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14100 E Arapahoe Rd, Ste. 250, Centennial, CO 80112
Phone (720) 979-0855 | Fax (303) 400-8311
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Phone (303)783.2670 Fax (303)290-6317

Dear

Thank you for choosing Rocky Mountain ENT Associates for your care. We have 4 physicians, 4 audiologists and three practice locations. We ask you to complete your paperwork ahead of time. The paperwork takes approximately 20 minutes to complete. If you are an established patient and have completed our paperwork in the past we may ask you to update it if it has been over one year. Below are some quick FAQs for you to help make your visit the best experience it can be:

**Arrive 10 minutes early with your completed paperwork*

**Bring a photo ID and your Insurance Card*

**Make sure your insurance company does not require a referral to be processed through your insurance company prior to your visit*

**If your Insurance is Medicaid make sure it is not Denver Health, University or Kaiser as we do not accept those plans.*

**If your insurance has a co-pay we will collect the co-pay at the time of visit.*

**If your insurance has co-insurance we will collect \$20.00 that will be applied to your co-insurance*

**If you see a physician and an audiologist on the same day it is possible your insurance will charge you two co-pays. We will only collect one at the time of service.*

After your visit you will receive an email asking you to complete a survey. The survey takes about 3 minutes. It is important to us to hear how we did. If your experience was not excellent please call Christy, our Practice Manager at 720-475-8714 or ask for her before you leave so we can make sure your visit meets your expectations.

We have a web portal for your convenience. You will receive the credentials at check in. If you do not, please ask. The web portal allows you to access your medical records any time. In order for you to access the portal we do need your social security number as it is a unique identifier.

If you need to cancel your appointment, please do so as soon as possible. We look forward to seeing you soon.

Your appointment is at the following location: _____ and on _____ at _____

Sincerely,

Rocky Mountain ENT Associates



1400 S. Potomac St. Suite 240 • Aurora, CO 80012
14100 E. Arapahoe Road • Centennial, CO 80112
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Pediatric Patient Intake Form

Date: _____ Name: _____ DOB: _____ Age: _____

Parent/Guardians Name(s): _____

Who referred you to us? (Referring Physician): _____

Please list the names of current medical providers:

Primary Care Provider: _____ Phone: _____

Other Provider: _____ Phone: _____

What is your preferred pharmacy?

Name/Location: _____ Phone: _____

What is the reason for the patient's visit today?

How long have the symptoms been present? _____

What makes them better? _____

What makes them worse? _____

What treatment(s) have been tried? _____

What tests have been done? _____

Has allergy testing been done? _____ If yes, when? _____

MEDICAL HISTORY

Please list your prescribed, over-the-counter, or herbal medicines. Include doses and number of times taken per day:

I am currently not taking medications

Name	Strength	# Taken	How Often	Start Date	End Date

Please List Any Allergies:

No known allergies

Agent/Substance	Reaction	Agent/Substance	Reaction

Date: _____ Name: _____ DOB: _____ Age: _____

Has the patient had any of the following health problems? Check all that apply

- | | | | | |
|--|---------------------------------------|---|--|--|
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Back problems | <input type="checkbox"/> Kidney infections | <input type="checkbox"/> Arthritis/ Joint Pain |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> AIDS/HIV+ | <input type="checkbox"/> Cystic Fibrosis |
| <input type="checkbox"/> Heart Murmurs | <input type="checkbox"/> Stroke | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Down's syndrome |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Seizures | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sinus Disease | <input type="checkbox"/> Cancer, Type: |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Hearing Loss | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Migraines | <input type="checkbox"/> Bleed Disorder | <input type="checkbox"/> Reflux Disease | |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Ulcers | |

None of these listed

Other Conditions:	Date Diagnosed	Other Conditions:	Date Diagnosed

Please List Prior Surgeries: **No surgeries**

Surgery	Date	Surgery	Date

Patient's Hobbies/Activities: _____ Is the patient exposed to smoking? Yes No
 Who lives in the patient's home? _____ Is the patient in daycare/school? Yes No What grade? _____

Please check if any blood relatives have any of the following:

Family Member	Alive/ Deceased	Diabetes	High Blood Pressure	Breast Cancer	Heart Disease	Lung Cancer	Colon Cancer	Heart Attack	High Cholesterol	Asthma	Hearing Loss
Father											
Mother											
Daughter(s)											
Son(s)											
Sister(s)											
Brother(s)											
Paternal Grand Father											
Paternal Grand Mother											
Maternal Grand Father											
Maternal Grand Mother											

Please check if you have had and of the following in the last month:

