

PATIENT DEMOGRAPHICS

FIRST NAME: _____ CELL PHONE (include area code): _____
 MI: _____ LAST NAME: _____ PCP &/or REFER PHYSICIAN: _____
 PRFX/SUFFIX: _____ SSN: _____ PREFERRED LANGUAGE: _____
 DOB: _____ SEX: _____ STUDENT: *Full Time Part Time Not Enrolled*
 STREET ADDRESS: _____ MARITAL STATUS: _____
 APT/UNIT # : _____ RACE: _____
 CITY/STATE: _____ ETHNICITY: _____
 ZIP: _____ CONTACT PREFERENCE: _____
 EMAIL ADDRESS: _____ EMPLOYER: _____
 HOME PHONE (include area code): _____ JOB STATUS: *Full Time Part Time Retired None*
 EMPLOYER PHONE NUMBER: _____
 PHARMACY NAME: _____ PHARMACY PHONE NUMBER: _____

I hereby authorize Metropolitan ENT to obtain/download my medical history from Pharmacies and/or Pharmacy Benefit Managers. This authorization will allow my physicians to check drug to drug interactions for any new prescriptions he/she may prescribe and to facilitate electronic pharmacy prescriptions. I understand this authorization will remain in effect until revoked by me in writing. INITIALS: _____ DATE: _____

EMERGENCY CONTACT INFORMATION:

EMERGENCY CONTACT: _____ RELATION: _____ PHONE: _____

CONSENT TO SHARE INFORMATION

Metropolitan ENT is authorized to release protected health information about the above-named patient to the entities named below:

NAME: _____ RELATION: _____ PHONE: _____
 NAME: _____ RELATION: _____ PHONE: _____

(Patient information: I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as result of this authorization may be subject to disclosure by the recipient and may no longer be protected by federal or state laws.)

THIS AUTHORIZATION SHALL BE IN EFFECT UNTIL IT IS REVOKED BY THE PATIENT IN WRITING. INITIALS: _____ DATE: _____

INSURANCE POLICY INFORMATION

PRIMARY INSURANCE

SECONDARY INSURANCE

NAME OF INSURANCE CO: _____
 NAME OF INSURANCE CO: _____
 POLICY NUMBER: _____
 GROUP ID: _____
 EFFECTIVE DATE: _____
 SUBSCRIBER NAME: _____
 RELATION TO SUBSCRIBER: _____
 SUBSCRIBER DOB: _____
 SUBSCRIBER SSN: _____
 SUBSCRIBER ADDRESS: _____

NAME OF INSURANCE CO: _____
 NAME OF INSURANCE CO: _____
 POLICY NUMBER: _____
 GROUP ID: _____
 EFFECTIVE DATE: _____
 SUBSCRIBER NAME: _____
 RELATION TO SUBSCRIBER: _____
 SUBSCRIBER DOB: _____
 SUBSCRIBER SSN: _____
 SUBSCRIBER ADDRESS: _____

I authorize my insurance benefits to be paid directly to the physician, and I am financially responsible for all charges. I hereby consent to the release and re-disclosure of my medical record to enable or facilitate the collection, verification or settlement of my account for any amounts due from me or any third-party payor, health maintenance organization, insurer or other health benefit plan. This consent applies to LMG, PC, or any of its affiliates or agents, lenders, or any third-party servicer acting for LMG, PC, or any of its affiliates. I also authorize LMG to test my blood for hepatitis and/or the AIDS virus, if in their opinion an employee has suffered an exposure incident as a result of my treatment, as defined by the Occupational Safety and Health Administration.

Print Name _____
Date

Signature

NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B OR C TESTING

LMG is required by § 32.1-45.1 of the Code of Virginia (1950), as amended, to give you the following notice:

1. If any LMG health care professional, worker or employee should be directly exposed to your blood or body fluids in a way that may transmit disease, your blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or health care provider will tell you the result of the test. Under Virginia Code § 32.1-45.1 (A), you are deemed to have consented to the release of the test results to the person exposed.
2. If you should be directly exposed to blood or body fluid of an LMG health care professional, worker or employee in a way that may transmit disease, that person's blood will be tested for infection with the human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or health care provider will tell you and that person the results of the test.

I understand that this consent will remain in effect as long as my dependent or I receive care from LMG or until I withdraw it in writing.

