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. 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.

I have received Advanced ENT notice of privacy practice and the Advanced ENT financial policy.

Responsible Party Signature: _____________________________ Date: _____________________________

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. 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.

I have received Advanced ENT notice of privacy practice and the Advanced ENT financial policy.

Responsible Party Signature: _____________________________ Date: _____________________________
Last Name: ___________________________ First: ___________________________ M I: _______
Date Today: /__/____ Birth Date: /__/____ Primary Doctor: _______________ Referring Doctor: _________________________
Chief Problem(s): ____________________________________________________________

PAST MEDICAL HISTORY

ENT: □ Ear Infections □ Sinus Infections □ Allergies □ Throat Problems □ Voice Problems
Eyes: □ Glaucoma □ Cataracts
Heart: □ Heart Attack □ Irregular Heartbeat □ Abnormal Heart Valve □ High Blood Pressure
Lung: □ Asthma □ COPD □ Tuberculosis □ Emphysema □ Sleep apnea
Gastrointestinal: □ Reflux □ Stomach problems □ Hepatitis □ Cirrhosis □ Hiatal Hernia
Kidney: □ Kidney Failure □ Incontinence □ Prostate Problems □ Bladder Problems
Neurologic: □ Stroke □ Headaches □ Seizures □ Multiple Sclerosis
Psychiatric: □ Depression □ Anxiety
Endocrine: □ Diabetes □ Thyroid Problems
Hematologic: □ Anemia □ Bleeding Disorder
Rheumatologic: □ Arthritis □ Fibromyalgia □ Autoimmune Disorder □ Osteoporosis
Dermatologic: □ Keloids □ Skin Conditions
Infectious: □ HIV □ Lyme disease □ Mononucleosis
Oncologic: □ Cancer: List site(s):
Other: __________________________

PAST SURGICAL HISTORY

ENT: □ Tonsillectomy/Adenoidectomy □ Ear Surgery □ Nose/Sinus Surgery □ Tracheotomy
Heart: □ Bypass □ Stent □ Valve Surgery □ Carotid Artery □ Pacemaker □ Other
Lung: □ Bronchoscopy □ Lung Surgery
GI: □ Surgery for reflux □ Stomach Surgery □ Intestinal Surgery □ Gall bladder
Orthopedic: □ Fracture □ Knee Replacement □ Hip replacement □ Back Surgery
Pelvic: □ Prostate □ Bladder □ D&C □ Gyn Surgery □ Kidney Surgery
Other: □ Breast □ Neurosurgery □ Dental □ Eye

MEDICATIONS

Please list all medications (or provide list on separate paper). Please include over the counter medications.

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PLEASE TURN PAGE OVER
ALLERGIES
Please list all allergies to medications and foods: □ No allergies

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FAMILY HISTORY
Check if any of these run in the family (only those related by blood):
□ Autoimmune Disease □ Bleeding/Coagulation disorder □ Heart Disease
□ Diabetes □ Thyroid Disease □ Hearing Loss
□ High Blood Pressure □ Tuberculosis □ Problems with Anesthesia

SOCIAL HISTORY
Marital Status: □ Single □ Married/Partnered □ Divorced □ Other
Occupation: Current
Prior
Noise Exposure: at Work? In military Noise from Hobbies
Tobacco: □ Never smoked □ Current Smoker: Amount: _______ per day # years smoking ______
□ Former Smoker: stopped ______
Alcohol: □ Never drank alcohol □ Drink currently □ Beer □ Wine □ Liquor Amt per day ______
□ Former drinker stopped ______
Caffeine: □ Coffee Oz/ day: ______ □ Tea Oz/ day: ______ □ Caffeinated soft drinks Oz/ day: ______

SPECIAL CONCERNS
□ Pregnant (due: ____________ ) □ Breastfeeding □ Taking Blood Thinners
□ Require antibiotics for procedures □ Latex allergy

REVIEW OF SYSTEMS
Check other active symptoms
Gen: □ Fatigue □ Fever □ Chills □ Night Sweats □ Weight Loss □ Weight Gain □ Loss of appetite
Eyes: □ Itchy eyes □ Eye discomfort □ Double Vision □ Blurred vision □ Change in vision □ Dry eyes
CV: □ Chest Pain □ Irregular Heartbeats □ Rapid Heartbeat □ Lightheadedness
Resp: □ Shortness of Breath □ Wheezing □ Cough □ Sputum production □ Coughing up blood
GI: □ Nausea □ Vomiting □ Diarrhea □ Difficulty Swallowing □ Heartburn □ Reflux
□ Vomiting blood □ Belching □ Abdominal Pain
GU: □ Problems passing urine □ Incontinence □ Possible Pregnancy
Derm: □ Rash □ Itchiness □ Pigmentation changes □ Dry skin
Neuro: □ Change in mental status □ Muscle weakness □ Loss of coordination □ Tingling or numbness
□ Change in speech □ Seizures □ Tremors □ Loss of balance □ Developmental delay
Rheum: □ Joint pain
Endoc: □ Cold intolerance □ Heat intolerance
Psych: □ Anxiety □ Depression □ Behavior Problems
Hem: □ Easy Bleeding □ Easy Bruising
Allergy: □ Allergic dermatitis
FINANCIAL POLICY

Our objective is to provide you with the highest quality healthcare in the most cost effective manner. However, the ability of our Practice to achieve this objective depends greatly on your understanding of our Financial Policy. If you have medical insurance, we will file insurance claims forms on your behalf. We do this as a courtesy to our patients and are anxious to help you receive the maximum allowable benefits from your insurer. Even though we will file insurance claims for you, we need your active participation in the insurance claims process.

