ENT CENTER OF EXCELLENCE

RICHARD BERGSTROM, MD GARY BUXA, MD FACS
3305 PLACER STREET, SUITE A REDDING, CA 96001
PHONE: 530-243-3687 FAX: 530-243-3383
WWW.ENTEXCELLENCE.COM

Please fill out this form in its entirety. It will be part of your medical records & kept confidential

PATIENT NAME:______________________________ DOB:__________ TODAY'S DATE: __________

REASON FOR YOUR VISIT:______________________________ HEIGHT: ________ WEIGHT: ________

WERE YOU REFERRED TO OUR OFFICE? YES ◯ NO ◯ IF YES, WHICH PHYSICIAN REFERRED YOU? ____________

FAMILY HISTORY:

HAVE ANY OF YOUR RELATIVES EVER HAD ANY OF THE FOLLOWING? IF YES, STATE RELATIONSHIP AND EXPLAIN

DIABETES YES ◯ NO ◯ ______________________________
HEART PROBLEMS YES ◯ NO ◯ ______________________________
TUBERCULOSIS YES ◯ NO ◯ ______________________________
CANCER YES ◯ NO ◯ TYPE: ______________________________

SOCIAL HISTORY:

HAVE YOU EVER SMOKED OR USED TOBACCO? YES NO
IF YES, HOW MUCH PER DAY?______________ AT WHAT AGE DID YOU START?____________
WHEN DID YOU QUIT? (IF APPLICABLE)______________________
ALCOHOL INTAKE (CIRCLE ONE): NONE/OCCASIONAL/MODERATE/HEAVY YEARS OF USE:__________
CAFFEINE INTAKE (CIRCLE ONE): NONE/OCCASIONAL/MODERATE/HEAVY
ILLICIT DRUG USE? YES ◯ NO ◯ IF YES, PLEASE LIST:______________________________

PERSONAL MEDICAL HISTORY:

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

DIABETES YES ◯ NO ◯
HIGH BLOOD PRESSURE YES ◯ NO ◯
HEART PROBLEMS YES ◯ NO ◯ CARDIOLOGIST NAME:______________________
TUBERCULOSIS YES ◯ NO ◯
CANCER YES ◯ NO ◯ TYPE:______________________
GOUT YES ◯ NO ◯
MENTAL ILLNESS YES ◯ NO ◯
KIDNEY DISEASE YES ◯ NO ◯
BLEEDING PROBLEMS YES ◯ NO ◯
EPILEPSY YES ◯ NO ◯
GLAUCOMA YES ◯ NO ◯
OSTEOPOROSIS YES ◯ NO ◯
OTHERS NOT LISTED: ______________________________

MEDICATION HISTORY:

DO YOU TAKE ANY MEDICATIONS (PRESCRIBED OR OVER-THE-COUNTER)? YES ◯ NO ◯ IF YES, PLEASE LIST:

MEDICATION NAME	STRENGTH	DOSAGE INSTRUCTIONS

Patient Name: ______________________________ DOB: ______________

SURGICAL HISTORY:

HAVE YOU HAD ANY SURGICAL OPERATIONS? YES ◯ NO ◯ IF YES, PLEASE LIST PROCEDURES WITH DATE

____

____

____

____

DO YOU HAVE OR HAVE HAD ANY REACTIONS, RASHES, OR ALLERGIES TO ANY MEDICATIONS? YES ◯ NO ◯

IF YES, PLEASE LIST WHAT REACTIONS YOU GET FROM WHAT DRUG:

____

____

____

REVIEW OF SYSTEMS-PLEASE CIRCLE IF YOU CURRENTLY HAVE ANY OF THE FOLLOWING:

CONSTITUTIONAL	APPETITE CHANGE	WEIGHT CHANGE	FEVER	CHILLS	FATIGUE	NONE
SKIN	ITCHING	RASH	HIVES	SKIN CANCER	NONE	
ENT	SNORING	HEARING CHANGES	EAR PAIN	RINGING	VOICE CHANGES	NONE
ALLERGY	FOOD	SEASONAL	NONE			
RESPIRATORY	COUGH	SHORTNESS OF BREATH	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 URINATION	NONE	
MUSCULOSKELETAL	JOINT PAIN	MUSCLE PAIN	GOUT	OSTEOPOROSIS	NONE	
NEURO	HEADACHE	DIZZINESS	SEIZURE	STROKE	TINGLING	
	VISION CHANGES	NONE				
ENDO	DIABETES	STEROID USE	THYROID PROBLEMS	NONE		
HEME/LYPMH	ANEMIA	BRUISE EASILY	BLEEDING	SWOLLEN GLANDS	NONE	
PSYCH	ANXIOUS	DEPRESSED	STRESS	NONE		

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 $75.00 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.

PATIENT OR GUARDIAN SIGNATURE ____________________ DATE: ________

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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

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RICHARD T. BERGSTROM, MD | GARY A. BUXA, MD FACS

I have been offered a copy of ENT CENTER OF EXCELLENCE Gary A. Buxa, MD FACS & Richard T. Bergstrom, MD's Notice of Privacy Practices.

___________Patient Initial

Under the **Patient Privacy Act,** otherwise known as **HIPAA,** our office cannot release or discuss patient information with anyone other than the patient, custodial parent, or legal guardian, unless we have written authorization from the patient.

If you would like us to be able to speak to family members, caregivers, or any other entities regarding your healthcare, please complete the following, indicating the person(s), **BY FULL NAME,** to whom we may speak to.

I, ________________________________, authorize ENT CENTER OF EXCELLENCE Gary A. Buxa, MD FACS & Richard T. Bergstrom, to release to or discuss my **Private Health** Information with the following person(s):

Name	Relationship

○ENTIRE RECORD or ○Specific Information Only:______________________________

OR

○ I DO NOT WANT ANY INFORMATION RELEASED TO ANYONE BY ENT CENTER OF EXCELLENCE Gary A. Buxa, MD FACS & Richard T. Bergstrom, WITH THE EXCEPTION OF THE PHYSICIAN WHO REFERRED ME TO THIS PRACTICE.

This authorization shall remain in effect until which time I have revoked this authorization in writing. My written revocation must be submitted to;
ENT CENTER OF EXCELLENCE Gary A. Buxa, MD FACS & Richard T. Bergstrom's PRIVACY OFFICER
3305 Placer Street, Suite A Redding, CA 96001

Signed By: ______________________________ ______________________________

Signature of Patient or Legal Guardian | Relationship to Patient

______________________________ ______________________________

Print Patient Name | Date

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION UPON REQUEST

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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. 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 **$15.00 fee for each form** that is completed. This fee will be paid prior to the form being completed. Please allow 2-3 business days for forms to be completed.

4. If you are new to our office, there are several forms that need to be completed before we can see you. These forms can be downloaded from our web site www.entexcellence.com. Please complete these forms, **in their entirety**, and return them to our office **prior** to your appointment or you will need to arrive **30 minutes early** to your scheduled appointment to complete the 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 cash pay until the correct information is provided to our office and payment in full will be collected at the time of service. Established patients will need to update their paperwork every year.

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 48-72 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.

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

OFFICE AND FINANCIAL POLICY CONTINUED

7. A 24-hour notice of cancellation is required for all **office appointments/procedures**. A missed appointment is a lost opportunity to help another patient. A **$75.00 fee** may be charged for each appointment/procedure scheduled, but not attended, due to the patient/guardian not calling at least 24 hours prior to the scheduled appointment/procedure. Office **VNG testing** cancelled with less than a 24 hour notice will be charged a fee of **$150.00**. There is also a **$200.00** fee charged for any hospital/ASC/office surgical procedures cancelled with less than a one week notice.

8. Dr. Buxa and Dr. Bergstrom do not treat patients at Shasta Regional Medical Center.

9. "For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public."

   https://openpaymentsdata.cms.gov.

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**