Signature of Patient, Parent/Legal Guardian, or Person Acting in Loco Parents _____
Date

Relationship (if signature is not patient)
Signature of Person Obtaining Consent

LIST ALL MEDICATIONS YOU ARE TAKING (Prescription, over-the-counter, herbal) No Current Medications

Medication	Dosage	How often	Reason

DRUG/NON-DRUG ALLERGIES No Allergies

Medication Name or Non-Drug Allergy	Type of Reaction

Have you ever had Surgery or Hospitalization? NO YES
 If yes list type/year: _____

Have you ever had problems with Anesthesia? NO YES

Have you ever had a serious injury or accident? NO YES
 If yes list type of injury/date: _____

If female, are you pregnant? NO YES

MEDICAL HISTORY: Have YOU or ANYONE in your family been diagnosed with.....? (check all that apply)

	No	Yes	Self/Family Member		No	Yes	Self/Family Member
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	_____	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____	Headache (Type?)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Angina/Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	_____	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Birth Defect	<input type="checkbox"/>	<input type="checkbox"/>	_____	Liver Condition	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bladder Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Lung Condition	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer (Type?)	<input type="checkbox"/>	<input type="checkbox"/>	_____	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Thyroid Condition	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

Patient Name: _____

DOB: _____

SOCIAL HISTORY

- Do you use Tobacco?** Yes No Former
 _____ No longer _____ Cigarettes _____ Pipe _____ Cigars
- Do you consume alcohol?** Yes No Former
 _____ Beer _____ Wine _____ Coolers _____ Liquor
- Do you use drugs recreationally?** Yes No Former
 _____ Cocaine _____ Heroin _____ Marijuana _____ Oxycodone _____ Other
- Do you use caffeine?** Yes No
 _____ 1 per day _____ 2-3 per day _____ 4 or more per day
- Do you have pets in the home?** Yes No
 _____ Cat _____ Dog _____ Other
- Do you exercise regularly?** Yes No Type _____
- Home Living Situation:** Alone w/Spouse w/Spouse & Children w/Children w/Parents Other _____
- Patient considers diet to be:** Healthy Not Healthy Other: _____
- Do you consider yourself generally:** Healthy Fair Not Healthy

PATIENT REVIEW OF SYSTEMS: *(check all that apply to today's visit)*

- | | | |
|---|---|---|
| <p>Ears</p> <p><input type="checkbox"/> Drainage
 <input type="checkbox"/> Dizziness
 <input type="checkbox"/> Hearing loss</p> <p>Nose & Sinus</p> <p><input type="checkbox"/> Congestion
 <input type="checkbox"/> Drainage
 <input type="checkbox"/> Itchy nose
 <input type="checkbox"/> Nosebleeds</p> <p>Throat & Mouth</p> <p><input type="checkbox"/> Hoarseness
 <input type="checkbox"/> Inflammation of Throat
 <input type="checkbox"/> Sore throat
 <input type="checkbox"/> Sore tongue
 <input type="checkbox"/> Sores in Mouth
 <input type="checkbox"/> Swallowing difficulty
 <input type="checkbox"/> Popping sound in mouth or ear (TMJ)</p> <p>Allergic, Infections, Immune System</p> <p><input type="checkbox"/> Dark circles under eyes
 <input type="checkbox"/> Food intolerance
 <input type="checkbox"/> Hives
 <input type="checkbox"/> Itchy Nose</p> <p>Cardiovascular (Heart and Blood Vessels)</p> <p><input type="checkbox"/> Blacking Out
 <input type="checkbox"/> Chest pain
 <input type="checkbox"/> Irregular heartbeat</p> <p>Hematologic</p> <p><input type="checkbox"/> Masses</p> | <p><input type="checkbox"/> Ringing in ears
 <input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> Runny nose
 <input type="checkbox"/> Sneezing
 <input type="checkbox"/> Snoring
 <input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> Hives
 <input type="checkbox"/> Snoring
 <input type="checkbox"/> Ulcers
 <input type="checkbox"/> Voice change
 <input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> Infections (recurring)
 <input type="checkbox"/> Mouth breathing
 <input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> Swelling
 <input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> Other _____</p> | <p>Genitourinary</p> <p><input type="checkbox"/> Urination at night
 <input type="checkbox"/> Other _____</p> <p>Eyes</p> <p><input type="checkbox"/> Blurred vision
 <input type="checkbox"/> Double vision
 <input type="checkbox"/> Itchy eyes</p> <p><input type="checkbox"/> Sensitivity to light
 <input type="checkbox"/> Other _____</p> <p>Integumentary (Skin)</p> <p><input type="checkbox"/> Bruises easily
 <input type="checkbox"/> Dryness
 <input type="checkbox"/> Itching</p> <p><input type="checkbox"/> Moles that have changed
 <input type="checkbox"/> Other _____</p> <p>Gastrointestinal (Stomach)</p> <p><input type="checkbox"/> Abdominal pain
 <input type="checkbox"/> Blood in stool</p> <p><input type="checkbox"/> Diarrhea
 <input type="checkbox"/> Other _____</p> <p>Respiratory (Lungs and Respiratory System)</p> <p><input type="checkbox"/> Cough, non-productive
 <input type="checkbox"/> Cough, productive
 <input type="checkbox"/> Coughing up blood
 <input type="checkbox"/> Sleep disturbance due to breathing</p> <p><input type="checkbox"/> Pain/tightness in chest
 <input type="checkbox"/> Wheezing
 <input type="checkbox"/> Other _____</p> <p>Neurological (Nerves)</p> <p><input type="checkbox"/> Numbness</p> <p><input type="checkbox"/> Other _____</p> <p>Psychiatric</p> <p><input type="checkbox"/> Depression
 <input type="checkbox"/> Feels sad more than usual</p> <p><input type="checkbox"/> Other _____</p> <p>Endocrine</p> <p><input type="checkbox"/> Appetite is increased
 <input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> Neck has enlarged
 <input type="checkbox"/> Other _____</p> <p>Musculoskeletal</p> <p><input type="checkbox"/> Loss of muscle strength
 <input type="checkbox"/> Other _____</p> |
|---|---|---|

Patient Name: _____

DOB: _____

Office Policies

Financial Responsibility

We accept most insurance plans and will submit claims on your behalf. You are responsible for all charges on your account, including any amounts not paid by your insurance.

