RUSSELL T. SNOW, D.O.
OTOLARYNGOLOGY (EAR, NOSE AND THROAT)
HEAD & NECK AND FACIAL PLASTIC SURGERY

ADULT PATIENT REGISTRATION

PLEASE PRINT: Today's Date: _____ I was referred by _____

PATIENT INFORMATION Male ( ) Female ( ) Are you an **active** member of the U.S. Military? _____

Name: _____ Home Phone: (_____)_____
First M.I. Last

Residence
Address: _____ City: _____ State: _____ Zip Code: _____
Mailing Address
(If different): _____ City: _____ State: _____ Zip Code: _____

Marital Status: ( )M ( )S ( )W ( )D Birth Date: _____/_____/_____ Age: _____ SS#: _____

Employer: _____ Work Phone: (_____)_____
Employer
Address: _____ City: _____ State: _____ Zip Code: _____

Occupation: _____ How long with present employer? _____

SPOUSE'S INFORMATION Is your spouse and **active** member of the U.S. Military? _____

Name: _____ Birth Date: _____/_____/_____ SS #: _____

Place of Employment: _____ Work Phone: (_____)_____
Employer
Address: _____ City: _____ State: _____ Zip Code: _____

Occupation: _____ How long with present employer? _____

INSURANCE INFORMATION

Insurance Company: _____ ID#: _____ Group#_____

Subscriber Name: _____ Relationship to patient: _____

DO YOU HAVE ADDITIONAL MEDICAL COVERAGE? ( ) YES ( ) NO

Insurance Company: _____ ID#: _____Group#_____

Subscriber Name: _____ Relationship to patient: _____

MEDICARE SIGNATURE AUTHORIZATION

_____ _____
Medicare HICN (Medicare #) Beneficiary (Please Print)

I request that payment of authorized Medicare benefits be made on my behalf to Russell T. Snow, D.O., P.A. for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services, formerly the Health Care Financing Administration, and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____
Date Beneficiary Signature

In case of EMERGENCY please contact (Please list someone NOT living in the same household):

Name: _____ Relationship: _____ Phone: (_____)_____

Address: _____ City: _____ State: _____ Zip Code: _____

SIGNATURE OF CONSENT
Please Read

1) TREATMENT: I AM AWARE THAT THE PRACTICE OF MEDICINE AND SURGERY IS NOT AN EXACT SCIENCE, AND I ACKNOWLEDGE THAT NO GUARANTEES HAVE BEEN MADE TO ME REGARDING THE RESULTS OF TREATMENTS OR EXAMINATIONS.

2) RELEASE OF INFORMATION: I AGREE THAT DR. SNOW'S OFFICE MAY DISCLOSE ALL OR ANY PART OF MY RECORDS TO ANY PARTY WHICH IS OR MAY BE LIABLE FOR ALL OR PART OF ANY CHARGES THAT OCCUR.

3) FOR CONTINUITY OF CARE, DR. SNOW'S OFFICE MAY DISCLOSE ALL OR ANY OF MY RECORDS TO ANY OTHER HEALTH CARE PROVIDER TO WHICH MY CARE MAY BE REFERRED.

4) I AUTHORIZE PAYMENT OF MEDICAL INSURANCE BENEFITS DIRECTLY TO DR. SNOW.

5) I AUTHORIZE DR. SNOW TO ACT AS MY AGENT IN HELPING ME OBTAIN PAYMENT FROM MY INSURANCE COMPANIES, AND AGREE TO PAY THE DIFFERENCE BETWEEN DR. SNOW'S FEES AND THE AMOUNT PAID BY MY INSURANCE.

6) I AUTHORIZE DR. SNOW'S OFFICE TO CONTACT ME BY PHONE TO CONFIRM APPOINTMENTS AND/OR DISCUSS INFORMATION REGARDING MY HEALTH OR ACCOUNT.

