

FINANCIAL POLICIES

Head and Neck Associates will submit claims to your insurance company for all medical services rendered. We will attempt to verify eligibility and benefits with your insurance company; however, this verification is not a guarantee of payment. Any expenses deemed not covered by your insurance company will be your financial responsibility.

All monies owed by the patient, i.e., office visit copayments and non-covered services or supplies are due at the time of service. Also, when applicable, coinsurance percentages and/or deductibles may be collected at the time of service. Please be aware that this office will bill only for the physicians' services. Any other services related to your office visits, i.e., laboratory, radiology or pathology will be billed by the facility providing these services.

It is your responsibility to provide Head and Neck Associates with proof of insurance and an authorization number or referral when applicable. If these items are not provided we ask that you pay in full at the time of service.

The contract between Head and Neck Associates and your health plan, as well as the contract between you and your health plan requires that you make payment in full of all co-payments and deductible amounts deemed to be your responsibility upon claims processing. Additional discounts are forbidden by contract unless financial hardship is documented in writing by the patient.

Our office accepts the following forms of payment: most major credit cards, cash, and personal checks. A \$20 service charge will be assessed to your account for any check returned by your bank.

ACKNOWLEDGEMENT OF RECEIPT
NOTICE OF PRIVACY PRACTICES

I hereby acknowledge receipt of the **Notice of Privacy Practices** being adhered to by Head and Neck Associates of Orange County. The Notice of Privacy Practices is supplied in accordance with the Privacy rule that is an integral part of the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

A physical copy of the HIPAA Acknowledgement can be provided upon request.

Printed Patient Name

Patient Birthdate

Date Signed

Signature of Patient
(Parent if Patient is Minor)

Relationship to Patient
(If Patient is Minor)



Head and Neck Associates of Orange County, Inc.

Patient we are required by the State of California to provide you with this notice of the Open Payments Database.

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at <https://openpaymentsdata.cms.gov>. For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars (\$10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.

Print Patient Name (or Guardian)

Signature

Date

HNA Allergy & Asthma

Geeta Venkat, MD
Jacquelyn Hunter, MD
Chongjia Chen, MD

You have been referred for allergy testing. You will be skin tested with various allergens on your back and arms. Please follow these instructions so we can make this more comfortable for you.

1. Diet: You may eat your normal diet
2. If you have long hair, you will need to pull your hair back before testing. If you have hair on your back, please make sure that it is removed prior to your appointment
3. Medications: Please discontinue all antihistamines as they inhibit the results of the allergy test.
4. Please do not use any lotion or oil on your arms or back on the day of the testing.

****Please inform us if you are taking Beta Blockers, high blood pressure medication, or have a heart condition**

Stop 5 days prior to your testing appointment:

All Antibiotics	Claritin (Loratadine)	Ryaltris
Ah-Chew	Claritin-D	Rynatan
Allerest	Dymista	Seldane
Allegra (Fexofenadine)	Nyquil	Tavist D
Benadryl (diphenhydramine)	Pataday	Triaminic
Bromfed	Patanase (Olopatadine)	Tylenol Sinus
Astelin (Azelastine) Astepro	Pepcid (Famotidine)	Tylenol PM
Cimetidine (H2 blocker)	Phenergan	non-prescription cold medicines
Chlor-Trimeton		Zantac (H2 blocker)

Stop 1 week prior to testing

Atarax (hydroxyzine), Xyzal (levocetirizine) and Zyrtec (cetirizine)

Medications okay to continue are listed below:

Flonase (fluticasone), Nasonex (mometasone), Rhinocort, Budesonide

1st part of testing: you will be asked to lie on your stomach, your back will be cleaned with rubbing alcohol, a panel of numbers will be written with a non-permanent pen, and the corresponding pricks of allergen will be applied. You can plan to lie on your stomach for approximately 20 minutes.

2nd part of testing: upper arm will be cleaned with rubbing alcohol, numbers will be written with a non-permanent pen, and the corresponding allergens will be injected.

