

Family Medical History

☐ No significant Family Medical History

Yes ☐ Anesthesia Reaction

Yes ☐ Bleeding Problems

Yes ☐ Cancer

Yes ☐ Hearing Loss

Yes ☐ Migraine Headache

Yes ☐ Thyroid Disorder

Social History

Yes ☐ Alcohol use: # __drinks p/Week
_____p/Day

Yes ☐ Tobacco use: #____ packs a day

Yes ☐ History of smoking ___ years, year quit _____

Yes ☐ Drug use

Yes ☐ Marijuana

_____ _____

Patient Signature ***Date***

Boulder Valley Ear Nose and Throt Assoc., P.C.

EMR Entered _____

BOULDER VALLEY
Ear | Nose | Throat

BOULDER VALLEY
Hearing Associates

NEW PT | **EST PT UPDATE**

ENT : ACG | **DDM** | **JDW** | **DAM** | **GMD** | **KCK** **AUDIO : GM** | **SW** | **HW** | **TL** | **JT**

LEGAL FIRST NAME _____ MIDDLE NAME _____ LEGAL LAST NAME _____ PREFERRED NAME _____

DATE OF BIRTH _____ SEX _____ PRONOUN(S) _____ MARITAL STATUS: **S** | **M** | **D** | **W**

MAILING ADDRESS _____ APT _____ CITY _____ STATE _____ ZIP _____

HOME # _____ CELL # _____ WORK # _____

EMPLOYER _____ EMAIL _____

HOW DID YOU HEAR ABOUT US? _____

PRIMARY CARE PROVIDER _____ PRIMARY CARE # _____ CLINIC NAME _____

REFERRING PROVIDER _____ REFERRING PROVIDER # _____ CLINIC NAME _____

IN CASE OF EMERGENCY, WHO SHOULD WE CONTACT?

CONTACT NAME _____ DATE OF BIRTH _____ RELATION TO PATIENT _____

CONTACT'S MAILING ADDRESS _____ APT _____ CITY _____ STATE _____ ZIP _____

HOME # _____ CELL # _____ WORK # _____

BOULDER VALLEY
Ear | Nose | Throat

BOULDER VALLEY
Hearing Associates

INSURANCE INFORMATION

PRIMARY INSURANCE

_____
CARRIER

_____ _____
POLICY HOLDER NAME (**IF SELF, WRITE SELF**) RELATION TO PATIENT

_____ _____
POLICY HOLDER D.O.B. POLICY HOLDER PHONE #

SECONDARY INSURANCE

_____
CARRIER

_____ _____
POLICY HOLDER NAME (**IF SELF, WRITE SELF**) RELATION TO PATIENT

_____ _____
POLICY HOLDER D.O.B. POLICY HOLDER PHONE #

TERTIARY INSURANCE

_____
CARRIER

_____ _____
POLICY HOLDER NAME (**IF SELF, WRITE SELF**) RELATION TO PATIENT

_____ _____
POLICY HOLDER D.O.B. POLICY HOLDER PHONE #

Financial Policy

Payment Policy and Benefits

TO OUR PATIENTS: To help answer questions you might have, we have outlined out payment policies below. Please feel free to discuss these with us at any time, should you have additional questions.

Payment Policy: Accounts are payable after your insurance carrier has paid your claim, or within 30 days of your first statement. We accept all forms of payment. Please note: past due accounts will be turned over to a collection agency if the account is not paid in full within 90 days from the date of your first statement. If you have any questions regarding our billing policies, please call 303-443-8814. BVENT may apply payments received to any outstanding balance. Patients will be financially responsible for any return check fees that BVENT incurs.

About Contracted Insurance Plans

As a patient, you are responsible for knowing if Boulder Valley ENT Providers are contracted with your insurance plan.

Benefits: If we are filing with your insurance, please keep in mind that we do this as a courtesy to our patients, and that we will do everything in our power to collect from the insurance company. You will receive an "Explanation of Benefits" (EOB) from your insurance company that will explain how your claim was processed and paid by them. You will receive a statement from us for any balance that your insurance company has deemed as your responsibility. We try to provide the most accurate information regarding network participation (i.e. in-network vs out-of-network) to you as our patient. However, we always suggest that you verify the network participation of our facility with your insurance carrier.

Insurance contracts are subject to change without notice.

About Non-contracted Insurance Plans

Patients with insurance plans that are non-contracted with Boulder Valley ENT will follow the Self-Pay Policy; Self-pay patient's coming in for a visit with Boulder Valley Ear, Nose and Throat will need to pay 194.00 at time of service, for visits with Boulder Valley Hearing Associates the self-pay rate will be 134.00 due at the time of service. These rates are the minimum amounts that would be coded and billed for by our providers for appointments associated with the practice you would be seeing for an appointment. Depending on what is performed/coded by the Physician or Audiologist during your visit, there may be an additional balance from the minimum collected at the time of service that will be billed to you after your visit

I have read and understand the above-reference policies and benefits.

