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. 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, arriving 15 minutes early. If desired, you may fax your paperwork to our office at 1-888-815-1651 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 also includes Medicare and Medicaid. 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. Financially, payment will be required at the time of service for your portion of the charges (co-pay and deductible amounts).

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.

If you do not cancel 24 hours prior to your appointment time or arrive to your appointment more than 30 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 at Boise 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 and denials. 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 _____

REGISTRATION

Patient's Legal Name First _____ Middle _____ Last _____

○ M ○ F D.O.B. _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email _____ 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 ☐ White ☐ Other(Multi-racial) ☐ Unknown ☐ Declined

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other _____

Patient's Employer _____

Spouse's Name _____ D.O.B. _____ 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 D.O.B. _____ Group No. _____ I.D. No. _____

Subscriber Name :

Name _____ Relationship _____

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. _____

BOISE ENT™

PHH

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

Referring Physician _____

Name and location of pharmacy used _____

What are you seeing the doctor for? _____

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

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ALLERGY

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
- ☐ 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

_____

_____

_____

Surgeries/Injury

Serious injury? ☐ No ☐ Yes Please Describe _____

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:

Past Health History

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

No Major Illnesses

1. Childhood Diseases

- ☐ Mumps
- ☐ Measles
- ☐ Chicken Pox
- ☐ Other _____

2. Cancer

- ☐ Lung Cancer
- ☐ Breast Cancer
- ☐ Skin Cancer
- ☐ Leukemia
- ☐ Other _____

3. Congenital (Birth) Problems

- ☐ Down Syndrome
- ☐ Heart Defect
- ☐ Prematurity (# of weeks)
- ☐ Other _____

4. Ears

- ☐ Chronic or Frequent Infection
- ☐ Fluid
- ☐ Hearing Loss
- ☐ Vertigo
- ☐ Other _____

5. Nose and Sinuses

- ☐ Chronic Sinusitis
- ☐ Deviated Septum
- ☐ Nasal Polyps
- ☐ Allergies
- ☐ Other

History of any other condition not listed?

6. Mouth and Throat

- ☐ Chronic Tonsillitis
- ☐ Cleft Palate
- ☐ Sleep Apnea
- ☐ Other _____

7. Heart

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

8. Lungs

- ☐ Asthma
- ☐ COPD/Emphysema
- ☐ Cystic Fibrosis
- ☐ Other _____

9. Digestive

- ☐ GERD/Reflux
- ☐ Hepatitis
- ☐ Diverticulitis
- ☐ Hemorrhoids
- ☐ Other _____

10. Skin

- ☐ Eczema
- ☐ Psoriasis
- ☐ Acne
- ☐ Other _____

11. Neurologic

- ☐ Headaches
- ☐ Stroke
- ☐ Multiple Sclerosis
- ☐ Other _____

12. Glands and Hormones

- ☐ Diabetes
- ☐ Thyroid Problem
- ☐ Other _____

13. Blood Disorder

- ☐ Low White Blood Cell Count
- ☐ Bleeding Disorder
- ☐ Anemia
- ☐ Low Platelets
- ☐ Other _____

14. Immune Disorder

- ☐ Rheumatoid Arthritis
- ☐ Sjogren's
- ☐ CREST
- ☐ HIV
- ☐ Other _____

15. Psychiatric History

- ☐ Depression
- ☐ Anxiety
- ☐ Mania
- ☐ Schizophrenia
- ☐ Other _____

Family History

☐ Family History Unknown

Do any of your BLOOD RELATIVES have a history of:

- ☐ Problems with Anesthesia
- ☐ Hearing Loss After Age 20
- ☐ Heart Problem
- ☐ 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, when was your most recent cervical cancer screening (pap test)? ☐ N/A or date _____
2. If you are a female patient between the ages of 42-69, when was your most recent breast cancer screening (mammogram)? ☐ N/A or date _____
3. If you are a patient between the ages of 50-75, when was your most recent colorectal cancer screening (Colonoscopy, Sigmoidoscopy or FOBT)? ☐ N/A or date _____
4. If you are a patient 65 years or older, when was your most recent pneumonia vaccination administered?
   ☐ N/A or date _____
5. If you are a patient 6 months or older, when was your most recent influenza immunization administered?
   ☐ N/A or date _____

Patient Signature _____ Date _____

YOUR INSURANCE IS ULTIMATELY YOUR RESPONSIBILITY

To our **Valued Patients:**

Your copay/co-insurance/deductible payment amount is due and payable at the time of your visit.

Please take a minute to do the following:

- Check with your insurance company to determine if authorization is required for your specialist visit and/or procedure.
- Find out which diagnostic facilities you can go to.
- Contact our office if we will need to get authorization for your visit and /or procedure.

