Directions

SUITE _____

Please arrive 10-15 minutes early with your paperwork completed. Thank you

WATERBURY OFFICE 60 Westwood Ave, Waterbury CT 06708

From I-84 Traveling Westbound

Take Exit 18. Bear left at the fork (follow signs for West Main Street).
Turn right at the end of the exit ramp onto **West Main Street**.
Follow West Main Street for approximately 1/2 mile to **Grandview Avenue**. Turn left onto Grandview Avenue.
Turn left onto **Westwood Avenue**. Our office building is at the top of the hill, on the right.

From I-84 Traveling Eastbound

Take Exit 18.
Turn right at the end of the exit ramp onto **Chase Parkway**.
At the light, turn right and cross over the highway. Turn right onto **West Main Street**.
Follow West Main Street for approximately 1 mile to **Grandview Avenue**.
Turn left onto Grandview Avenue. Follow Grandview Avenue to the top of the hill.
Turn left onto **Westwood Avenue**. Our office building is at the top of the hill, on the right.

From CT-8 Traveling Northbound

Take Exit 30B (Downtown Waterbury).
Go straight off the exit ramp, through the first traffic light. Pass the Route 8 Entrance Ramp (left) and keep going straight.
At the next traffic light (at the top of the hill), turn right onto **Grandview Avenue**.
Go up the hill. Take your next left onto **Westwood Avenue**.
Our office building is at the top of the hill, on the right.

From CT-8 Traveling Southbound

Take Exit 30D.
At the first traffic light, turn right onto **West Main Street**.
At the first traffic light on West Main St, turn right onto **Grandview Avenue**. Go up the hill. Take your next left onto **Westwood Avenue**. Our office building is at the top of the hill, on the right.

Please note, if you do not see 60 Westwood Professional in front of our building, you are in the wrong building.

PATIENT INFORMATION				
Last Name:	First Name:		MI:	D.O.B:
Address:			City, State, Zip:	
Preferred Method of Contact: [ ] Email [ ] Home [ ] Mail [ ] Mobile [ ] Work	[ ]Male [ ]Female	[ ]Married [ ]Single [ ]Separated [ ]Domestic Partner	SSN:	
Home Phone:	Cell Phone:		Email:	
Patient's Employer:	Occupation:		Work Phone:	
Employer Address:		City:	State, Zip:	
Primary Care Physician:		Primary Care Physician Phone #:		
Emergency Contact:	Relationship to Patient:		Contact Phone #:	

How did you hear about us? Doctor Billboard Relative/Friend Instagram Facebook Other:_____

GUARDIAN INFORMATION (If under 18 years old)					
Guardian Last Name:	First Name:	Relationship:	D.O.B:	SSN:	
Address (if Different from Patient):			Phone #:		
Employer:	Occupation:	Employer Address:	City:	State:	

PRIMARY INSURANCE			
Insurance Carrier:	Policy Holder:		Date of Birth:
Insurance ID Number:	Employer:		SSN:
Group Number:	Referral Required? [ ] Yes [ ] No	Copay:	Effective Date:

SECONDARY INSURANCE			
Insurance Carrier:	Policy Holder:		Date of Birth:
Insurance ID Number:	Employer:		SSN:
Group Number:	Referral Required? [ ] Yes [ ] No	Copay:	Effective Date:

Additional Info:		
Ethnicity (circle one) Not Hispanic Latino Hispanic or Latino Decline to state	Race (circle one): White / Black or African American / Asian Native Hawaiian Other Pacific Islander American Indian or Alaskan native Decline to state	Primary Language: English Spanish Other: Decline to state

I HEREBY AUTHORIZE PAYMENT OF INSURANCE BENEFITS DIRECTLY TO THE PHYSICIAN FOR MEDICAL SERVICES PROVIDED. I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS. IN THE EVENT THAT MY INSURANCE COMPANY DENIES PAYMENT OF CLAIMS IN WHOLE OR PART, **I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT IN FULL.**

PRINT PATIENT/GUARDIAN NAME: _____ DATE: _____

PATIENT/GUARDIAN SIGNATURE: _____

Signature on File, Assignment of Benefits, Financial Agreement

Patient Name: _____ Date of Birth: _____

I accept full financial responsibility for charges incurred today if:

1. The service rendered or supplies used/purchased are not covered under my insurance plan.
2. My insurance plan requires that I pay a deductible, co-payment, or co-insurance fee.
3. There are charges that have resulted because I have failed to provide current and valid insurance policy information; or
4. My insurance plan requires that I obtain a referral prior to my visit, and I do not have one in place.