MEDICARE PATIENTS:
As a participating provider of Medicare Part B (physician services), our Practice will only bill for your Medicare co-insurance, deductible, and any services rendered but not covered by Medicare. All other services will be billed directly to Medicare.

NOTE: You will be informed of services not covered by Medicare prior to these services being rendered. Your signature upon the appropriate Medicare waiver form represents your authorization for the physician to perform these services and your acceptance of the financial responsibility for these services.

If you have Medicare Part A only, then the services that you receive from our Practice will not be covered by Medicare.

COMMERCIAL INSURANCE PATIENTS:
Remember that your insurance contract is between you and your insurer. If your insurance company pays only part of your bill or rejects your claim, you are financially responsible for the balance and are to pay it upon receipt of your statement. If your claim remains unpaid by your carrier for more than 90 days from the date of service provided, the balance will become your responsibility.

NON-PARTICIPATING PLAN PATIENTS:
As the insurance industry changes, our office must make choices about which plans to participate in. Your plan may be one that covers certain areas with “out of network” benefits. These are usually Preferred Provider Organizations (PPO), Point of Service (POS) or indemnity plans that cover percentages of our fees based on the contract with your carrier. In some instances, your carrier will send a check directly to you, the patient or the account guarantor rather than the provider’s office. Due to this, we offer several options for you to insure that your services are paid timely. 1) You may elect to pay your balance at the time of service or before the services are rendered and receive a 30% prompt pay discount. 2) If you prefer that we bill your insurance carrier, the full charge will have 30 days to be satisfied, with no discount, either from the check you receive from the insurance carrier or your own funds. If your balance is not paid within 30 days of services being rendered, your account may incur additional collection fees to satisfy the account balance.

HMO/MANAGED CARE INSURANCE PATIENTS:
Many HMO/Managed Care plans require you to obtain a referral in order to receive a specialist. It is your responsibility to obtain this referral if required. Unauthorized services will be the financial responsibility of the patient. Please have your referral forms and membership card available when you check in. You will be required to pay the co-pay for authorized services at the time of service. We will make every attempt to collect for our services with your insurance company, however if your claim remains unpaid over 90 days from the date services were rendered, the payment will become your responsibility.

PATIENTS WITH NO INSURANCE:
Patients with no insurance are required to pay for their visits at the time of service. If special financial arrangements are deemed necessary, you will be given information regarding whom to contact at the time of your visit. It is imperative you follow those instructions immediately to satisfy your financial responsibility for services provided to you.
CULTURAL COMPETENCY

The State of New Jersey mandates that every physician documents any barrier to care, including cultural and linguistic needs, in the medical record. Factors affecting care are visual or auditory factors, which may impede your ability to comprehend medical discussion and language, cultural and/or religious customs, which may impact the provider’s ability to provide medical care. Addressing these needs will improve patient satisfaction and also decrease health care disparities.

Patient Name: ___________________________ Date of Birth: ___________________________

1. Do you have any impairment? (Please circle any that apply)
   • Visual
   • Hearing
   • Speech
   • Learning
   • Physical
   • Language/Cultural barrier
   • None

2. What language do you speak, read and write? _______________________________________

3. Do you have any religious or culture customs that the doctor should know about? (If choose yes, please explain)
   • Yes, Please explain ___________________________________________________________
   • No

4. ADVANCE DIRECTIVES: FOR ALL PATIENTS 18 YEARS AND OLDER: Advanced Directive is a federal and state mandated Self-Determination Act enacted in 1990. This allows you to provide specific instruction and direction regarding your own medical care wishes if you become incapacitated. The patient-physician relationship provides a direct opportunity for you to discuss these types of decisions.

Do you have a “Living Will” or Advance Directive? (Please circle)
   • Yes
   • No

__________________________________________________________________________
Signature

__________________________________________________________________________
Date
Patient Name: _____________________________________________ Date: ______________________________

PROCEDURE NOTICE

Please know that some commonly performed procedures of your ENT examination in this office may not be covered by your insurance carrier.

These may include FIBEROPTIC EXAMINATIONS of the nose and or larynx/vocal cords. If such a procedure is performed, a procedural fee will be submitted to your insurance carrier. You should know that your insurance carrier may refer to these routine parts of your specialist’s consultation as PROCEDURES or even SURGICAL PROCEDURES. If our office participates with your insurance carrier, you will only be obligated to pay for any deductibles, co-insurance and/or co-pays as agreed upon by you and your carrier. Please know that the performance of these procedures by your specialist is to give you the most accurate and best care available.

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AFFILIATION NOTICE

PATIENT DISCLAIMER & ACKNOWLEDGEMENT

Advanced ENT is please to be affiliated with Penn Medicine and to participate in the Penn ENT Specialty Network. As part of the network, Advanced ENT is working with Penn Medicine to improve the quality of care provided to its patients.

Advanced ENT is an independent physician practice group and is not owned by or a part of the University of Pennsylvania Health System. Neither the University of Pennsylvania Health System nor the Hospital of the University of Pennsylvania dictates or directs the manner in which care is provided by Advanced ENT. Each physician affiliated with Advanced ENT exercises independent medical judgment in the care of his or her patients. If you have any questions about the relationship that Advanced ENT has with Penn Medicine, please ask your physician.

Please sign below indicating that you have read and understand the both notices above and have had an opportunity to ask questions.

SIGNATURE: _____________________________________________ DATE ______________________________