Please sign below, stating that you have read, understand, and agree to the above insurance office policy. You, our patient, are ultimately responsible for your own insurance requirements.

Thank you.

Please Print Name _____ Date _____

Signature _____

CONSENT TO TREAT

I, the undersigned, do hereby agree and give my consent for Boise ENT to furnish medical care and treatment to the patient identified above.

Please Read & Sign Below Recognizing the inherent risks of transmission of contagious diseases. Especially during surgery, I voluntarily agree to be tested for such diseases as hepatitis, syphilis, HIV/AIDS, herpes, etc., when deemed necessary by physician. Questions should be discussed with your physician. I hereby authorize the doctors of BOISE ENT to furnish the insured's insurance company all information which said insurance company may request concerning my present illness or injury. I hereby assign to the doctors all money to which I am entitled for medical and/or surgical expense relating to the services performed from time to time, but not to exceed my indebtedness to said physicians and surgeons. It is understood that any money received from the above-named insurance company over and above my indebtedness will be refunded to me or, in the proper case, to my employer or other provider of insurance, when my bill is paid in full. I understand I am financially responsible to said doctors for charges not covered by this assignment. I further authorize the doctor's office to make photocopies of this authorization and assignment, in order for them to attach a copy to any insurance form and to be able to retain the original copy in the doctor's files, and authorize the insurance company to accept the photocopy, I release you from all legal responsibility or liability that may arise from this authorization. This authorization shall continue and reinforce and effect until revoked in writing by me

Please Print Name _____ Date _____

Signature _____

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.

Please Print Name _____ Date _____

Signature _____

HIPAA – PHI Release Form

Name: _____ Date of Birth __

Please check all applicable boxes and fill in any blank spaces where information is requested.

☐ Only release information to me personally ☐ If minor, release to guardians only

☐ You have my permission to speak with my Spouse/Significant Other about my medical care and test results.
Spouse/Significant Other's Name _____ Phone _____

☐ You have my permission to speak with my children or other family members involved with my medical care.
Name _____ Phone _____
Relationship _____

Name _____ Phone _____
Relationship _____

Name _____ Phone _____
Relationship _____

☐ You have my permission to leave information on my answering machine regarding my medical care and test results.

☐ You have my permission to email me information regarding my appointments, medical care and test results.

☐ Other, please describe: _____

Emergency Contact:
Last Name _____ First Name _____ Phone Number _____
Address _____ City _____ State _____ Zip _____
Relationship to Patient _____

Patient Contact
Patient Email _____
Phone (Home) _____ Phone (Cell) _____
Phone (Work) _____ Preferred Message/Contact Phone ☐Home ☐Cell ☐Work

Patient Signature _____ Date _____ Time _____

People assisting with paperwork:

_____	_____	_____
Parent/Guardian Name	Parent/Guardian Signature	Date and Time
_____	_____	_____
Interpreter's Name	Interpreter's Signature / and/or ID #	Date and Time
_____	_____	_____
Office Staff Name	Office Staff Signature	Date and Time

Patient Rights, Responsibility and Consent to Treat

- I acknowledge that the Patient Rights, Responsibilities, and Consent to Treat forms was offered to me and is available in the registration area and upon request.
- Duration of Consent. For outpatient clinic visits, this written consent shall remain valid for one year from the date of Patient's/Patient Representative's signature, unless revoked in writing prior to that time.

This form has been explained to me, and I certify that I have read it, understand its contents, and have had an opportunity to have my questions answered. By signing this form, I consent to medical care by Providers and to each of the provisions set forth in this form. In the event I do not understand, or consent to, any provision of this form, I will immediately speak with a representative of Boise ENT to ask questions or to register my lack of consent. I acknowledge, however, that in certain cases such lack of consent may prevent Providers from providing Patient with medical services, may shift all or a portion of the financial obligation for such services to me, and/or may be of no effect to the extent Boise ENT has already taken action in reliance upon any consent given hereby.

Patient Signature: _____ Date: _____

The patient is unable to sign because _____

For this reason, I give consent to medical care on behalf of the above-named patient.

_____ _____ _____

Signature of Patient's Representative: Relationship to Patient: Date:

Interpretor only

Interpreter's name: _____ Language used: _____

Interpreter's Signature / and/or ID #: _____ Date: _____

Staff Signature or Witness: _____ Date: _____

SINO-NASAL OUTCOME TEST (SNOT-22)

I.D. _____ DATE: _____

Below you will find a list of symptoms and social/emotional consequences of your rhinosinusitis. We would like to know more about these problems and would appreciate your answering the following questions to the best of your ability. There are no right or wrong answers, and only you can provide us with this information. Please rate your problems as they have been over the past two weeks. Thank you for your participation. Do not hesitate to ask for assistance if necessary.