I agree:

1. That payment be made to Westwood Ear, Nose & Throat P.C. / CT Sinus Center by my insurance carrier for services rendered or product received.
2. And I understand that Westwood Ear, Nose & Throat P.C. / CT Sinus Center may use and disclose medical information about me for services and procedures so they may be billed and collected from an insurance agency or any third party.
3. To pay for my co-pay and other charges that are not covered by my insurance carrier today or make financial arrangements satisfactory to Westwood Ear, Nose & Throat P.C. / CT Sinus Center for payment.
4. To pay for any returned check fees incurred by Westwood Ear, Nose & Throat P.C. / CT Sinus Center.
5. If I am the parent/guardian bringing a child for treatment, I am responsible for all fees incurred by the child.
6. If an account is sent to collection or attorney for collection, to pay collection expenses and attorney's fees.

Patient/Guardian Signature: _____ Date: _____

Patient Insurance & Policies Agreement

Patient Name: _____ Date of Birth: _____

We would like to thank you for choosing Westwood Ear, Nose & Throat P.C. / CT Sinus Center as your healthcare provider. Westwood Ear, Nose & Throat P.C. / CT Sinus Center is committed to providing you with the best possible medical care. We are sure that you understand that payment for this healthcare is your responsibility. The following outlines your financial responsibilities related to payment for professional services.

For Our Patients with Medical Insurance Benefits: We participate in most major health plans. We have contracts with many HMO's, PPO's insurance companies and government agencies including Medicare and Medicaid. Our business office will submit claims for any services rendered to a patient who is a member of one of these plans and will assist you in any way we reasonably can to get your claims paid. It is the patient's responsibility to provide all necessary information before leaving the office. If you have secondary insurance, we will automatically file a claim with them as soon as the primary carrier has paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please bring your insurance card with you at the time of your appointment. If you are insured by a plan we do business with but don't have an insurance card with you, payment in full for each visit is required until we can verify your coverage. If a patient is a member of an insurance plan with which we do not participate, payment in full is due at the time of service.

Co-payments, Co-Insurances & Deductibles: Your insurance company requires us to collect co-payment, co-insurance and/or deductible at the time of service. Waiver of such may constitute fraud under stated and federal law. Please help us in upholding the law by paying at each visit. For your convenience, we accept cash, checks, Visa, MasterCard, Discover and American Express. If you do not have your payment, your appointment may be rescheduled. Any outstanding balance on your account, after adjusting for all your insurance's responsibilities, will be billed to you.

Non-Covered and Out of Network Services: Medical services that are considered by your insurance company to be non-covered, out of network, or not medically necessary will be your responsibility.

Covered Changes: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

For Our Patients with No Medical Insurance: If you do not have group or individual medical insurance, payment for all professional services is expected at the time of your visit. Please note, we do offer discounted fees for patients without health insurance.

Payment Plan: Please let us know if you are having difficulty paying your account. We may be able to help you by setting up a payment plan based on your financial hardship; please call (203) 574-5997 for assistance.

Late Arrivals: A patient who arrives more than 15 minutes after his/her appointment is considered a late arrival. A late arrival, not considered to be the responsibility of the Practice, and may be worked into the schedule same day. If it is not possible to do so, the patient appointment may be rescheduled for another day.

Appointment No-Shows: Any patient who fails to arrive for a scheduled appointment without canceling the appointment at least 24 hours prior to the scheduled time is considered a "no-show". A patient no-show may be charged **$50.00**, as set by the Practice, for failure to show.

