Denver Ear
ASSOCIATES

701 E. Hampden Ave, Suite 415,
Englewood, CO 80113
303-788-7880

Dear Valued Patient,

Thank you for choosing Denver Ear Associates as your healthcare Specialist. We want to give you the best possible service. In order to become more efficient and to serve you better, we ask you to understand the following procedures and policies of our office.

Hours: Our phones are open from 8:00am – 5:00pm Monday through Friday. We close for lunch from 12:00pm – 1:00pm daily. During this time if you call our office you will reach a recording. You may leave a message and we will call you back as soon as possible. However, we would love to speak with you and greatly appreciate you calling during the hours our phones are open.

Appointments: You should receive a telephone reminder/confirmation call two days prior to your appointment. Please plan to arrive 30 minutes prior to your appointment. This allows us time to input your account and facilitate proper billing of your insurance, without delaying your visit. As we strive to respect our patients scheduled appointment times, if you do not arrive 30 minutes prior to your appointment time, you could be asked to reschedule your appointment. Please bring with you your insurance card, photo id and your copay.

Cancellation and No Show Policy: Our goal is to provide quality individualized medical care in a timely manner. Late cancellations and No Shows (includes arriving more than 15 minutes late) create inconvenience and prevent scheduling of other patients who need access to medical care in a timely manner. We understand situations arise when you may need to cancel your appointment and we appreciate advance notice when that happens. This helps us be respectful of other patients needs and enables us to give the appointment time to another patient who needs to see us.

Thank you for choosing Denver Ear Associates for your healthcare needs.

Denver Ear Associates

- ATTACHED YOU WILL FIND THE NEW PATIENT FORMS THAT NEED TO BE PRINTED, COMPLETED AND BROUGHT TO YOUR APPOINTMENT.
- BRING YOUR PHOTO IDENTIFICATION CARD and INSURANCE CARD(S).
- IF YOUR INSURANCE REQUIRES A REFERRAL TO SEE A SPECIALIST OR IS AN HMO, CONTACT YOUR PRIMARY DOCTOR TO OBTAIN A REFERRAL AND BRING IT TO YOUR APPOINTMENT.
- WE ALSO RECOMMEND YOU CHECK WITH YOUR INSURANCE THAT OUR PHYSICIANS AND FACILITY IS IN NETWORK WITH YOUR SPECIFIC PLAN.
- PLEASE BRING AN UPDATED LIST OF YOUR CURRENT MEDICATIONS.
- YOU WILL RECEIVE AN AUTOMATED REMINDER CALL 2 DAYS PRIOR TO YOUR APPOINMENT.

FOR MORE INFORMATION ON OUR OFFICE YOU CAN VISIT US AT www.denverear.com, THERE YOU CAN FIND OUR ADDRESS, DIRECTIONS AND ANY OTHER ADDITIONAL INFORMATION.

Thank you.
We will see you soon!!!

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Patient Information

Patient's Last Name:	First:	Middle:	Birth date:	Sex: ☐ M ☐ F
Street Address:	PO Box:	City:	State:	ZIP Code:
Social Security no.:	Home phone:	Work phone:	Cell phone:	
Email Address:	Marital Status:			

Billing and Insurance Information Please be sure to provide a copy of all insurance cards

Subscriber's Last Name:	First:	Middle:	Birth date:	Sex: ☐ M ☐ F
Street Address: (if different from patient)	PO Box:	City:	State:	ZIP Code:
Social Security no.:	Home phone:	Work phone:	Cell phone:	
Primary Insurance:	Patient's relationship to subscriber: ☐ Self ☐ Spouse/Partner ☐ Child ☐ Other			
Member Identification Number	Group Number	Customer Service/Provider Service Phone Number		
Secondary Insurance:	Patient's relationship to subscriber: ☐ Self ☐ Spouse/Partner ☐ Child ☐ Other			
Member Identification Number	Group Number	Customer Service/Provider Service Phone Number		

Parent/Guardian Information (Minors Only)

Parent/Guardian Last Name:	First:	Middle:	Birth date:	Sex: ☐ M ☐ F
Street Address: (if different than patient)	PO Box:	City:	State:	ZIP Code:
Social Security no.:	Home phone:	Work phone:	Cell phone:	
Parent/Guardian Last Name:	First:	Middle:	Birth date:	Sex: ☐ M ☐ F
Street Address: : (if different than patient)	PO Box:	City:	State:	ZIP Code:
Social Security no.:	Home phone:	Work phone:	Cell phone:	

Race ☐ African American/Black ☐ Asian ☐ Caucasian/White ☐ Native American ☐ Pacific Islander ☐ Other ☐ Decline to state

Ethnicity ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Decline to State

Primary Language ☐ English ☐ Spanish ☐ Other: _____

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information.