Please give our office 24 hours' notice if you are unable to make your appointment.

Feel free to call if you have any questions: 949-481-9701

www.ocallergycenter.com

HNA Allergy & Asthma

Patient Questionnaire

Name: _____ DOB: _____ Date: _____

	Mother	Father	Siblings				Children			
Age (if alive)										
Health(good/bad)										
Cancer										
Tuberculosis										
Diabetes										
Heart Issues										
Hypertension										
Stroke										
Epilepsy										
Nervous Breakdown										
Asthma, hives, hayfever										
Blood disease										
Age (at death)										
Cause of death										

Personal History

Please **circle** symptoms that apply to why you are being seen by us today:

Constitutional:

- Abnormal weight change
- Fever
- Chills
- Fatigue

Respiratory:

- Snoring
- Wheezing
- Shortness of breath

Cardiovascular:

- Chest Pain
- Palpitations

Gastrointestinal:

- Abdominal Pain
- Constipation
- Diarrhea
- Vomiting

Ear/Nose/Throat:

- Hearing Loss
- Ear Pain
- Excessive ear wax
- Hearing noises in ear
- Dizziness
- Trouble swallowing
- Change in Voice
- Throat Pain
- Post-nasal drip
- Nosebleeds
- Nasal Congestion
- Headache
- Jaw pain

Neurological:

- Trouble walking
- Non-restorative sleep
- Fainting
- Tingling

Psychological:

- Increased anxiety
- Depression
- Behavior changes
- Increased stress

Musculoskeletal:

- Neck stiffness
- Increased muscle pain
- Increased joint pain
- Muscle weakness

Genitourinary:

- Change in urinary color
- Increased urgency
- Blood in urine
- Pain when urinating

Past Medical History: Please **check** what you have been diagnosed with

- | | |
|---|--|
| <input type="checkbox"/> Anesthesia Complications | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Irregular Heartbeat |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Immune Suppression |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer: Type _____ | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Diabetes: Type _____ | <input type="checkbox"/> Hyperthyroidism |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Reflux (GERD) |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Enlarged glands |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Irregular bowel movements |
| <input type="checkbox"/> Headaches | |
| <input type="checkbox"/> Heart Attack | |

Please list any other medical conditions: _____

Please list all **Allergies** (i.e. medications, foods, household products, etc)

- | | |
|----------|-----------|
| 1. _____ | 7. _____ |
| 2. _____ | 8. _____ |
| 3. _____ | 9. _____ |
| 4. _____ | 10. _____ |
| 5. _____ | 11. _____ |
| 6. _____ | 12. _____ |

Please list **ALL** surgeries **AND** hospitalizations:

- | | |
|----------|-----------|
| 1. _____ | 7. _____ |
| 2. _____ | 8. _____ |
| 3. _____ | 9. _____ |
| 4. _____ | 10. _____ |
| 5. _____ | 11. _____ |
| 6. _____ | 12. _____ |

Please list **ALL** diagnostic/radiological tests and **WHY** they were done:

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

HNA Allergy & Asthma

- Do you exercise adequately? **NO** **YES, how?** _____
- Do you sleep well? **NO** **YES**
- How many hours per night do you sleep? _____
- Do you have regular bowel movements? _____
- Do you like your **NO** **YES**
work?
- Do you work Indoors or outdoors? _____
- How many hours a day do you watch TV? _____
- How many hours a day do you read? _____
- How many weeks in a year do you take vacation? _____
- Have you ever been treated for alcoholism? **NO** **YES**
- Have you ever been treated for drug abuse? **NO** **YES**

Please list **ALL** medications/supplements you take:

- | | |
|----------|-----------|
| 1. _____ | 7. _____ |
| 2. _____ | 8. _____ |
| 3. _____ | 9. _____ |
| 4. _____ | 10. _____ |
| 5. _____ | 11. _____ |
| 6. _____ | 12. _____ |

Do you often feel any of the below emotions?