Delinquent Balance Appointment: Patients with a delinquent balance are required to make payment in full for future services. A delinquent account is defined as a patient balance of more than 120 days if patient has not made any payments or sought assistance via financial hardship during this time. If such payment is not made, services may be refused.

Nonpayment: All patient responsible balances that remain delinquent after 120 days, with no response to our request for payment, may be referred to a collection agency. Please be aware that if a balance remains unpaid, you and/or the guardian may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis. Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

Patient /Guardian Signature: _____ Date: _____

Written Acknowledgment of Receipt of Notice of Privacy Practices

I, _____ hereby acknowledge that I have received a copy of the Notice of Privacy Practices. I understand that if I have further questions or complaints, I may contact the practice's Privacy Officer at (203) 574-5997.

I also understand that I am entitled to receive updates upon request if the Practice's Notice of Privacy Practices is amended or changed in a material way.

Signature: _____

Relationship to Patient: _____

Date: _____

To be Completed by Practice If Unable to Obtain Written Acknowledgment from Patient

On _____, I attempted to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

[ ] Patient declined to sign this Written Acknowledgment.

[ ] Patient did not understand the request to sign the Written Acknowledgment.

[ ] Other (specify):

_____

_____ _____

Name of Employee Date

Patient Name: _____

Date: ____/____/_____ **DOB:** ___/___/___ **Account:** _____

What are your concerns for today's visit?	Pharmacy/ Location:
Medication Allergies:	

Past Medical History:

1) Please check the "Yes" or "No" box to indicate if you have any of the following illnesses; for "Yes" answers, please explain

	Yes	No	
Cancer	☐	☐	
Diabetes	☐	☐	
Hypertension (high blood pressure)	☐	☐	
Heart Disease	☐	☐	
Elevated Cholesterol	☐	☐	
Respiratory Problems	☐	☐	
Stomach or Intestinal Problems	☐	☐	
Allergy Problems/Therapy	☐	☐	
Kidney Problems	☐	☐	
Neurological Problems	☐	☐	
Infectious Diseases	☐	☐	
Other Medical Diagnosis	☐	☐	

2) Please list any surgeries you have had:

3) Please list any daily medications (and amounts, times per day):

(include aspirin, hormone replacement, birth control, herbal supplements, OTC nasal spray/cold/sinus/allergy meds)

Social History:

	Yes	No
Do you smoke?: If yes, how much?	☐	☐
If no, did you smoke previously?	☐	☐

☐ Cigarettes/Cigars ☐ Vaping ☐ Marijuana

How many alcoholic beverages do you drink per week?

What is your occupation?

Patient Name: _____

Date: ____/____/_____ **DOB: ____/____/____** **Account: _____**

Review of Systems:

1) Please check the box to indicate whether you <u>presently</u> have any of the following symptoms:

		Yes		Yes
ALLERGY	Sneezing	☐	post nasal drip	☐
	environmental allergy	☐	ear drainage	☐
ENT	ear pain or itch	☐	ear noises	☐
	hearing loss	☐	throat clearing	☐
	vertigo (spinning)	☐	sinus pressure or pain	☐
	nasal congestion	☐	problem snoring, apnea	☐
	sense of smell problem	☐	throat pain	☐
	hoarseness	☐	excessive nasal discharge	☐
RESPIR.	cough	☐	coughing blood	☐
	wheezing	☐	shortness of breath	☐
EYES	new vision changes	☐	watery or itchy eyes	☐
GI	difficulty swallowing	☐	heartburn	☐
NEURO	headache (tension, migraine)	☐	dizziness	☐
HEME/LYM	swollen glands	☐	sweating at night	☐
	bleeding problems	☐	easy bruising	☐

Family History:

Please check the "Yes" or "No" box to indicate whether any relatives have had any of the following conditions:
If yes, please indicate which relatives have had the condition.

	Yes	No	
Hearing Problems	☐	☐	_____
Allergy	☐	☐	_____
Nasal Polyps	☐	☐	_____
Head & Neck Cancer	☐	☐	_____
Bleeding Disorder	☐	☐	_____
Anesthesia Problems	☐	☐	_____
Heart Problems	☐	☐	_____

Reviewed by: