BOISE ENT™

Don J Beasley, MD
208-229-2368

To our new patients:

Welcome to Boise ENT, LLC. Our physicians strive to provide the best possible care for all patients, and part of this process is obtaining accurate demographic and health history information. In order to expedite the check-in process for your appointment, we have included the necessary forms for you to complete in advance.

Please fill out your paperwork completely and bring it with you to your appointment, and arrive 15 minutes early. If desired, you may fax your paperwork to our office at (208) 229-2368 prior to your appointment. Your insurance cards will be required at check-in, and we encourage you to find and submit the most recent copy of your card. This includes Medicare and Medicaid as well. If your insurance plan (including Medicaid) requires a referral, please follow up to ensure that it is in our office so that your appointment will not need to be rescheduled. Payment will be required at the time of service for your portion (co-pay and deductible amounts) of the charges.

Please feel free to contact our office with any questions you may have. Our physicians and staff look forward to caring for you and your family. Thank you for choosing Boise ENT, LLC.

FINANCIAL POLICY

Our practice is committed to providing the best treatment possible for our patients. Our charges are usual and customary for our specialty. Your insurance policy is a contract between you and your insurance company. It is the patient's responsibility to know what services are covered under their insurance policy. Full payment is due at the time of service for all co-pays, co-insurance or any deductible amounts. We are not affiliated with any hospital, and we are unable to accept their approval for financial assistance. We do not offer a sliding fee scale for our charges. If you require financial assistance from our office or want to arrange a payment plan, please contact our billing office at (208) 229-2368. We accept cash, check, Visa, Mastercard, American Express, Discover and CareCredit.

If you do not cancel 24 hours prior to your appointment time or arrive to your appointment more than 15 minutes late, you will be charged a no-show fee of $50.

Boise ENT, LLC uses third party agencies to collect on accounts that are past due. Returned checks are subject to an additional fee and will be sent to a third-party agency if not paid in full after receiving notification. The physicians atBoise, ENT LLC may need to perform additional testing during your visit. In order to accurately diagnose and treat your medical condition, your physician may prescribe diagnostic tests such as hearing and balance tests, nasal endoscopy, laryngoscopy, CT scans, biopsies and/or other diagnostic testing including cerumen removal (ear cleaning). Each insurance policy processes these tests differently, and charges may be applied to your deductible and/or co-insurance or co-pay. Every effort will be made to obtain any required authorization prior to your testing. If you wish to discuss charges prior to testing, please ask to speak with the billing staff.

I authorize the release of any information necessary to determine liability for payment or obtain reimbursement on any insurance claim. I request that payment of authorized benefits be made on my behalf. I assign benefits to which I am entitled, including private insurance and other health plans, to Boise ENT, LLC. This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges that are not paid by insurance including all diagnostic testing.

I hereby authorize Boise ENT, LLC to appeal any incorrect insurance payment. I release Boise ENT, LLC from all legal responsibility or liability that may arise from this authorization. I AGREE TO THE ASSIGNMENTS AND ACKNOWLEDGE MY FINANCIAL RESPONSIBILITIES DISCUSSED ABOVE.

Signature _____ Date _____

Responsible Party Signature

HIPAA Notice of Privacy Practices

I acknowledge the receipt of Boise ENT, LLC's notice of privacy practices.

Signature _____ Date _____

Is your visit the result of accident? YES ☐ NO ☐ Date of Injury: _____ Description: _____

Is this a Worker's Compensation claim? YES ☐ NO ☐ Claim Number: _____

Patient's Legal Name: First _____ Middle _____ Last _____ ☐ Male ☐ Female

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____ Ext. _____ D.O.B. _____

Email Address _____ Marital Status ☐ M ☐ S ☐ D ☐ W

Primary Care Physician _____ Referring Physician _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ Caucasian ☐ Hispanic or Latino

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other _____ Preferred language _____

Patient's Employer _____

Spouse's Name _____ Date of Birth _____ Employer _____

Work Phone _____ If Applicable, Patient's Legal Guardian _____

Father's Name (IF MINOR) _____ D.O.B. _____

Father's Home Address _____ City, State, Zip _____ Phone _____

Father's Employer _____ Occupation _____ Work Phone _____

Mother's Name (IF MINOR) _____ D.O.B. _____

Mother's Home Address _____ City, State, Zip _____ Phone _____

Mother's Employer _____ Work Phone _____

PRIMARY INSURANCE COMPANY NAME _____ Phone _____

Subscriber Name Relationship to Subscriber ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Step Parent ☐ Other

Subscriber D.O.B. _____ Group No. _____ I.D. No. _____

SECONDARY INSURANCE COMPANY NAME _____ Phone _____

Subscriber Name _____ Relationship to Subscriber ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Step Parent ☐ Other

Subscriber D.O.B. _____ Group No. _____ I.D. No. _____

To whom may we disclose your health information (e.g. appointment times, test results, financial) if you are not available?