- | | |
|------------------------------------|--|
| <input type="checkbox"/> Depressed | <input type="checkbox"/> Jumpy |
| <input type="checkbox"/> Anxious | <input type="checkbox"/> Jittery |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Trouble concentrating |

Completed by Patient or _____ Relationship _____

Reviewed by: _____ Date Reviewed: _____ Page 3 of 3

HNA Allergy & Asthma

Nasal/Sinus Worksheet

Name: _____ DOB: _____ Date _____

Do you have nasal obstruction/blockage/congestion:

- Yes, which side is worse right left both
 No

Do you use nasal sprays?

- Never
 Currently name of spray _____
 In the past name of spray _____

How many sinus infections have you been treated for in the past year? _____

Have you has a recent CT or MRI of your head/sinuses?

- No
 Yes Date _____ Location _____

Please check all symptoms that apply

- Nasal drainage
 Decreased sense of smell
 Headache, location _____
 Postnasal drainage
 Facial pain pressure fullness
 Sneezing
 Itchy eyes or nose
 Watery eyes or nose

Have you ever been tested for allergies? Yes, result: _____

No

Have you ever had allergy shots (allergy immunotherapy)?

- Yes, for how long? _____ Date stopped _____
 No

For office use only

Diagnosis:

Today's treatment:

Aims of treatment:

L-M score:

Reviewed by: _____ Date Reviewed: _____

HNA Allergy & Asthma

Sino-Nasal Outcome Test (SNOT 22)

Please circle the number that best describes your symptoms over the past **2 weeks**.

Use this scale to describe how bad the problem when it occurs →	No Problem	Very mild problem	Mild or slight Problem	Moderate problem	Severe problem	Worst the problem can be
Need to blow nose	0	1	2	3	4	5
Sneezing	0	1	2	3	4	5
Runny Nose	0	1	2	3	4	5
Cough	0	1	2	3	4	5
Post-Nasal drainage	0	1	2	3	4	5
Thick nasal discharge	0	1	2	3	4	5
Ear fullness	0	1	2	3	4	5
Dizziness	0	1	2	3	4	5
Ear pain/pressure	0	1	2	3	4	5
Facial pain/pressure	0	1	2	3	4	5
Difficulty falling asleep	0	1	2	3	4	5
Waking up at night	0	1	2	3	4	5
Lack of a good night's sleep	0	1	2	3	4	5
Waking up tired	0	1	2	3	4	5
Fatigue during the day	0	1	2	3	4	5
Reduced productivity	0	1	2	3	4	5
Reduced concentration	0	1	2	3	4	5
Frustrated/restless/irritable	0	1	2	3	4	5
Sad	0	1	2	3	4	5
Embarrassed	0	1	2	3	4	5
Loss of smell/taste	0	1	2	3	4	5
Congestion/obstruction of nose	0	1	2	3	4	5

Reviewed by: _____ Date Reviewed: _____



HNA Allergy & Asthma

Only applies to patients with Medicare coverage

Assignment of Benefits And Release of Information to Medicare

I request the payment of authorized Medicare benefits be made either to me or on my behalf to the physician(s) or supplier listed below for any services provided to me by that physician or supplier. I authorize any holder of medical information about me to release to the **Centers for Medicare and Medicaid Services** and its' agents, any information needed to determine benefits payable for related services. I understand my signature requests that payment be made and authorizes the release of medical information necessary to pay the claim. If other insurance coverage is listed on my claim form or electronic claim, my signature authorizes the release of information to the insurer shown. In Medicare-assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, co-insurance and/or non-covered services. Deductible and co-insurance are based upon the charge determination of the Medicare carrier. This assignment is valid from today's date and remains in effect until I, the patient, revoke this agreement.

HNA Allergy & Asthma

Geeta Venkat, MD

Jacquelyn Hunter, MD

Chongjia Chen, MD

Signature of Patient

Date Signed

Medicare Number (Required)