NAPERVILLE EAR, NOSE & THROAT ASSOCIATES

Leonard S. Piazza, M.D., F.A.C.S
Rodney T. Caniglia, M.D.
Robert J. Kany, M.D.

10 West Martin Ave. #260
Naperville, Naperville, IL 60540
TEL: (630)355-5668
FAX: (630)355-2071

By signing this form, you acknowledge that Naperville Ear, Nose, and Throat Ltd. (NENTA) have offered you a copy of its Privacy Notice, which explains how your health information will be handled in various situations. We must try to have you sign this form on your first date of service with us after. Oct 27th 2014

If your first date of service with us was due to an emergency, we must try to give you this notice and get your signature acknowledging receipt of this notice as soon as we can after the emergency.

[ ] I have received NENTA's Privacy Notice.

[ ] NENTA has offered me a copy of their Privacy Notice and the chance to discuss my concerns and questions about the Privacy of my health information.

Please list any person with whom we MAY share details about your health care. Indicate below whether this may include sensitive health information (SHI) such as mental health, developmental disabilities, AIDS/HIV or other STD treatment and/or diagnosis, Drug/Alcohol abuse diagnosis, treatment and/or referral and genetic testing.

Name	Relationship	Phone Number	Release SHI?
			Yes ☐ NO ☐
			Yes ☐ NO ☐
			Yes ☐ NO ☐

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases when the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to physician's office.

Signature: _____ Date: _____

Printed Name: _____

Patient, Parent or Guardian Signature

NENTA's staff should complete if Acknowledgement Form is not signed:

Does patient have a copy of the Privacy Notice? [ ] Yes [ ] No

Please explain why the patient was unable to sign an acknowledgement form and NENTA's efforts in trying to obtain the patient's

signature: _____

_____

NAPERVILLE
EAR, NOSE & THROAT
ASSOCIATES

Leonard S. Piazza, M.D., F.A.C.S
Rodney T. Caniglia, M.D.
Robert J. Kany, M.D.

10 West Martin Ave. #260
Naperville, Naperville, IL 60540
TEL: (630)355-5668
FAX: (630)355-2071

Patient's Name: _____ Date of Birth: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____Cell Phone: _____Work Phone:_____

Which phone number is best to use during the day (9am-5pm)? ☐Home ☐Cell ☐ Work

Which phone number is best to use during the evening (5pm-7pm)? ☐Home ☐Cell ☐Work

Patient's SS#: _____

Pharmacy: _____ Pharmacy Number: _____

Responsible Person's Name: _____

Responsible Person's address: _____

Primary Care Physician and Phone Number: _____

Primary Insurance Information

Insurance Name: _____ Effective Date: _____

Policy Holder's Name: _____ Date of Birth: _____

Policy Holder's SS#: _____ Employer: _____

Relationship to patient: _____

Secondary Insurance Information

Insurance Name: _____ Effective Date: _____

Policy Holder's Name: _____ Date of Birth: _____

Policy Holder's SS#: _____ Employer: _____

Relationship to patient: _____

In Case of an Emergency

Contact: _____ Phone: _____ Relationship: _____

_____

Responsible Party Signature Date

NAPERVILLE
EAR, NOSE & THROAT
ASSOCIATES

Leonard S. Piazza, M.D., F.A.C.S
Rodney T. Caniglia, M.D.
Robert J. Kany, M.D.

10 West Martin Ave. #260
Naperville, Naperville, IL 60540
TEL: (630)355-5668
FAX: (630)355-2071

Welcome, to Naperville Ear, Nose and Throat Associates, LTD. Our professional staff is readily available to meet your family's medical needs. The business office is able to assist you in meeting the financial obligations, which go along with Medical care.

It is our Office Policy to receive payment for all office services at the time services are rendered. For your convenience, we accept cash, check, Discover, Visa, and MasterCard. If you have insurance, we will provide the necessary information for you to file for insurance reimbursement or we will file the claims for you. However, **IT IS THE PATIENT'S RESPONSIBILITY** to know their own insurance plan and to obtain the necessary elements needed to satisfy the contract between you and your insurance company (i.e.: referrals, co-pays, deductibles, and coinsurances). Please provide us with your current insurance card(s) at the time of your office visit to avoid delay in filing claims.

HMO/POS: Members may be required to pay a co-payment and obtain a referral or authorization from their Primary Care Physician. **Co-payments and referrals are due at the time services are rendered.** Insurance claims will be filed for patients. Co-insurance balance will be the responsibility of the patient

MEDICARE: We are Medicare participating physicians. Charges for services rendered to Medicare patients will be filed with carrier. Medicare patients are responsible for the 20% co-insurance and any amount not paid by Medicare and/or any supplemental insurance.

