ENT Center of Excellence

Board Certified Surgeons specializing in all aspects of medical and surgical needs pertaining to the EAR, NOSE & THROAT.

Gary A. Buxa, MD, FACS Richard T. Bergstrom, MD

Last Name, First, Middle Initial			Employer's Name Work Phone
Social Security Number			Full Time Part Time Unemployed Disabled Student Homemaker Retired Self
Date of Birth	Sex M F	Marital Status M D S W	Circle One: African American Asian Native American White Other
Mailing Address			Pharmacy of Choice
City State Zip Code			**Patient / Guardian E-Mail**
Home Phone		**Cell Phone**	Emergency Contact Name
May we leave messages on voicemail? YES NO			Emergency Contact Phone Relationship
IF PATIENT IS A MINOR—NAME AND RELATION OF RESPONSIBLE PARTY			

INSURANCE INFORMATION: (If you are "**SELF PAY**" check here and skip this section) ☐

Primary Insurance		Secondary Insurance	
Policy or ID Number		Policy or ID Number	
Group Number		Group Number	
Subscribers Name	Relationship to Patient	Subscribers Name	Relationship to Patient
Subscribers Social Security #	Subscribers Date of Birth	Subscribers Social Security #	Subscribers Date of Birth
Subscribers Employer		Subscribers Employer	

Primary Care Physician Name & Phone Number _____

Referring Physician Name & Phone Number _____

HAVE YOU SEEN ONE OF OUR DOCTORS IN THE PAST? _____IF SO, WHEN? _____

PLEASE CONTACT OUR OFFICE 24 HOURS IN ADVANCE TO CANCEL OR RESCHEDULE AN APPOINTMENT
THERE WILL BE A $25.00 CHARGE FOR MISSED APPOINTMENTS

I consent to treatment and authorize this office to release to the named insurance company any information necessary to expedite insurance payment. I understand that I am responsible for all charges, regardless of insurance coverage.

PARENT OR GUARDIAN SIGNATURE _____ DATE: _____

3305 Placer Street, Suite A • Redding, CA 96001
Office: 530.243.ENTS (3687) • Fax: 530.243.3383 • www.ENTexcellence.com
Office email: buxabergstrom@sbcglobal.net

ENT Center of Excellence
Dr. Richard Bergstrom & Dr. Gary Buxa

OFFICE AND FINANCIAL POLICY

ENT Center of Excellence thanks you for the trust you have placed in us by selecting our practice for your needs. We are acutely aware of the escalating costs of health care and strive to maintain fees which are reasonable and customary for our area. We believe that communication is critical to our relationship and have established the following office and financial policies. We welcome any questions or comments you may have. Our staff is ready and willing to make your visit with us as smooth as possible.

1. We bill all insurances as a courtesy to you. **NOTE:** We are **NOT** contracted with **ALL** insurance carriers. If we do not have a contract with your insurance carrier you will be required to pay your full balance at the time of service. Any office visit copay is to be paid in full at the time of service. Your ***estimated*** amount due for any surgical service(s) is due prior to any services being rendered. We will balance bill you for any amounts due over the estimated charge(s). You will be reimbursed for any overpayment made by you, the patient, once all charges have been fully processed by your insurance plan. **It is the patient's responsibility to contact their insurance company to determine if we are in your provider network. Failure to do so may result in additional cost to you. Please contact your insurance company if you have any questions about your specific policy.**

2. As a courtesy to our patients, we accept Visa and MasterCard, at no charge. We also accept personal checks and money orders. A $25.00 processing fee will be charged on all returned checks.

3. We will be happy to complete your disability insurance forms for you. However, there will be a $10.00 fee for each form that is completed. This fee will be paid prior to the form being completed.

4. If you are a new patient to our office, there are several forms that need to be completed, **in their entirety**, before we can see you. We can mail or fax the forms to you or they can be downloaded from our web site www.entexcellence.com. Please complete the forms and return them to our office **prior** to your appointment, or you may arrive **15 minutes early** to your scheduled appointment with the completed paperwork. This will allow us the time we need to get your account and chart ready and avoid any delays in your appointment or possibly having to reschedule your appointment to another day. **Patients are required to present their photo ID and their current/valid insurance card(s) at the time of their visit.** If you do not have your insurance card(s) with you at the time of service you will be considered private pay until the correct information is provided to our office.