General: No Problems	Nose: No problems	Heart :No Problems	Neuro/Psych: No problems	Skin: No problems
Fever	Obstruction/congestion	Chest pain	Numbness	Skin lesions/rashes
Weight Loss	Postnasal drip	Shortness of breath	Weakness	Pigmentation changes
Weight gain	Drainage/pus	Swollen legs/ ankles	Tingling	Allergy: No problems
Night sweats	Loss of smell	Dizziness or fainting	Convulsions	Inhalant allergy
Loss of appetite	Throat: No problems	Palpitations	Blackouts	Contact allergy
Eyes: No Problems	Recent voice change	Gastro: No problems	Sensory disturbances	Environmental allergies
Blurry vision	Difficulty breathing	Nausea/vomiting	Motor disturbances	Food allergy
Double Vision	Difficulty swallowing	Vomiting blood	Depression	Latex allergy
Change in vision	Can't clear throat	Heartburn	Memory difficulties	Hematology:No problems
Eye pain	Chronic cough	Abdominal pain	Endocrine: No problems	Anemia
Excess tearing	Hoarseness	Constipation	Increased appetite	Bleeding tendency
Ears: No Problems	Sore throat	Blood in stool	Heat intolerance	Prior transfusion
Hearing loss	Loss of taste	Diarrhea	Cold intolerance	
Ringling in ears	Pulmonary: No problems	Genitourinary: No Problems	Increased water intake	
Ear pain	Wheezing	Painful urination	Muscle/Joint: No Problems	
Ear drainage	Coughing	Frequent urination	Joint pain/limited motion	
Ear fullness	Coughing up blood	Blood in urine	Muscle weakness	
Dizziness	Pain with breathing		Back pain	

Patient Registration Form

(Please Print)

PATIENT INFORMATION

Form fields for Patient Information including Name, Marital Status, Social Security Number, Date of Birth, E-Mail Address, Phone Numbers, Address, City, State, ZIP (+4), Employment Status, Employer, Occupation, Emergency Contact Name, Relationship, and Referring Provider Name.

RESPONSIBLE PARTY INFORMATION

Form fields for Responsible Party Information including Name, Social Security Number, Date of Birth, E-Mail Address, Phone Numbers, Address, City, State, ZIP (+4), Employment Status, Employer, Employer Phone Number, and Patient Relationship to Responsible Party.

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Form fields for Primary Insurance Information including Name of Insured, Patient Relationship to Insured, Insured Employer Name, Insurance Company/Phone Number, Subscriber ID (Policy Number), Group ID, Copay Amount, Effective Date, Termination Date, Insured Date of Birth, Insured's Social Security Number, and Insurance Company Address.

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Form fields for Secondary Insurance Information including Name of Insured, Patient Relationship to Insured, Insured Employer Name, Insurance Company/Phone Number, Subscriber ID (Policy Number), Group ID, Copay Amount, Effective Date, Termination Date, Insured Date of Birth, Insured's Social Security Number, and Insurance Company Address.

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature _____ Date _____

General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative

Date

Printed Name of Patient or Personal Representative

Relationship to Patient

Printed Name of Witness

Employee Job Title

Signature of Witness

Date

**ROCKY MOUNTAIN ENT ASSOCIATES
FINANCIAL POLICY**



We would like to thank you for choosing Rocky Mountain ENT Associates for your care. We are committed to providing you with the best possible care. We want you to be informed of our office financial policy and require a signature to document that you have read and understand our policy. You will be given a copy for your records.

SERVICE

You are here to receive a service. There are charges associated with the services we provide. Services include, and are not limited to: consultation, evaluation, and procedures. ***If you see one of our audiologists in addition to the physician, there is a separate charge for their service.** Services provided outside of our office will be charged by the entity providing the service. (i.e: labs, radiology)

MISSED APPOINTMENT/LATE CANCELLATION

Our office will call to confirm your appointment two business days prior to the appointment date. Broken appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. In order to maintain our schedule, we request **24 hour notice** for cancellations or rescheduling of appointments.

CHECK IN

We respect and value your time. ***If you are more than 10 minutes late for your appointment, we may need to reschedule.*** We apologize for any inconvenience this may cause you, but we do our best to run on time and by being punctual, everyone will be served in a timely and efficient fashion while receiving the highest quality care.

ESTABLISHED PATIENTS: We request that **all** of our established patients **arrive 10 minutes prior** to their appointment for check in.

NEW PATIENTS: If it is your first time to our office, please arrive 15 minutes prior to your appointment time with your **paper work completed**. If the paper work is not complete, please arrive **30 minutes** prior to the appointment time.

PAYMENT

For patients with a **co-pay** plan, payment is expected at the time of service*. When you check in for the appointment, we will collect the amount indicated on your card unless instructed otherwise. We accept credit cards, checks and cash. All insurance carriers have a fee schedule from which they will reimburse. Any services not covered, **deductibles and coinsurance** are your responsibility and will be billed to you by our office. Payment is due with-in 30 days.

***We do not collect co-pays at the time of service for our audiology services. If your plan applies a co-pay for these services, we will send a statement to you.** *Most Aetna and Cigna plans apply co-pays to both the office visit and to the audiology service.*

SCOPE FINANCIAL FORM

_____ ***I have read the Diagnostic Nasal Endoscopy Financial Notice and agree to pay my patient balance if this surgical procedure is applied to my deductible or co-insurance.***

If you do not have insurance, payment is required at the time of service. If special circumstances make immediate payment impossible, payment arrangements must be approved in advance.

INSURANCE

All services performed by our providers will be submitted as a courtesy to your insurance. Insurance plans vary considerably. It is your responsibility to provide accurate and timely insurance information.

INSURANCE REFERRALS:

It is your responsibility to understand the requirements of your insurance policy. If a referral is needed prior to seeing a specialist, you will need to obtain one through your primary care doctor office. If you choose to be seen without a valid referral in place, you will be responsible for any charges not covered by your insurance company.

Guardian/Responsible Party Signature: _____

Date: _____