Patient / Guardian Initials _____

Assignment of Benefits

I, the undersigned, hereby authorize BVENT to release any medical or other information necessary to process my claims for services rendered to me or my dependent.

Patient / Guardian Initials _____

Authorization to Pay

I, the undersigned, hereby authorize payment of medical benefits to the physician for services rendered to me or my dependent in connection with any visit or surgery with my provider.

Patient / Guardian Initials _____

Collection Billing Procedures and the TCPA Act

I authorize BVENT, its assignees, and third-party billing/collection agencies to utilize all contact information I have provided to communicate with me. This includes, but is not limited to, home telephone, cell phone and email/text communications. I hereby grant permission and consent to BVENT, its assignees, and third-party billing/collection agencies to place calls to my home telephone, cell phone; leave messages (whether voice or text); and utilize pre-recorded messages used as appointment or payment reminders. Information will only be supplied to BVENT assignees and third-party billing/collection agencies in order to collect on outstanding balances.

Patient / Guardian Initials _____

Cancellation & No-show Policy

We understand there are times when you must miss an appointment due to emergencies or obligations for work or family. We would request that you call in to cancel or reschedule your appointment at 303-443-2771. If an appointment is not cancelled or you no-show an appointment, there will be a $50.00 fee which will not be covered by your insurance company.

We understand that delays can happen. We would request that you call us if you are running late for your appointment. If you are 15 min past your appointment time, you may have to reschedule, although we will do everything in our power to have you seen.

By signing below, I hereby acknowledge that I have read, understand and consent to all policies set forth herein.

Patient / Guardian Signature _____ Date _____

Patient HIPAA Acknowledgement and Consent

First Name	M.I.	Last Name	Date of Birth

Notice of Privacy Practices/clinics

I acknowledge that I have received the practice/clinic's Notice of Privacy Practice/clinics, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice/clinic's Notice of Privacy Practice/clinics.

Patient / Guardian Initials _____

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below.

Name	Relationship	Contact Number

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Communication about My Healthcare

I agree the Provider, or an agent of the Provider or an independent physician's office may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice's/clinic's health care operations purposes (e.g., quality improvement activities). I understand that the practice/clinic retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications

If at any time I provide an email address or cellphone number at which I may be contacted, I consent to receiving unsecure instructions and other healthcare communications at the email or text address I have provided or you or your EBO Servicer have obtained, at any text number forwarded, or transferred from that number. These instructions may include, but not be limited to: post-procedure instructions, follow-up instructions, educational information, and prescription information. Other healthcare communications may include, but are not limited to, communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care. Note: You may opt out of these communications at any time. The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Note: This clinic uses an Electronic Health Record that will update all your demographics and consents to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated clinics that share an electronic health record in which you have a relationship.

Release of Information

I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

Healthcare information regarding a prior service(s) at other HCA affiliated providers may be made available to subsequent HCA-affiliated providers to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.

If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician

progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.

Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

I certify that I have read and fully understand the above statements from all pages and consent fully and voluntarily to its contents.

Patient / Guardian Signature _____ Date _____

PORTAL ACCESS CONSENT

By allowing access to family members, friends, significant other, etc. (We cannot send portal access to healthcare providers) Please keep in mind they will have access to your medical information. The following items are viewable but not limited to the following list as other information may be available in the future:

Demographic Updates | Prescription Information | Past/Future Appointments | Outstanding Balance | Office Visit Notes | Send Messages to Our Office | Medical History

Portal Opt In ☐ (Check Box to Opt In)

I,_____, would like access to my patient portal that Boulder Valley ENT, Boulder Valley Hearing Assoc. & Boulder Allergy Clinic offers. **Our portal is separate from Boulder Community Hospital, Centura Health, etc.** Any individual(s) listed below are also authorized to access my portal account and I understand that they'll have access to all of my information available on the portal.

Individuals Authorized for Portal Access (If no one is authorized, leave blank):

**First name, last name, date of birth, complete address and email address are required for the following individual(s) to receive an invite and have access to your portal.*
***Individuals listed below also need to be on consent form in order to receive portal access.*

INDIVIDUAL 1 | DATE OF BIRTH | EMAIL

ADDRESS | APT | CITY | STATE | ZIP

INDIVIDUAL 2 | DATE OF BIRTH | EMAIL

ADDRESS | APT | CITY | STATE | ZIP

Portal Opt Out ☐ (Check Box to Opt Out)

I,_____, am declining access to my patient portal that Boulder Valley ENT, Boulder Valley Hearing Assoc. & Boulder Allergy Clinic offers. I understand that I will not receive an invite to the portal and have access to the following information above.

PATIENT SIGNATURE | DATE OF BIRTH | DATE

PARENT/GUARDIAN SIGNATURE