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OFFICE AND FINANCIAL POLICY CONTINUED

5. Please be sure we have a current list of any medications you may be taking. This also includes any over the counter vitamins, supplements, etc. Please also list any allergies you may have to certain medications.

6. If you are in need of a prescription refill please call your pharmacy with the request and they will contact our office. We require 48 hour notice on refills as we do not always have a doctor in the office to review the request. Refills will **not** be given over the weekend, so please plan accordingly.

7. A 24 hour notice of cancellation is required on all appointments and/or procedures. A missed appointment is a lost opportunity to help another patient. A $25.00 fee may be charged for each appointment/procedure scheduled, but not attended, due to the patient/guardian not calling to cancel at least 24 hours prior to the scheduled appointment/procedure. If you are scheduled for a **VNG test** and do not keep the appointment or cancel within 24 hours a fee of $50 will be charged.

This will acknowledge that I have read and fully understand the office and financial policies discussed above and further agree to be responsible for payment of all medical services rendered on my behalf or of those for whom I am financially responsible. I authorize this office to release to the named insurance company(ies) any information necessary to expedite insurance payment. I assign all insurance benefits directly to Dr. Richard Bergstrom or Dr. Gary Buxa.

I agree to all terms of this contract and will be responsible for all services and fees associated with collection costs and litigation in the event my services are unpaid.

_____
Print Name of Patient

_____ _____
Signature of Patient / Responsible Party **Date**

Gary A. Buxa, MD FACS

Richard T. Bergstrom, MD

Authorization for Use or Disclosure of Protected Health Information

Patient Name:_____ **Date of Birth:**_____
(print)

Address:_____ **City:**_____ **State:**_____ **ZIP Code:**_____

Telephone Number:_____

I,_____**, authorize ENT CENTER OF EXCELLENCE, DR. RICHARD BERGSTROM AND DR. GARY BUXA to release protected health information about me to:**

Name	Relationship to Patient
_____	_____
_____	_____
_____	_____

Protected Health Information will be used and/or disclosed for the following purposes:
( ) At the request of the individual (check the box if applicable)
( ) Other (Please list each purpose of the use(s) or disclosure(s) in the space provided):
_____
_____

- **I understand that if the person or entity receiving protected health information is not a health plan or health care provider covered by federal privacy regulations, the authorized information may be re-disclosed by the recipient and may no longer be protected by federal or state law.**
- **I understand that I may revoke this authorization at any time by notifying ENT CENTER OF EXCELLENCE in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by ENT CENTER OF EXCELLENCE before receiving my revocation.**
- **I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.**
- **I understand that ENT CENTER OF EXCELLENCE may require me to sign an authorization prior to receiving research-related treatment or treatment solely for the purpose of creating health information for another party and that ENT CENTER OF EXCELLENCE will not provide such research –related treatment unless I provide this authorization. NOTE: If this provision is applicable, the third party for whom the information is being created must be listed under "Person or Class of Person to Whom the Use or Disclosure of Protected Health Information May be Made." Also, the purpose for which the information is to be created and disclosed must be listed under "Protected Health Information will be Used or Disclosed for the Following Purposes."**

This authorization expires on the following date _____ **OR the date the following event occurs (whichever is earlier):**

_____
(describe event or write "not applicable")

I am the individual to whom the information/record applies to or that person's parent (if a minor) or legal guardian.

Signature:_____ **Date:**_____

Name:_____ **Relationship:** _____
(print)

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Patient & Family History

Patient Name: _____ Age: _____ DOB: _____ Today's Date: _____

Who referred you to our office: _____ Primary Care Physician _____

Reason for this visit: _____ **Height**_____ **Weight**_____

Please be as accurate and complete as possible. This information will assist the Doctor in your treatment.