7) I AUTHORIZE THE FOLLOWING PERSONS TO RECEIVE MY HEALTH OR FINANCIAL INFORMATION ABOUT ME: (THIS WOULD INCLUDE A SPOUSE, CHILDREN OR OTHERS YOU WISH TO HAVE ACCESS TO YOUR INFORMATION. THIS DOES NOT APPLY TO OTHER PHYICIANS.)

   NAME _____ RELATIONSHIP _____ PHONE _____

   NAME _____ RELATIONSHIP _____ PHONE _____

   NAME _____ RELATIONSHIP _____ PHONE _____
   TO REVOKE THE ABOVE, A WRITTEN REQUEST MAY BE SUBMITTED BY THE PATIENT AT ANY TIME.

8) ONLY THE PATIENT OR LEGAL GUARDIAN MAY REQUEST COPIES OF MEDICAL RECORDS PRODUCED BY DR. SNOW FOR PERSONAL USE. A SIGNED RELEASE OF INFORMATION AND PHOTO IDENTIFICATION WILL BE REQUIRED.

SIGNED: _____ DATE: _____

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PAYMENT POLICY

Welcome to our office and specialty services of Dr. Russell T. Snow. Please review our payment policy. Payment is expected when services are rendered. Any other arrangement must be made in advance. Please contact the receptionist if you have any questions.

FIRST VISIT: The **FIRST VISIT** is on a CASH basis except for Medicare and Medicaid.

CASH: Payment for office visits is due in advance of each visit. If necessary, credit arrangements may be considered after the first visit.

INSURANCE: As a courtesy to you we file claims for most insurance companies. Co-payments and unmet deductibles are due at each visit.

MEDICARE: Dr. Snow accepts "assignment." This means that Medicare pays 80% of allowed charges and you pay 20%. You are responsible for your yearly deductible. We file all Medicare claims.

MEDICAID: CURRENT Medicaid cards are necessary at EACH visit. Non-covered services are your responsibility for payment at the time of service. **We accept IDAHO MEDICAID ONLY**. **If you DO NOT have Medicaid at the time of service we will NOT back bill Medicaid for the visit.**

WORKMEN'S COMPENSATION: We will file your claim, but you will be responsible for payment if the claim is denied.

NOTE: YOUR INSURANCE IS NOT A SUBSTITUTE FOR PAYMENT. IF YOU CANNOT COMPLY WITH OUR POLICY, PLEASE SEE AN OFFICE STAFF MEMBER. THANK YOU.

INTEREST WILL BE ADDED TO UNPAID ACCOUNTS AT 21% ANNUALLY.
ALL NON-COVERED CHARGES ARE YOUR RESPONSIBILITY

PLEASE INDICATE METHOD OF PAYMENT BY CHECKING ONE OF THE FOLLOWING:

_____ I agree to pay for each visit at the time of service by
( ) Cash ( ) Personal Check ( ) Credit Card

_____ I agree to pay my insurance portion (e.g. 20% or deductible) at the time of service.

_____ I agree to pay my Medicare deductible or co-pay on covered services and other amounts for which the patient is responsible.

_____ This is a Workmen's Compensation claim.

_____ I have a CURRENT Medicaid card. **If you DO NOT have Medicaid at the time of service we will NOT back bill Medicaid for the visit.**

I acknowledge the above policy and agree to comply.

_____ _____
Signature of Responsible Party Date

PATIENT MEDICAL AND SOCIAL HISTORY **RUSSELL T. SNOW, D.O., P.A.**

Date: _____ **Living Will: Yes**_____ **No:**_____

Name: _____ **Date of Birth:** _____ **Age:** **M or F** _____

Marital status: PLEASE CIRCLE ONE **Occupation-Current and former:**

Single Divorced Married Widowed _____

Referring Physician: **Primary Physician:**

Reason for Visit (Describe ALL Pertinent Symptoms and Date of Onset):

Past Medical History: (list all medical diagnoses)_____

Previous Surgeries:_____

Have you or a **biological** family member had complications with anesthesia? No Yes Explain:_____

List Current Medications: NONE _____

Name:	Strength: (e.g. 500mg tablets)	Dose**:** (e.g. 1 tablet 2 times daily)

Preferred Pharmacy:_____

Medication Allergies: None Known_____ **Yes** (Explain: Name and reaction)_____

Patient Social History:

Use of alcohol: Never:_____ Type/Frequency:_____ Quit when? _____

Use of tobacco: Never:_____

CURRENT Smoker: packs/day:_____ How long?____ yrs.