PPO/OTHER INSURANCE: Insurance claims will be filed for all services provided. Patients may be required to pay a co-payment at the time of service. Insurance will be filed for all services provide in the hospital. It is important for the patient to provide the correct insurance information for filing. Not all insurance plans pay the same benefits or apply the same deductible, thus there may be a balance due after insurance has paid. Since the Insurance contract is an agreement between you and your insurance company, any unpaid balance will remain the responsibility of the patient. **ALL PATIENTS ARE RESPONSIBLE FOR ANY AMOUNT NOT PAID FOR BY THEIR INSURANCE.**

STATEMENTS: Every effort is made to avoid the cost of having to mail statements. Statements are mailed monthly to those patients with balances due and payment is due upon receipt.

COLLECTIONS: You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 30% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

AUDIOLOGY COPAYMENTS: We would like to inform you, Aetna and Cigna Insurance Companies will require you to pay an additional copay for the hearing test. Please contact your insurance company for further information.

OFFICE FEES: A) Filling out **Disability Forms** will be a charge of $30. B) Copying of **patient medical records** will be a charge of $20 or more. For NSF checks there will be a fee of $30.

DISCLOSURES: NENTA would like to inform our patients that NENTA has financial interest in Naperville Center for Sleep Health as well as the Center for Surgery as well as Entellus. Patients can feel free to request to obtain services elsewhere and they will not be treated differently if they choose to go to another facility.

We hope this provides you with the basic information needed concerning our payment structure.

If you have any questions, please feel free to contact our Insurance Department at (630)355-5668.

I hereby voluntarily consent to medical treatment by Naperville Ear Nose & Throat Associates, LTD.

Please sign below verifying you have read and understand our payment policy.

Responsible Party Signature Date

NAPERVILLE EAR, NOSE & THROAT ASSOCIATES

Leonard S. Piazza, M.D., F.A.C.S
Rodney T. Caniglia, M.D.
Robert J. Kany, M.D.

10 West Martin Ave. #260
Naperville, Naperville, IL 60540
TEL: (630)355-5668
FAX: (630)355-2071

PATIENT HISTORY ~ Please fill out front and back of form~

Date: _____ **Weight:** _____
Age: _____ **Height:** _____
Date of Birth: _____ **Sex:** _____**M** _____**F**

Current Medications:
List Current Medications and Dosages Please list all Herbal supplemental and Vitamin, over the counter:
_____
_____
_____

Drug Allergies:
Do you have any allergies to medication: _____ Yes _____ No
If yes, list the medication and the reaction:
_____
_____

PAST MEDICAL HISTORY: (Place an **X** in the box next to your associated medical conditions)

_____ Diabetes
_____ Asthma
_____ Allergies (pollen, mold, etc)
_____ Emphysema
_____ Arthritis
_____ Migraines
_____ Anxiety
_____ Depression
_____ Hepatitis
_____ Diverticulosis
_____ Gallstones
_____ Heart Attack
_____ Stroke

_____ High Cholesterol
_____ High Blood Pressure
_____ Irritable Bowel
_____ Stomach Ulcer
_____ Kidney Stones
_____ Enlarged Prostate
_____ Abnormal Heart Rhythm
_____ Heart Valve Damage
_____ Heart Murmur
_____ Ulcerative Colitis
_____ Glaucoma
_____ Pancreatitis
Other: _____

_____ Crohn's Disease
_____ Hyperthyroid (High Level)
_____ Hypothyroid (Low Level)
_____ Breast Cancer
_____ Colon Cancer
_____ Uterine Cancer
_____ Skin Cancer
_____ Prostate Cancer
_____ Lung Cancer
_____ Mouth Cancer
_____ Thyroid Cancer
_____ Other Cancer

_____

PREVIOUS OPERATIONS:
(Next to your previous operation, write-in your age at which time the surgery was done)

_____ Ear Tubes (age) _____
_____ Hernia (age) _____
_____ Cystoscopy (Bladder)(age) _____
_____ Hemorrhoidectomy (age) _____
_____ Breast Biopsy (age) _____
_____ Varicose Veins (age) _____
_____ Pacemaker (age) _____
_____ C-sections (age) _____
_____ D and C (age) _____
_____ Mastectomy (age) _____
_____ Angioplasty (age) _____

_____ Tonsils (age) _____
_____ Knee Arthroscopy (age) _____
_____ Wisdom Teeth (age) _____
_____ Stomach for Ulcer (age) _____
_____ Gallbladder (age) _____
_____ Fracture, Plates/ Screws (age) _____
_____ Hip Surgery (age) _____
_____ Colon Surgery (age) _____
_____ Vascular Surgery (age) _____
_____ Carotid Artery Surgery (age) _____
_____ Aorta Aneurysm Surgery (age) ___