Responsible Party Signature: _____ *Date:* _____

Patient Name: _____ DOB: _____ Date: _____

USE AND DISCLOSURE OF HEALTH INFORMATION

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent:

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices:

You have been offered a copy of the Notice of Privacy Practices. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read our Notice of Privacy Practices brochure carefully and completely before signing the Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our office manager:

Telephone: 303-788-7880 Email: cwalrath@denverear.com

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation. Please understand that revocation of this consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

HIPAA Approved Contacts

Primary Care Physician: _____ Referring Physician/Provider: _____

Unless otherwise noted, Denver Ear Associates will communicate with your primary care and/or referring providers, as well as any provider we refer you to. If there are others that you authorize us to communicate with please indicate below:

Additional Providers:

_____

_____

Please list spouse, any family member, personal friend or other third party (Attorney, Case Manager, Work Compensation Carrier, etc.) you give us permission to share your protected health information

Name	Phone Number	Address	Relationship

Voice mail messages including test results, appointment reminders and other personal information can be left at the following number(s):

Home Phone: _____ Cell Phone: _____

I, _____ (print name) have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:_____ Date:_____

Financial Agreement

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time.
Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. WE WILL REQUEST TO PHOTOCOPY YOUR INSURANCE CARD(S) FOR YOUR FILE. PLEASE BRING PHOTO ID. WE WILL ALSO TAKE A PICTURE OF YOU FOR OUR MEDICAL RECORDS.

- **CO-PAYMENTS** – we MUST collect your carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit.

- **OUT OF NETWORK PLANS** – You will be responsible for any balance your plan indicates as due on their explanation of benefits form. All patients will be responsible for their co-insurance and deductible. Although we participate with most insurance companies, it is your responsibility to confirm your specific plan coverage with your insurance company.

- **SELF-PAY PATIENTS** – Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.

- **MEDICARE** – We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one.

- **DIVORCED/SEPERATED PARENTS OF MINOR PATIENTS** – The parent who consents to the treatment of a minor child is responsible for payment of services rendered. Denver Ear Associates will not be involved with separation or divorce disputes.

You are responsible for the timely payment of your account. Should it become necessary for us to use an outside agency to collect payment from you, you will be additionally responsible for whatever charges we incur as a result of this.

WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, OR DISCOVER CARD.

THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share with us any concerns.

I hereby agree that you may contact me for whatever reason concerning my account on any and all of the phone numbers I have provided to you, including but not limited to home phone, work phone, cell phone or any other phone number.

I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to the physician unless my account has been paid in full.

Patient's Name: _____ DOB: _____

Responsible Party Signature: _____ Date: _____

Print Name: _____ Relationship: _____

Patient Name: _____ **Date of Birth:** _____

Reason for Visit: _____

ALLERGIES? ☐ **No Allergies**

Allergies to Medications	Type of Reaction		Allergies to Medications	Type of Reaction

Have you ever had an allergic reaction to anesthesia ☐ Yes ☐ No

LIST ALL MEDICATIONS YOU ARE TAKING (Prescription, over-the-counter or herbal) or

Allow Denver Ear Associates to obtain medication history via electronic means directly from insurer/pharmacy_____initial here

☐ **No Current Medications**

Medication	Dosage	How often taken		Medication	Dosage	How often taken

Pharmacy Name (Include Address &/or Phone)_____

SURGICAL HISTORY

PROCEDURE	WHEN

IMMUNIZATION HISTORY

Have you had:

Influenza (flu) Vaccine? **Y** **N** **If Yes, When (Month/Year)** _____

Pneumococcal (pneumonia) Vaccine? **Y** **N** **If Yes, When (Month/Year)** _____

HAVE YOU BEEN EXPERIENCING ANY OF THE FOLLOWING

SYMPTOMS:	Yes	Today
Dizziness, Imbalance or Vertigo	☐	☐
Nausea	☐	☐
Vomiting	☐	☐

SYMPTOMS RELATED TO YOUR EAR:

HEARING LOSS:		Date of Onset	Sudden/Rapid	Slowly/ Progressive
Right Ear	☐	_____	☐	☐
Left Ear	☐	_____	☐	☐

PRESSURE:		RINGING:		DRAINAGE:		PAIN:	
Right Ear	☐	Right Ear	☐	Right Ear	☐	Right Ear	☐
Left Ear	☐	Left Ear	☐	Left Ear	☐	Left Ear	☐

Please describe any additional symptoms _____

HAVE YOU FALLEN IN THE LAST 12 MONTHS? **Y** **N** **IF YES, HOW MANY FALLS?** _____