FORMER smoker: packs/day:_____ Started? _____ Quit?_____

Smokeless Tobacco? Type:_____ Amount: _____ How long:_____ Quit when?_____

Does anyone in the home smoke:_____ If yes, do they smoke inside or outside of the home:_____

Use of recreational drugs: Never:_____ Type/Frequency:_____ Quit when? _____

Pets in home: None_____ If Yes, What Kind:_____

Lives with: Spouse:_____ Father:_____ Mother:_____ Siblings:_____ Other:_____

Hearing Loss? No:_____ Yes:_____ Right ear ____ Left ear ____ Both ears ____ How long?_____

Noise Exposure History (sources, how long):_____

Has any blood relative had hearing loss prior to age 65? No or Yes Type:

Family History: (**Biological** Family Members only)

	IF LIVING: Current **Age** and Health Status (Healthy or Medical Problems and/or Illnesses)	**IF DECEASED**: Age at Death/Cause
Father		
Mother		
Brothers		
Sisters		

Other Family Illnesses:_____

Russell T. Snow, D.O.

Systems Review

List only **CURRENT** abnormal conditions unless designated as history

1) General Constitution	**Yes**	**No**	**Comment**
Weight change, recent over 10 lbs			_____
Fevers			_____
Night sweats/Chills			_____
General ill feeling			_____
2) Eyes			
Recent change in vision			_____
Eye pain			_____
Eye drainage			_____
Watering or itching			_____
3) ENT and Mouth			
Hearing loss, recent or previous?			_____
Ear pain or drainage			_____
Noise in ears (ringing, buzzing etc.)			_____
Nasal bleeding			_____
Nasal drainage (runny nose) (color?)			_____
Nasal congestion, breathing difficulty			_____
Sense of smell, absent or poor?			_____
Snoring problem			_____
Long breathing pauses during sleep			_____
Daytime sleepiness			_____
Facial pain			_____
Teeth aching or painful			_____
Sore throat			_____
Bad breath			_____
Hoarseness			_____
Choking on food or fluid			_____
Difficulty swallowing			_____
Painful swallowing			_____
Lump sensation in throat			_____
Lump or swelling in neck or jaw			_____
Open sores in nose, mouth or throat			_____
4) Cardiovascular			
Heart attack history			_____
Heart surgery history			_____
High blood pressure			_____
Chest pain (angina) history			_____
Irregular heart beat			_____
Leg ulcers or swelling			_____
5) Respiratory			
Persistent cough			_____
Cough up blood			_____
Shortness of breath			_____
Wheezing			_____
6) Gastrointestinal			
Nausea or vomiting			_____
Diarrhea			_____
Abdominal pain			_____
Heartburn, frequent			_____
Bloody vomiting			_____
Bloody or black stool			_____

7) Genitourinary	**Yes**	**No**	**Comment**
Congenital kidney disease, history			_____
Painful/Bloody urination			_____
8) Musculoskeletal			
Painful or swollen joints			_____
Arthritis			_____
Other rheumatoid diseases, history			_____
Chronic TMJ (jaw joint) problem			_____
9) Skin/Scalp Face, Head or Neck			
Non-healing sores			_____
Lumps, bumps, thick spots			_____
Red/flaking spots or patches			_____
Brown or black spots or patches			_____
10) Neurological			
Frequent or severe dizziness			_____
Imbalance, chronic or recurrent			_____
Seizure/Epilepsy history			_____
Numbness in face, head or neck			_____
Weakness/Paralysis face or neck			_____
Headaches, chronic or recurrent			_____
11) Psychiatric			
Depression			_____
Stress/Anxiety			_____
12) Endocrine			
Thyroid disease			_____
Diabetes			_____
13) Hematological/Lymphatic			
Bleeding disorder			_____
Anemia/Other blood disease			_____
Taking Aspirin or other blood thinner			_____
High Cholesterol			_____
Enlarged glands in head, neck or face			_____
14) Allergic/immunologic			
Sneezing			_____
Environmental allergy symptoms			_____
AIDS or HIV positive			_____
Tetanus vaccine, date of last dose			_____
15) Women Only			
Pregnant now			_____
Birth control, type			_____
Menopause			_____

