

JOHN J. FINAZZO, M.D.

Board Certified Otolaryngology
Head and Neck Surgery Ear, Nose and Throat

To Our Patients:

We have implemented a policy, effective March 1, 2010, in which we will require a current credit or debit card number and expiration date to be kept securely in your patient file. We are requesting signature authorization to charge your card only for past due amounts.

Billing of insurances will continue as before. After your insurance has issued an explanation of benefits, you may be responsible for a balance. We will then bill you for this balance, as we have in the past. However, if there is no response within 30 days, we will make two attempts to contact you (or the responsible party). If at this time there is no response or other arrangement made for payment, we will go ahead and charge your card for the balance due.

This will in no way compromise your ability to dispute a charge or question your insurance company's determination of payment.

Copayments due at the time of the visit will still be collected as before. If a statement has been sent and no payment has been received, an annual interest rate of 7% will be applied to the account after 30 days.

The only exception will be for those patients who do not have a balance forward, i.e. patients who will settle their accounts in full at the time of their visit.

Please keep us informed of any changes in your accounts, such as expiration dates, or if you wish to change the card which is on file. We will remind you when we become aware of card expiration dates.

If you have any questions, please do not hesitate to speak to our billing coordinator.

Thank you

John J. Finazzo, M.D.

Initials

Date

Witness

JOHN J. FINAZZO, M.D.

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I, _____, authorize John J. Finazzo, M.D. to charge my credit / debit card for any balances greater than 30 days past due on my account. An annual interest rate of 7% will be applied to all balances 30 days past due.

I understand that John J. Finazzo, M.D. will mail me a copy of the charge for my records upon request.

I understand that an attempt will be made to notify me of the prevailing charge, and if I do not reply within the next 3 business days, my credit / debit card will be charged.

This in no way will compromise my ability to dispute a charge or question my insurance company's determination of payment.

Signature _____

Address _____

_____ Zip Code _____

Type of Credit / Debit Card (please circle one) VISA MasterCard

Card Number _____ Exp date _____

Security Code _____

Card holder's name (please print) _____

Card holder's signature _____ Date _____

*****Please be prepared to show card to our registration clerk*****

JOHN J. FINAZZO, M.D.

73950 Alessandro Dr., Suite 4, Palm Desert, CA 92260
Tel: (760) 773-0762 • Fax: (760) 773-5643

PATIENT INFORMATION

Date _____

Name _____ Race: White Hispanic
First Middle Initial Last African American Asian Other: _____

Date of Birth: _____ Sex (Male) (Female) Age: _____ Social Security #: _____

Address _____

City _____ State _____ Zip _____

Home Phone () _____ Cell Phone: () _____

Email Address _____

Name of Doctor that referred you: _____

Your Employer _____ Work Phone: () _____

Person to Contact in Case of Emergency _____ Tel: () _____

**NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT OF RECEIPT**

I acknowledge that I have been given the opportunity to read the NOTICE OF PRIVACY PRACTICES for the offices of John J. Finazzo, M.D., a copy of which is available in the waiting area. I understand that a copy of this notice will be made available to me at my request.

Patient Name _____ Date _____

I do _____ do not _____ wish to have marketing materials (including appointment reminder cards) mailed to my home address.

Initial

INSURANCE INFORMATION

Primary Insurance Name _____ Primary Ins. I.D. # _____
Group # _____ Union/Local # _____

Secondary Insurance Name _____ Secondary Ins. I.D. # _____
Group # _____ Union/Local # _____

I hereby authorize Dr. Finazzo to release any and all medical information to the above-named insurance carrier (or to designated attorney) for purposes of claims administration and evaluation, utilization review and financial audit. This authorization remains valid and effective from the date of signing until revoked in writing. I understand that I may request a copy of this authorization. I have read this authorization and understand it. I hereby assign to Dr. Finazzo all money in which I am entitled for medical and/or surgical expense related to the service rendered by him, but not to exceed my indebtedness to said physician and/or surgeon. It is understood that any money received from the above named insurance company, over and above my indebtedness, will be refunded to me when my bill is paid in full. I understand I am financially responsible to said doctor for charges not covered by my assignment. I further agree, in the event of non-payment, to bear the cost of collection, and/or court cost and reasonable legal fees should this be required.

INSURED OR GUARDIAN'S SIGNATURE

PATIENT'S SIGNATURE

INSURANCE SUBSCRIBER INFORMATION

This information is for the person who is the primary holder of the insurance. For example: Both you and your spouse work but the insurance is from your spouse's employer. This would then be your spouse's information.

Name _____ DOB _____ Sex (Male) (Female)
First Middle Initial Last

Relationship to Patient _____

Address _____

City _____ State _____ Zip Code _____

Home Phone () _____ Cell Phone () _____

Social Security Number _____ (Required for billing purposes)

Employer _____ Work Phone () _____

Address _____

If patient is a minor, please complete the following information with the parent / guardian information:

Name _____ DOB _____
First Middle Initial Last

Relationship to Patient _____

Address _____

City _____ State _____ Zip Code _____

Home Phone () _____ Cell Phone () _____

Social Security Number _____ (Required for billing purposes)

Employer _____ Work Phone () _____

Address _____

This information is intended only for use by designated individuals. It may contain confidential information protected by local, state, or federal regulations, including HIPAA. Thank you.