Medical Illness's:

	Yes	No		Yes	No
Cardiac Disease (heart attack, heart disease	___	___	Glaucoma	___	___
Cardiologist name: _____			Osteoporosis	___	___
High Blood Pressure	___	___	Other: _____		
Kidney Disease	___	___	_____		
Convulsion Disorder (epilepsy)	___	___	_____		
Chronic Lung Disease	___	___	_____		
Diabetes	___	___	_____		
A Bleeding Tendency	___	___	_____		

Past Surgeries:

_____

_____

Current Medications with Strength: **Please indicate if none ( ) List of medications attached ( )**

_____

_____

Known allergies to medications: **Please indicate if none ( )**

_____

Family Medical History: **Please indicate if none ( )**

Cancer _____ Diabetes _____ Heart disease _____ TB _____ Other _____

_____

Social History:

Occupation _____ Employer _____ Marital Status _____

Do you use Tobacco? Yes___ No ___ Daily amount used? _____ How many years? _____

Do you use Alcohol? Yes ___ No ___ Daily amount used? _____ Caffeine use? Yes ____ No ____

Are you pregnant? Yes___ No ___ illicit drug use? _____

Review of Systems - Please circle if you have or have had any of the following:

Constitutional	Appetite change	Weight chg	Fever	Chills	Fatigue	None
Skin	Itching	Rash	Hives	Skin cancer	None	
Allergy/Imm.	Food	Seasonal	None			
ENM&T	Hearing changes	Ear pain	Ringing	Voice Changes	None	
Eyes/Head	Vision changes	Headaches	Dizziness	None		
Respiratory	Shortness of Breath	Cough	Wheezing	None		
CV	Leg swelling	Irregular heart beat		None		
GI	Indigestion/heartburn	Nausea	Bowel changes	Pain/difficulty swallowing		None
GU	Painful urination	Blood in urine	Decreased flow	Frequent night urination		None
Endo	Diabetes	Steroid use	Thyroid problems	None		
Musculoskeletal	Joint pain	Muscle pain	Gout	Osteoporosis	None	
Neuro	Seizure	Stroke	Tingling	None		
Psych	Anxious	Depressed	Stress	None		
Heme/Lymph	Anemia	Bruise easily	Bleeding	Swollen glands	None	

All other systems _____

Indicate if you use the back of the form or attach additional medical information ( )

Do not write below this line. For office use only! _____

Reviewed by Doctor: _____ Date: _____

Gary A. Buxa, MD FACS

Richard T. Bergstrom, MD

PATIENT NOTIFICATION
DISCLOSURE OF PHYSICIAN OWNERSHIP

We would like to disclose to you that the physicians have a financial interest in the following healthcare facilities:

Apogee Outpatient Surgery Center
North State Surgery Centers

You have the right to use a healthcare facility other than those listed, if you choose. You will not be treated differently by your physician if you choose another health care facility.

If you have any questions concerning this notice, please feel free to ask for additional information from your physician or a representative of ENT Center of Excellence.

If you are uncomfortable with your physician's relationship with any of these healthcare facilities and prefer to have your surgery performed elsewhere, we will be happy to honor your request. Please do not hesitate to talk to us about scheduling your surgery at another healthcare facility.

I have read and understand this Disclosure of Physician Ownership.

_____

Patient or Responsible Party Signature **Date**

_____

Patient Name – Please print

Gary A. Buxa, MD FACS **Richard T. Bergstrom, MD**

Acknowledgment of Receipt of Notice of Privacy Practices

Patient Name:_____ ***DOB:***_____

I acknowledge that I have received a copy of **ENT Center of Excellence,**

Gary A. Buxa, MD FACS & Richard T. Bergstrom, MD's Notice of Privacy Practices.

_____ _____

Signature of Patient or Responsible Party/Legal Guardian Date

FOR OFFICE USE ONLY

[ ] Consent received by_____

[ ] Consent refused by patient, and treatment refused as permitted.

[ ] Consent added to the patient's medical record on _____

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