Note: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so or by court order.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my (my child's) health. It is my responsibility to inform Dr. Snow's office of any changes in my (my child's) medical status.

Print Patient's Name: _____

PATIENT/RESPONSIBLE PARTY SIGNATURE:

_____

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Insurance Billing Policy

Our practice accepts insurance from all major insurance companies. Payment in full of your share is expected at the time of service. As a courtesy, our practice will review your insurance coverage, estimate your insurance company payment and file your claim with your insurance carrier. We ask that you assign all insurance company payments directly to our office to avoid any misunderstanding regarding payment of professional services. If you request your insurance company to pay you directly, we will require full payment when services are rendered. You will be responsible for any portion of your bill which is denied or not paid by your insurance carrier. Your insurance coverage is a contract between you and your insurance carrier, however, we will assist you to maximize your insurance benefits.

If an insurance problem occurs, you will be asked to assist us in contacting your insurance carrier. If your insurance company has not paid within 30 days of submitting the claim, we ask that you pay the insurance portion. When the insurance company does pay, we will gladly reimburse any credit balance to you within 30 days of receipt. We feel it is necessary to work together to resolve any insurance problems.

All patients without insurance will be asked to pay for each visit, in full, at the time of service. If necessary, credit arrangements may by considered after the first visit. For any unpaid portions, we require a written financial agreement and a copy of a photo ID.

Our practice firmly believes that a favorable doctor/patient relationship is based upon understanding and open communication. Our staff has been instructed to make every effort to clarify any misunderstanding you may have concerning your balance. If you have any questions concerning our payment policy or need assistance, please let one of our staff know immediately.

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Keep This Notice for Future Use
Your Billing Rights

This notice contains important information about your rights and our responsibilities under the Fair Credit Billing Act.

Notify Us in Case of Errors or Questions About Your Bill

If you think your bill is wrong, or if you need more information about a transaction on your bill, write us (on a separate sheet) at the address listed on your statement. Write to us as soon as possible. We must hear from you no later than 60 days after we sent you the first bill on which the error or problems appeared. You can telephone us, but doing so will not preserve your rights.

In your letter, give us the following information:

-Your name and account number.
-The dollar amount of the suspected error.
-Describe the error and explain, if you can, why you believe there is an error. If you need more information, describe the item you are not sure about.

Your Rights and Our Responsibilities After We Receive Your Written Notice

We must acknowledge your letter within 30 days, unless we have corrected the error by then. Within 90 days, we must either correct the error or explain why we believe the bill was correct.

After we receive your letter, we cannot try to collect any amount you question, or report you as delinquent. We can continue to bill you for the amount you question, including finance charges, and any unpaid amount may limit your credit. You do not have to pay any questioned amount while we are investigating, but you are still obligated to pay the parts of your bill that are not in question.

If we find that we made a mistake on your bill, you will not have to pay any finance charges related to any questioned amount. If we didn't make a mistake, you may have to pay finance charges, and you will have to make up any missed payments on the questioned amount. In either case, we will send you a statement of the amount you owe and the date that it is due.

If you fail to pay the amount that we think you owe, we may report you as delinquent. However, if our explanation does not satisfy you and you write to us within ten days telling us that you still refuse to pay, we must tell anyone we report you to that you have a question about your bill. And, we must tell you the name of anyone we reported you to. We must tell anyone we report you to that the matter has been settled between us when it finally is.

If we don't follow these rules, we can't collect the first $50.00 of the questioned amount, even if your bill was correct.