NAME _____ AGE _____ DATE _____

CHIEF COMPLAINT: Please write a brief description of your main Ear, Nose & Throat/Head & Neck problem:
(The reason for your visit today) _____

PATIENT HEIGHT: _____ PATIENT WEIGHT: _____

Please check (X) any of the following you have:

- | | | | |
|---|---|--|--|
| Heart Disease <input type="checkbox"/> | Asthma <input type="checkbox"/> | Stroke <input type="checkbox"/> | High Blood Pressure <input type="checkbox"/> |
| COPD/Emphysema <input type="checkbox"/> | Kidney Disease <input type="checkbox"/> | Ulcer Disease <input type="checkbox"/> | Hepatitis <input type="checkbox"/> |
| Diabetes <input type="checkbox"/> | High Cholesterol <input type="checkbox"/> | Bleeding Disorder <input type="checkbox"/> | HIV <input type="checkbox"/> |

OTHER MEDICAL PROBLEMS:

1. _____
2. _____

PREVIOUS SURGERIES:

1. _____
2. _____
3. _____

HAVE YOU SEEN AN EAR, NOSE & THROAT DOCTOR BEFORE?:

Yes No If yes, Who? _____

MEDICATIONS CURRENTLY TAKING:

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

YOUR PHARMACY NAME: _____ LOCATION: _____

ARE YOU ALLERGIC TO ANY MEDICATIONS:

Yes If yes, list below No

- | | |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

SOCIAL HISTORY/HABITS:

Are you? Married Divorced Single Widowed

Do you have children? Yes No If yes, how many? _____

Have you ever used tobacco? _____ If yes, for how many years? _____ If you quit, when? _____

Do you currently smoke? _____ If yes, how much? _____ (packs per day)

Do you drink alcohol? _____ How many drinks per day? _____

FAMILY HISTORY:	Bleeding Disorder	Cancer	Diabetes	Hearing Loss	Heart Disease	High Blood Pressure	Kidney Disease	Thyroid Disease
Patient's Father								
Patient's Mother								
Patient's Father's Parents								
Patient's Mother's Parents								
Siblings (brothers/sisters)								
Children								

HISTORY & REVIEW OF SYSTEMS:

Please check (X) the following symptoms you presently have.

EARS:

- Ear pressure/fullness
- Drainage
- Pain
- Dizziness/Vertigo
- Decreased hearing
- Ringing in ears

THROAT:

- Sore throat
- Voice change
- Frequent clearing
- Difficulty swallowing

CARDIAC (HEART):

- Heart Disease
- High Blood Pressure
- Chest pain/pressure
- Heart murmurs
- Heart palpitations

NEUROLOGIC:

- Headaches
- Light headedness
- Nervous disorders
- Epilepsy/seizures
- Strokes

PULMONARY (LUNG):

- Shortness of breath
- Chronic cough
- Coughing up blood
- Asthma
- Emphysema

NOSE:

- Runny nose
- Post nasal drip
- Obstruction
- Sinus pain/pressure
- Allergies
- Loss of sense smell/taste
- Sleep Apnea
- Snoring

MOUTH:

- Dry mouth
- Ulcers

MUSCULAR/SKELETAL:

- Back pain
- Arthritis/Rheumatism
- Muscle pain/weakness
- Osteoporosis
- Jaw pain/popping

ENDOCRINE:

- Diabetes
- Thyroid problems
- Goiter/Nodule
- Thyroid medication

GASTROINTESTINAL:

- Weight loss
- Liver/cirrhosis
- Hepatitis
- Ulcer
- Heartburn/Reflux

Explanation: _____

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- **1 in 3 Americans have undiagnosed sleep disorders**
- **Over 40 million Americans are chronically ill with various sleep disorders**
- **40% of Americans report difficulty either falling asleep or staying asleep**
- **It is estimated that 90% of the population of patients with obstructive sleep apnea have not been diagnosed**

Sleep Apnea Questionnaire

Date: _____

Name: _____

THIS QUESTIONNAIRE WAS DEVELOPED BASED UPON PUBLISHED ARTICLES
BY THE AMERICAN ACADEMY OF SLEEP MEDICINE (A.A.S.M.)

Points

Have you been told that you stop breathing while you sleep?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	8
Have you ever fallen asleep or nodded off while driving?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	6
Do you awaken suddenly with shortness of breath, gasping or with your heart racing?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	6
Do you feel excessively sleepy during the day?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	4
Has anyone ever told you that you snore while you are sleeping?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	4
Have you had weight gain and found it difficult to lose?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	2
Have you taken medication for or been diagnosed with high blood pressure?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	2
Do you kick or jerk your legs while sleeping?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	3
Do you feel burning, tingling or crawling sensations in your legs when you wake up?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	3
Do you wake up with headaches during the night or in the morning?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	3
Do you have trouble falling asleep?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	4
Do you have trouble staying asleep once you fall asleep?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	4

Add the points together when you answered "Yes"

Score & Risk Factor _____

LOW 0-7	MODERATE 8-11	HIGH 12-15	SEVERE 16+
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Patient Consent

I hereby consent to the disclosure of my responses to the sleep Apnea questionnaire for the purpose of assisting in the diagnosis and treatment of a potential sleep disorder.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose to my protected health information to another entity, and I consent such disclosure for the permitted uses, including, but not limited to, disclosures via fax. I fully understand and accept the terms to this consent.

Patient Signature

Date