Don J Beasley, MD
Dylan Bybee PA-C
Phone: 208-229-2368
Fax: 1-888-815-1651

Welcome to Boise ENT, LLC.

To our new patients,

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.

For all same day no-show's there will be a $35 charge. If you are unable to keep your appointment please call us to reschedule or cancel in advance.

Please fill out your paperwork completely and arrive 15 minutes prior to your appointment time.

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.

REGISTRATION

PATIENTS LEGAL NAME First:_____Middle:_____Last:_____

☐M ☐F DOB:_____ Marital Status: ☐M ☐S ☐D ☐W

Mailing Address:_____City:_____State____Zip_____

Home Phone: _____Cell Phone:_____

Patient/Guardian Email: _____

Patients Employer:_____ Work Phone:_____

Primary Care Physician:

Name: _____ PH:_____ FAX: _____

Referring Physician:

Name:_____ PH:_____ FAX:_____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Other
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Unknown ☐ Declined

Origin: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other ☐ Declined

Primary Insurance Company Name:_____

ID_____Group #_____

Subscriber Name:_____DOB:_____Relationship:_____

Secondary Insurance Company Name:_____

I.D_____Group #_____

Subscriber Name:_____DOB:_____Relationship:_____

Don J Beasley, MD ▪ BoiseENT.com ▪ Phone: 208-229-2368 ▪ Fax: 1-888-815-1651 ▪ 8854 W Emerald St., Suite 150, Boise, ID 83704

HIPPA - 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:

GUARDIAN:_____

PHONE:_____

You have my permission to speak with my Spouse/Significant Other about my medical care and test results:

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.

☐ You have permission to send text messages to my cell phone.

Emergency Contact

First Name:_____ Last Name:_____Phone Number:_____

Address:_____

Relationship to Patient:_____

SIGNATURE:_____ (Responsible Party Signature)

DATE:_____

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. 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. CT scans, biopsies, cultures, and/or other diagnostic testing may be recommended and orders sent to outside facilities. Their charges and billing are seperate for their servies at their facilities. CT scans, MRI's, Audiograms, and sleepstudy reviews are billed to insurance so copays will be due at time of appointment.

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:_____ (Responsible Party Signature)

DATE:_____

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.

SIGNATURE:_____ **(Responsible Party)**

DATE:_____

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 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.

SIGNATURE:_____ **(Responsible Party)**

DATE:_____

HIPAA Notice of Privacy Practices

I acknowledge the receipt of Boise ENT, LLC's notice of privacy practices were offered to me, available @boiseent.com OR in the registration area and upon request.

SIGNATURE:_____ **(Responsible Party)**

DATE:_____

Patient Rights, Responsibility and Consent to Treat

I acknowledge that the Patient Rights, Responsibilities, and Consent to Treat forms were offered to me, available @boiseent.com OR 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:**_____
(Responsible Party)

The patient is unable to sign because _____
For this reason, I give consent to medical care on behalf of the above-named patient.

PRINT NAME:_____

SIGNATURE OF PATIENTS REPRESENTATIVE:_____

RELATIONSHIP:_____

DATE:_____

STAFF SIGNATURE OR WITNESS:

_____

DATE:_____

PHH

PATIENT'S NAME:_____ D.O.B._____

REFERRING PHYSICIAN:_____ ADDRESS: _____

NAME AND LOCATION OF PHARMACY USED:_____

What are we seeing you for today?_____

PLEASE LIST ALL CURRENT MEDICATIONS, INCLUDING ANY OVER THE COUNTER SUPPLEMENTS

☐ **NOT CURRENTLY TAKING ANY MEDICATIONS**

NAME OF MEDICATION	DOSAGE

LIST ANY DRUG ALLERGIES OR MEDICATIONS YOU CAN NOT TAKE

☐ **NO KNOWN DRUG ALLERGIES**

NAME OF MEDICATION	TYPE OF REACTION

FAMILY HISTORY:

Do any of your **BLOOD RELATIVES** have a history of:

- ☐ Problems with Anesthesia
- ☐ Hearing Loss After Age 20
- ☐ Heart Problem
- ☐ Cancer
- ☐ Family History Unknown
- ☐ Other Major Health Problems (Please list Below)

_____
_____
_____
_____

SOCIAL HISTORY:

Occupation: _____

TOBACCO USE (please circle one)

Never Quit Yes Cigarette Cigar Pipe Chew Vape

If cigarettes, how many daily? _____
When did you first start? Age or Year_____
When did you stop? Age or Year_____

Past Health History

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

BOISE ENT
SINUS & SNORING SPECIALISTS

☐ **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

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 _____

History of any other condition not listed?

_____

_____

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ALLERGY

Do you have a known allergy to any of the following? ☐ ***NO KNOWN ALLERGIES***

☐ 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

Have you ever had problems with anesthesia (being put to sleep for surgery)? ☐ YES ☐ NO

What problem? _____

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

☐ **NO SURGICAL HISTORY**

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:

PATIENTS SIGNATURE/REPRESENTATIVE SIGNATURE:_____

RELATIONSHIP TO PATIENT:_____ **DATE:**_____

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Consent for Debridement, Nasal Endoscopy, and Laryngoscopy

Date: _____

Patient Name: _____

Nasal Endoscopy/Laryngoscopy: Your doctor has recommended a thorough examination of your nose. This will be done with a lighted and magnified scope. You will be given a nasal spray to anesthetize (numb) the lining of the nose and throat to minimize any discomfort.

Complications are very uncommon from this procedure. Occasionally, blood-tinged nasal secretions occur after the procedure. Other possible but rare, complications include infection and a reaction to the topical anesthetic used to numb the nose. The examination allows precise visualization of the nasal and/or throat structures. This will aid in the diagnosis and treatment of your problem.

This procedure is in addition to the general examination of the nose and throat. There will be a separate charge from the office visit charge to the insurance company on your claim (this charge is frequently listed as a surgery or procedure). If you have any questions, please ask the doctor or assistant.

A Nasal Endoscopy is required by insurance to move forward with any recommended surgery or procedure.

Cost for Nasal Endoscopy/Laryngoscopy: $300- $500 (This is the amount billed to insurance, your out of pocket will be billed to you after insurance processes the claim) We recommend you check with your insurance provider to understand your coverage for CPT code 31231.

Signature: _____ Date:_____
(Responsible Party)

Witness: _____