ENT Associates of Worcester

Sinus • Hearing • Allergy

Christopher C. Charon, M.D. | Deirdre Monahan PA

145 Pomfret St. Putnam, CT 06260 Phone (860)928-7330 Fax (860)928-1907

Last Name: _____ First Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

SS#_____-____-_____ Date of Birth: _____ Sex: _____

Language: _____ Ethnicity: _____ Race: _____

Marital Status: _____ Occupation: _____

E-Mail: _____

☐ Home Phone: _____ ☐ Cell Phone: _____

Please check preferred number **Do you want us to be able to text you? Yes/No**

Emergency Contact:

Name: _____ Relationship: _____ Phone: _____

Primary Care Physician: _____

Pharmacy: _____ Address: _____

Primary Insurance Card Holder **Self:** ☐

Last Name: _____ First Name: _____

Date of Birth: _____ Phone: _____ Relationship: _____

Address: _____

Guarantor Information (If Minor):

Last Name: _____ First Name: _____

Address: _____ SS#_____-____-_____

City: _____ State: _____ Zip Code: _____ Date of Birth: _____

****Is this appointment Workers Comp or Accident related? YES or NO**

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN/TO RELEASE INFORMATION: I HERBY AUTHORIZE PAYMENT DIRECTLY TO THE PHYSICIAN OF THE SURGICAL AND/OR MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR HIS/HER SERVICES AS DESCRIBED, REALIZING I AM RESPONSIBLE TO PAY NON-COVERED SERVICES. I HEREBY AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF TREATMENT NECESSARY TO PROCESS MY INSURANCE CLAIMS. I AM ALSO AGREEING TO THE OFFICES NO SHOW POLICY.

_____ _____

Patient/Parent Signature **Date:**

Turn Over for Page 2

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Chief Complaint: _____ **Height:** _____ **Weight:** _____

Past Surgeries - Please check all that apply: **None:** ☐

_____ Tonsillectomy
_____ Adenoidectomy
_____ Myringotomy
_____ Septoplasty
_____ Tympanoplasty
_____ Sinus Surgery
_____ Appendectomy
_____ Cholecystectomy (Gallbladder)
_____ Cesarean
_____ Hip Surgery - Left / Right
_____ Hernia Repair
_____ Hysterectomy
_____ Knee Surgery - Left / Right
_____ Shoulder Surgery - Left / Right
_____ Pacemaker
_____ Thyroidectomy
_____ Other _____
_____

Past Medical History - Please check all that apply: **None:** ☐

_____ Heart Attack
_____ Heart Disease
_____ High Cholesterol
_____ High Blood Pressure
_____ Heart Murmur
_____ Pneumonia
_____ Tuberculosis
_____ Asthma
_____ Hepatitis
_____ HIV
_____ Blood Transfusion
_____ AFIB
_____ Acid Reflux
_____ ADD/ADHD
_____ Alzheimer's
_____ Anemia
_____Aneurysm
_____ Autism
_____ Cancer
_____ Clot Factor Deficit
_____ Cleft Palate
_____ COPD
_____ Dementia
_____ Diabetes
_____ Eczema
_____ Emphysema
_____ Glaucoma
_____ Lyme Disease
_____ Migraines
_____ MS
_____ Rheumatic Fever
_____ Stroke / TIA
_____ Substance Abuse
_____ Pacemaker
_____ Other_____
_____

Review of Symptoms: - Please check all that apply: **None:** ☐

_____ Recent Chest Pain
_____ Shortness of Breath
_____ Easy Bruising
_____ Easy Bleeding
_____ Tremors
_____ Fever
_____ Vomiting
_____ Pain/blood w/ urination
_____ Muscle Cramps
_____ Eyesight Problems
_____ Pregnancy
_____ Palpitations
_____ Wheezing
_____ Fatigue

Family History:

	Mother	Father	Sister	Brother	MGM	MGF	PGM	PGF
Heart Attack								
Heart Disease								
Asthma								
COPD								
Emphysema								
Cancer								

If the patient is a dependent, with whom do they live? _____

Social History:

Do you smoke? _____ If yes, how many packs per day? _____ For how many years? _____

Did you smoke previously? _____ When did you quit?_____ Chewing tobacco? _____

Alcohol use? YES or NO Is yes, how much per week? Beers: _____ Wine: _____ Hard Liquor _____

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Medications & Allergies

Name: _____ **D.O.B** _____

Medications:

Please list name of Medications/Vitamins/Supplements None: ☐

MEDICATION NAME ONLY – FREQUENCY/DOSE NOT NEEDED

If you have a list of medications, please provide it to the front desk

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Allergies:

Please list **medication** allergies & your reactions **None:** ☐

Name:_____ **Reaction:**_____

Name:_____ **Reaction:**_____

Name:_____ **Reaction:**_____

Name:_____ **Reaction:**_____

Name:_____ **Reaction:**_____

Name:_____ **Reaction:**_____

Name:_____ **Reaction:**_____

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CONSENT FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS (TPO)

I. CONSENT TO TREATMENT

1. I give my permission to be treated. This may include examinations, tests and procedures, medical treatment and admission to facilities under the care of a doctor and/or care provider, which they or their authorized agent may think is necessary or the best course of action. I understand specific consent forms may need to be signed for specific procedures. If I have a religious objection to specific care to be provided, I may ask not to provide that care.
2. I understand and agree that my care may include taking photographs/video and making sound recordings that may be used for my care and/or for education, as well as health care operations purposes.
3. I understand and agree that others, under the direction of a doctor and/or care provider, may help with or take part in giving hospital and/or medical care to me. These may include doctors and/or care providers in training and medical/nursing students.
4. I give permission to properly dispose of any specimens/tissue taken from my body. I understand specimens/tissue may be used for educational or research purposes in accordance with state and federal law.
5. I understand that no guarantees have been made about the outcome or results of any examination or treatment, and I understand that I have the right to refuse treatment at any time.
6. I understand and agree that care or services may be provided through telehealth. The provider will decide whether the condition being diagnosed or treated can be properly managed through telehealth.
7. I authorize and consent to communicate by phone, email and/or text.

II. FINANCIAL ARRANGEMENTS

1. I also understand and agree that, to the extent permitted by my insurance or coverage, I am financially responsible for all charges, co-payments and deductibles remaining after insurance payments, and all ENT Associates charges that are not covered by my insurance or third-party payers.
2. I assign benefits and insurance proceeds to ENT Associates of Worcester for services provided.
3. **Medicare Patient Certification and Assignment of Benefit:** I certify that any information I provide in applying for benefit under Title XVIII (“Medicare”) or Title XIX (“Medicaid”) of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to ENT Associates by the Medicare or Medicaid program.
4. I acknowledge that I have received, read, and understand the Practice’s Appointment and No-Show Policy. I agree to comply with the policy, including providing required notice for cancellations or rescheduling. I understand that failure to provide adequate notice or failure to attend a scheduled appointment may result in a no-show or late cancellation fee, for which I am financially responsible.

III. PATIENT VALUABLES

I release ENT Associates of Worcester from responsibility for loss or damage to personal property I choose to keep with me.

IV. AGREEMENT THAT ANY LEGAL ACTION WILL BE FILED IN A COUNTY IN WHICH CARE IS PROVIDED

I understand and agree that any legal action related to my care must be filed in the county where care was provided.

ACKNOWLEDGMENT

I have read this Authorization/Consent for Treatment, Payment and Health Care Operations (TPO) form or have had it read to me and it has been explained to my satisfaction.

Patient Signature: _____ Date: _____

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HIPAA NOTICE OF PRIVACY PRACTICES & CONFIDENTIAL COMMUNICATION

Patient Name: _____ Date of Birth: _____

CONFIDENTIAL COMMUNICATION REQUEST

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have the right to request that we communicate with you about your health information in a specific way or at a specific location.

May we speak with someone other than you about your medical information?

YES or NO If YES, please complete below:

Name: _____

Relationship: _____

Phone: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that my protected health information may be used and disclosed for:

- Treatment, including coordination among healthcare providers
- Payment for services
- Healthcare operations such as quality review and administrative activities

I understand:

- I may request restrictions on certain uses and disclosures (in writing).
- If I pay in full out-of-pocket, I may request that information about that service not be sent to my insurance.
- Certain disclosures (such as psychotherapy notes or marketing use) require my written authorization.
- I will be notified in writing if a breach of my protected health information occurs.
- I may request a full copy of the complete Notice of Privacy Practices at any time.

Signature: _____ Date: _____

If signed by someone other than patient, relationship: _____

NO SHOW & APPOINTMENT POLICY

At ENT Associates, we are committed to providing timely, high-quality care to all patients. Keeping scheduled appointments allows us to serve you and others effectively.

Cancellations & Rescheduling

If you need to cancel or reschedule an appointment, please notify our office at least 24 hours in advance.

Missed Appointments (No-Shows)

A missed appointment occurs when a patient does not arrive for a scheduled visit and does not provide advance notice.

Missed Appointment Fee: **$200.00**

These fees are not covered by insurance and are the patient's responsibility. Fees may be waived for emergencies or reasonable circumstances. Medicaid and certain plans may not allow fees.

Appointment Reminders

We provide reminders via phone, text, or email. Please keep your contact information up to date.

Repeated Missed Appointments

Repeated missed visits may result in changes to scheduling or transfer of care in accordance with regulations.

Acknowledgment

By scheduling an appointment, you acknowledge this policy.