_____ Adenoids (age)
_____ Bunions (age) _____
_____ Appendix (age) _____
_____ Prostate Surgery (age) _____
_____ Coronary Artery Bypass (age) _____
_____ Nose Repair (age) _____
_____ Breast Implants (age) _____
_____ Plastic Surgery (age) _____
_____ Heart Valve (age) _____
_____ Hysterectomy (age) _____
_____ Ovaries Removed (age) _____

_____ Septoplasty (correction of a crooked or deviated septum (age) _____
_____ Endoscopic Sinus Surgery (age) _____
_____ Palate Surgery for snoring/sleep apnea (age) _____
Other: _____
_____

Patient Signature: _____ Date: _____

Print Patient Name: _____ Date: _____

REVIEW OF SYSTEMS:

1. **Constitution:** **Poor Health**: ____Yes ____No **Fatigue**: ____Yes ____No **Weight Loss**: ____Yes ____No

2. **Ear, Nose and Throat:**

Ear Problems Yes No	**Sinus Problems** Yes No	**Hoarseness** Yes No
Ringing in Ears Yes No	**Nasal Congestion** Yes No	**Throat Pain** Yes No
Hearing Loss Yes No	**Smell Disorder** Yes No	**Swallowing Difficulty** Yes No
Dizziness Yes No	**Allergies** Yes No	**Snoring/Sleep Apnea** Yes No
Meniere's disease Yes No	**Nose Bleeds** Yes No	**Taste Problems** Yes No

3. **Eyes:**

Blurred Vision Yes No	**Painful Eyes** Yes No	**Irritation from Light** Yes No

4. **Respiratory:**

Asthma Yes No	**Chronic Cough** Yes No	**Emphysema** Yes No
Shortness of Breath Yes No	**Lung Infections** Yes No	**Tuberculosis** Yes No

5. **Cardiovascular (Heart):**

Chest Pain Yes No	**Heart Trouble** Yes No	**Heart Murmur** Yes No
High Blood Pressure Yes No	**Palpitations/Fluttering of Heart** Yes No	

6. **Gastrointestinal (Stomach):**

Ulcers/Heartburn Yes No	**Hepatitis** Yes No	**Bowel Irregularity** Yes No

7. **Genitourinary:**

Kidney Disorder Yes No	**Urinary Tract Infections** Yes No	**Prostate Disease** Yes No

8. **Endocrine (Glands):**

Thyroid Disorder Yes No	**Diabetes** Yes No

9. **Allergy/Immunology (Blood Problems):**

Bleeding Disorder Yes No	**Frequent Infections** Yes No	**Cancer** Yes No
Anemia Yes No	**Blood Transfusion** Yes No	**Arthritis** Yes No

10. **Neurological/Psychiatric (Nerves):**

Seizures Yes No	**Mental Disorder** Yes No	**Stroke** Yes No

FAMILY HISTORY: (Please circle M-mother, F-father, S-sister, B-brother, C-children if they had the following)

Allergies	M F S B C	Cancer	M F S B C
Asthma	M F S B C	Diabetes	M F S B C
Reaction to anesthesia	M F S B C	Bleeding Disorder	M F S B C
Hearing Loss	M F S B C	Heart Disease	M F S B C
Stroke	M F S B C	Arthritis	M F S B C
Thyroid Disease	M F S B C	Kidney Disease	M F S B C

11. **Social History and Habits:**

CURRENT Tobacco use: **Cigarettes** Yes No (___ packs per day) **Cigars/pipes/chew** Yes No (_____ # per day)
PAST Tobacco use: Age Started ____ Age Stopped ____ Packs/Day (average) ____
FOR CHILDREN: Does anyone smoke inside the home where the child lives or spends a significant amount of time? Yes No
Has patient ever been exposed to second hand smoke? Yes No

12. **Alcohol:**

Present Use: **Never** Yes No **Occasional** Yes No **Frequently** Yes No **Daily** Yes No
Past Use: **Never** Yes No **Occasional** Yes No **Frequently** Yes No **Daily** Yes No

Occupations: Current: _____Past:_____

Married: Yes No **Single:** Yes No **Divorced:** Yes No **Separated:** Yes No **Widowed:** Yes No

Number of children: ____ Women Only: **Are you pregnant** Yes No **Planning pregnancy** Yes No

THANK YOU FOR ENTRUSTING US WITH YOUR CARE!