Name _____ Relationship _____

Whom may we contact in case of an emergency? Name _____

Relationship _____ Phone _____

PHH ADULT

Patient's Name: _____ D.O.B. _____

Referring Physician: _____

For Women: Are you currently pregnant? ☐ Yes ☐ No ☐ Possibly/Not Sure

Name and Location of Pharmacy Used: _____

What are you seeing the doctor for today? _____

List all current medications, including any over-the-counter (OTC) medications or supplements.
(If needed, please provide on separate sheet.)
☐ Not taking any medications

NAME OF MEDICATION	DOSAGE

List any drug allergies or medicines you can not take.
☐ No known drug allergies

NAME OF MEDICATION	TYPE OF REACTION

Do you have a known allergy to any of the following? ☐ None

☐ Latex ☐ Iodine ☐ Tape ☐ Contrast Agents (Dye) ☐ Other _____
Please Describe

Allergies
☐ None
☐ Dust
☐ Moldy Places
☐ Pollen
☐ Cut Grass
☐ Animals
☐ Exercise
☐ Foods
☐ Smoke/Fumes
☐ Outside in Spring and/or Fall
☐ Outside on Windy Days
☐ Air Conditioning

Allergy Testing
☐ Never Done
☐ Skin Blood
☐ Negative
☐ Testing Location
_____

Allergy Injections
☐ Never Done
☐ In the Past
☐ Currently

Other Allergies/Problems Not Listed
(Please Describe)
_____
_____
_____
_____
_____
_____

Describe Reaction
_____
_____
_____

PAST HEALTH HISTORY

Please indicate any diseases or problems that you have had or been diagnosed with by a doctor.

☐ No Major Illness

Congenital (Birth) Problems
☐ Down Syndrome
☐ Heart Defect
☐ Prematurity (# of weeks)
☐ Other_____

Childhood Diseases
☐ Mumps
☐ Measles
☐ Chicken Pox
☐ Other_____

Cancer
☐ Lung Cancer
☐ Breast Cancer
☐ Throat Cancer
☐ Leukemia
☐ Other_____

Head and Face (not incl. brain or nervous system)
☐ Tension/Stress Headache
☐ Other_____

Ears
☐ Chronic or Frequent Infection
☐ Fluid
☐ Hearing Loss
☐ Vertigo
☐ Other_____

Nose and Sinuses
☐ Chronic Sinusitis
☐ Deviated Septum
☐ Nasal Polyps
☐ Allergies
☐ Other_____

Mouth and Throat
☐ Chronic Tonsillitis
☐ Cleft Palate
☐ Sleep Apnea
☐ Vocal Polyps
☐ Other_____

Heart
☐ Atrial Fibrillation
☐ Chest Pain/Angina
☐ Heart Attack
☐ High Blood Pressure
☐ Mitral Valve Prolapse
☐ Heart Murmur
☐ Pace Maker
☐ Other_____

Lungs
☐ Asthma
☐ COPD/Emphysema
☐ Cystic Fibrosis
☐ On Oxygen
☐ Other_____

Digestive
☐ GERD/Reflux
☐ Hepatitis
☐ Diverticulitis
☐ Hemorrhoids
☐ Other_____

Skin
☐ Eczema
☐ Psoriasis
☐ Acne
☐ Other_____

Neurologic
☐ Headaches
☐ Stroke
☐ Multiple Sclerosis
☐ Other_____

Glands and Hormones
☐ Diabetes
☐ Thyroid Problem
☐ Other_____

Blood Disorder
☐ Low White Blood Cells
☐ Bleeding Disorder
☐ Anemia
☐ Low Platelets
☐ Other_____

Immune Disorder
☐ Rheumatoid Arthritis
☐ Sjogrens
☐ CREST
☐ HIV
☐ Other_____

Psychiatric History
☐ Depression
☐ Anxiety
☐ Mania
☐ Schizophrenia
☐ Other_____

History of any other condition not listed?

_____

SURGERIES/INJURY

Have you ever had problems with anesthesia (being put to sleep for surgery)? ☐ No ☐ Yes What Problem? _____

Indicate any major surgeries (if you choose OTHER please describe).

☐ No Surgery

Eyes	☐ Cataract ☐ Eyelid Surgery ☐ Tear Duct ☐ LASIK ☐ Other:
Ears	☐ Tubes ☐ Ear Drum ☐ Mastoid ☐ Other:
Nose	☐ Septoplasty ☐ Rhinoplasty ☐ Sinus Surgery ☐ Other:
Throat	☐ Adenoidectomy ☐ Tonsillectomy ☐ Other:
Neck	☐ Thyroidectomy
Heart	☐ Angioplasty ☐ Bypass ☐ Valve ☐ Stent ☐ Other:
Digestive	☐ Appendectomy ☐ Gallbladder ☐ Hiatal Hernia ☐ Other:
Female Health	☐ Hysterectomy ☐ Ovary Removal ☐ Other:
Other	☐ Any other major surgery:

Serious injury? ☐ No ☐ Yes *Please Describe* _____

FAMILY HISTORY

☐ Family History Unknown

Do any of your BLOOD RELATIVES have a history of:

☐ Problems with Anesthesia, malignant hypothermia
☐ Hearing Loss after age 20
☐ Hearing Loss before age 20
☐ Heart Problems
☐ Bleeding/Clotting Problems
☐ Cancer
☐ Other Major Health Problems

_____

Please Describe

☐ No family history problems known

SOCIAL HISTORY

Current Occupation _____ ☐ Retired ☐ Student

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Tobacco Use: ☐ Never ☐ Quit ☐ Yes: ☐ Cigarette ☐ Cigar ☐ Pipe ☐ Chew ☐ Vape

How many per day? _____

When did you start? Age _____ or Year _____ When did you stop? Age _____ or Year _____

Alcohol Use: ☐ Yes ☐ No

How many drinks per week on average? _____

Have you ever been dependent on or addicted to any drugs? ☐ Yes ☐ No

TESTS AND IMMUNIZATIONS

If you are not sure of the exact date of the test/procedure/immunization (month and day are not necessary), please list at least the year to the best of your recollection.

1. If you are a female patient between the ages of 24-64 yrs., when was your most recent cervical CA screening (pap test)?
   N/A or date: _____
2. If you are a female patient between the ages of 42-69 yrs., when was your most recent Breast CA screening (mammogram)?
   N/A or date: _____
3. If you are a patient between the ages of 50-70 yrs., when was your most recent Colorectal CA screening (Colonoscopy, Sigmoidoscopy or FOBT)?
   N/A or date: _____
4. If you are a patient 65 or older, when was your most recent pneumonia vaccination administered?
   N/A or date: _____
5. If you are a patient 6 months and older, when was your most recent influenza immuniza-tion administered?
   N/A or date: _____

Patient Signature: _____ Date: _____

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

BOISE ENT™

Don J Beasley, MD
208-229-2368

PATIENT: _____

OTHER LAST NAMES: _____

SOCIAL SECURITY NO: _____ DOB: _____

This document authorizes Boise ENT, LLC (hereafter, "Boise ENT") to release information regarding my medical condition to:

Name: _____

Address: _____

City, State, Zip Code: _____

Telephone Number: _____

The person or organization who receives this authorization has my consent to release/disclose protected health information in accordance with the other terms of this authorization. Boise ENT may release medical records regarding my medical condition, in accordance with the other terms of this authorization, to a medical doctor, physician, surgeon, chiropractor, psychiatrist, psychologist, pharmacist, therapist, medical technician, hemophilia treatment center, nurse, consultant, osteopath, podiatrist, vocational rehabilitation specialist, dentist, hospital, health care clinic, alcohol and/or drug and/or substance abuse treatment center, pharmacy, laboratory or other health care specialist.

Boise ENT is authorized to release all information regarding my medical condition – including, but not necessarily limited to, any and all documents, records, writings, reports, notes, correspondence, charts, billings, invoices, office charts, office reports, operative or surgical reports, emergency room records, outpatient department records, physical therapy records, radiology reports, radiology films, laboratory reports, pathology slides including accompanying pathology reports, progress notes, physicians' notes, physicians' orders, narrative summaries, nurses' notes, consultation reports, prescription records, medication charts, x-ray reports, CT scan reports, MRI reports, myelogram reports, vocational rehabilitation reports and thermographic reports – related to any examination, testing, evaluation, diagnosis, treatment, hospitalization, surgery, therapy, counseling, prognosis or other health care, service and/or supplies provided to me at any time with regard to any past, present or future mental, emotional, physical or medical disease, illness, impairment, disability, injury or other condition.

Boise ENT is authorized to release information regarding my medical condition, whether the information was initially prepared by Boise ENT or by some other person or entity, even if the person or entity that prepared the information is not associated with or employed by Boise ENT.

The purpose or need for the records are as follows: _____

_____

_____

I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I understand that I may refuse to sign this authorization. I may inspect or copy any information used/disclosed under this authorization.

I understand that I may revoke this authorization in writing at any time except to the extent that information has already been released in response to this authorization. Unless otherwise revoked, this authorization is valid for a period of one (1) year.

SPECIFIC AUTHORIZATION

I understand that my health information to be released MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV), behavioral or mental health services and/or treatment for alcohol and/or drug abuse. My signature below authorizes release of all such information, unless I have marked "No" and initialed it.

☐ Yes ☐ No _____ Initials

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my consent to the use or disclosure of my protected health information for purposes of treatment, payment or health care operations.

Signature of Patient or Personal Representative	Date
Printed Name of Personal Representative (If Applicable)	Relationship to Patient

BOISE ENT™

Don J Beasley , MD

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HOSPITAL OWNERSHIP DISCLOSURE

As a patient of ours, your physician may order tests or schedule procedures that are performed at local hospitals. These include (but are not limited to) laboratory tests, X-rays, CAT scans, MRI's, injections and surgical procedures. The physicians in Boise ENT are investors at Treasure Valley Hospital, which is one of the local hospitals, that provides these services. Our physicians also practice at St. Alphonsus and St Luke's where they do not have an ownership interest. This form is to confirm that you understand, as a patient of ours, that you have the right to choose the hospital where you would like to receive your services.

Patient Signature: _____ Date: _____