1. Considering how severe the problem is when you experience it and how often it happens, please rate each item below on how "bad" it is by circling the number that corresponds with how you feel using this scale: →	No Problem	Very Mild Problem	Mild/slight Problem	Moderate Problem	Severe Problem	Extreme Problem		5 Most Important
1. Need to blow nose	0	1	2	3	4	5		◯
2. Nasal Blockage	0	1	2	3	4	5		◯
3. Sneezing	0	1	2	3	4	5		◯
4. Runny nose	0	1	2	3	4	5		◯
5. Cough	0	1	2	3	4	5		◯
6. Post-nasal discharge	0	1	2	3	4	5		◯
7. Thick nasal discharge	0	1	2	3	4	5		◯
8. Ear fullness	0	1	2	3	4	5		◯
9. Dizziness	0	1	2	3	4	5		◯
10. Ear pain	0	1	2	3	4	5		◯
11. Facial pain/pressure	0	1	2	3	4	5		◯
12. Decreased Sense of Smell/Taste	0	1	2	3	4	5		◯
13. Difficulty falling asleep	0	1	2	3	4	5		◯
14. Wake up at night	0	1	2	3	4	5		◯
15. Lack of a good night's sleep	0	1	2	3	4	5		◯
16. Wake up tired	0	1	2	3	4	5		◯
17. Fatigue	0	1	2	3	4	5		◯
18. Reduced productivity	0	1	2	3	4	5		◯
19. Reduced concentration	0	1	2	3	4	5		◯
20. Frustrated/restless/irritable	0	1	2	3	4	5		◯
21. Sad	0	1	2	3	4	5		◯
22. Embarrassed	0	1	2	3	4	5		◯
2. Totals:	☐	☐	☐	☐	☐	☐		

3. Please mark the most important items affecting your health (maximum of 5 items).

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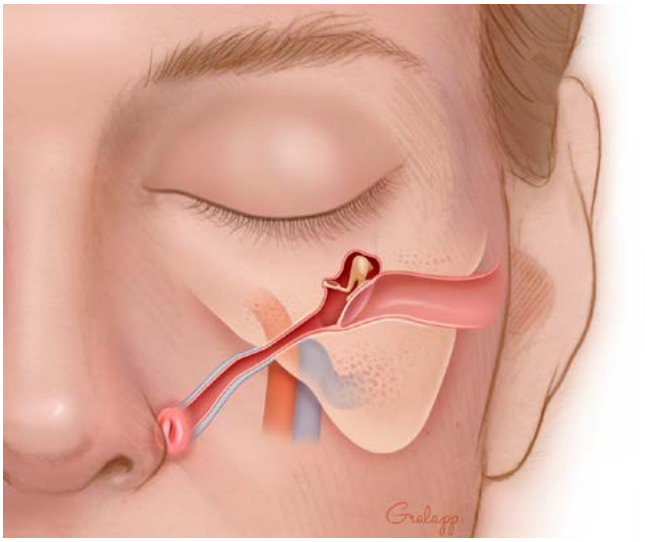
EUSTACHIAN TUBE DYSFUNCTION PATIENT QUESTIONNAIRE (ETDQ-7)



Eustachian tube dysfunction (ETD) means that the Eustachian tube is blocked or does not open properly. Air cannot get into the middle ear. Therefore, the air pressure on the outer side of the eardrum becomes greater than the air pressure on the inner side of the eardrum.

The most common causes of Eustachian tube dysfunction are excessive mucus and inflammation of the tube caused by a cold, the flu, a sinus infection or allergies.

NEXT TO EACH SYMPTOM, CIRCLE THE NUMBER THAT BEST DESCRIBES HOW YOU FEEL.*

During the past 1 month how much of a problem were each of the following?	No problem		Moderate problem			Severe problem	
Pressure in the ears?	1	2	3	4	5	6	7
Pain in the ears?	1	2	3	4	5	6	7
A feeling that your ears are clogged or “under water”?	1	2	3	4	5	6	7
Ear problems when you have a cold or sinusitis?	1	2	3	4	5	6	7
Crackling or popping sounds in the ears?	1	2	3	4	5	6	7
Ringing in the ears?	1	2	3	4	5	6	7
A feeling that your hearing is muffled?	1	2	3	4	5	6	7

Total score _____ **÷ 7 = mean item score** _____

Do you get these symptoms in one ear only or both ears?

◯ Left ear only ◯ Right ear only ◯ Both ears

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