Payment of any applicable copay, deductible, and coinsurance is due at the time services are rendered, in accordance with your insurance plan. If insurance information is not available at the time of your visit, payment of one hundred percent of charges is required prior to the visit.

If you have an outstanding balance, prompt payment in full is expected. If you are unable to pay in full, please inquire about available payment arrangements. Our billing department can be reached at 703 313 7700 option 8. If reasonable attempts to collect payment are unsuccessful, we reserve the right to forward the balance to a collection agency. You will be responsible for any collection or legal fees incurred as permitted by law.

A self-pay fee schedule is available upon request.

Statements, Email and Text Reminders, and Card on File

Statements are mailed to the address on file. Courtesy reminders regarding balances may be sent by email or text message. If you have a card on file and a balance under five hundred dollars remains due, the balance may be charged to the card on file. A five-day advance notice will be provided prior to any charge. To update your payment method or opt out, please contact our office. A credit card agreement is available upon request.

Referrals and Prior Authorizations

Please be aware of your insurance plan's referral and authorization requirements. It is the patient's responsibility to ensure that any required referral or authorization is valid and on file prior to services being rendered. Referrals are typically valid for thirty to sixty days depending on the insurance carrier.

Please request referrals from your Primary Care Physician as early as possible, as some offices require three to seven days' notice. In some cases, referrals may be faxed directly to our office. Our referral fax number is 703 313 4989.

Cancellations and Missed Appointments

Appointment reminders are sent twenty-four to forty-eight hours prior to your visit. If you are unable to keep your appointment, a minimum of twenty-four hours' notice is required.

Failure to cancel or show to your appointment may result in a missed fifty-dollar appointment fee, which is not covered by insurance.

Surgical procedures that are not cancelled at least ten days in advance or are missed without notice may result in a two hundred to five hundred dollar missed procedure fee.

Prescription Refills

Please allow twenty-four hours for prescription refill requests. Call 703 313 7700 option 2. The most efficient way to request a refill is through your pharmacy, which will contact our office directly.

Release of Medical Records

To request medical records, please complete a Medical Records Release Form. Processing time is five to seven business days. A photo ID is required when picking up records.

Forms and Administrative Fees

Disability forms, FMLA forms, Nexus letters, and accommodation letters require a twenty-five-dollar administrative fee and five to seven business days for processing. Forms must be submitted before processing can begin.

Fees Summary

- Missed appointment fee: \$50
- Missed or late cancelled surgical procedure: \$200 to \$500
- Administrative forms fee: \$25
- Card on file balance threshold: Under \$500

Emergencies

If you are experiencing a life-threatening emergency or believe your condition requires immediate medical attention, please call 911 or go to the nearest emergency room.

For urgent but non-life-threatening concerns during office hours, please call our office for instructions. After hours, an On-Call provider is available through our messaging system. Call our office and follow the prompts to leave an urgent message.

Patient Acknowledgment

I acknowledge that I have read and understand the office policies outlined above.

Patient Initials: _____ **Date:** _____

****IMPORTANT BILLING NOTICE****

READ BEFORE SIGNING - Your office visit copayment covers the ENT evaluation only. Diagnostic tests and procedures are NOT included in the office visit and are billed separately. During your visit to Metropolitan ENT & Facial Plastic Surgery, diagnostic testing or procedures may be medically necessary to fully evaluate and treat your condition. These services may result in additional patient responsibility based on your insurance plan.

COMMON DIAGNOSTIC SERVICES

CPT codes and standard charges listed below are shown before any applicable discounts or insurance adjustments.

- **Hearing Test/** CPT 92557- \$174
- **Flexible Laryngoscopy/** CPT 31575 – \$342 (a quick, 1–5-minute outpatient ENT procedure using a thin, fiberoptic camera passed through the nose to examine the throat, larynx, and vocal cords.)
- **Nasal Endoscopy/** CPT 31231 – \$449 (in-office procedure where a thin, flexible, or rigid tube with a light and camera (endoscope) to examine the nasal and sinus passages.)

Insurance companies often apply diagnostic procedures to **deductible and or coinsurance**.

INSURANCE RESPONSIBILITY -You are responsible for understanding your insurance benefits. We encourage you to verify coverage directly with your insurance plan. CPT codes, Tax ID, and provider information are available per request.

PATIENT ACKNOWLEDGMENT- I understand that diagnostic tests or procedures performed during my visit are **separate from the office visit and may result in additional charges based on my insurance benefits.**

Patient Signature: _____ **Date:** _____