

THINGS TO BRING TO YOUR VISIT WITH THE DOCTOR

Please check each item to ensure you've brought everything.

- Current insurance card (s).
- Correct co-payment amount. Credit card (MC or Visa) or check, payable to Head & Neck Associates.
- New patient packet, if mailed to you in advance. Arrive 30 minutes early if you did not receive a new patient packet. You may also obtain it at www.hnaoc.com. Click on new patient tab.
- Parent/Legal guardian, if a minor.
- CT, MRI & all other diagnostic films (x-ray films or CDs) and reports.

It is your responsibility to ensure that you bring the films and reports. Failure to do so will delay your visit or require an additional visit to our office. Don't just bring the report.

- Copies of any diagnostic tests done by another doctor (i.e. sleep study, biopsy).
- Name, address and telephone number of the physicians treating you. Include the doctor who referred you to our practice
- List of all medications & dose you currently taking.

Any questions, please contact our office at (949) 364-4361



John S. Supance, M.D., F.A.C.S. • Mark A. Wohlgenuth, M.D., F.A.C.S. • James K. Bredenkamp, M.D., F.A.C.S.
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Dennis M. Crockett, M.D., F.A.C.S.
Diplomates, American Board of Otolaryngology
Head & Neck Surgery Pediatric & Adult Otolaryngology Facial Reconstructive Surgery

Welcome to *Head and Neck Associates of Orange County, Inc*
We are delighted that you have chosen our practice for your medical care!
We are located at:
26726 Crown Valley Parkway, Suite 200
Mission Viejo, CA 92691

Our office is located on the corner of Crown Valley Parkway and Los Altos. To park, turn south on Los Altos and continue forward to the parking gate. Head and Neck Associates does not validate for parking. Our building will be directly to your left. Take the elevator to the second floor.

At this time, we would like to confirm your appointment with:
Dr. _____, scheduled at _____ : _____ AM/PM
On: _____ / _____ / _____

It is the policy of our office to insist that a parent or legal guardian accompany their minor child. The physician may choose to reschedule your child's appointment if he/she is not accompanied by a parent or legal guardian. On the day of your appointment, please arrive at our office 30 minutes prior to your scheduled visit time. This allows extra time to complete any additional information needed.

We have enclosed a new patient information sheet, a copy of our financial policies, a medical questionnaire, an arbitration agreement and a map to help locate the office. Please fill out each section of the information sheet completely. **This office mandates the use of arbitration agreements. An arbitration agreement will be presented to you at the time of your initial visit.**

Bring your completed forms, along with your current insurance card, and any x-ray/CT films (with reports) to your appointment. **Please do not mail these forms back to our office.** In order to assist you with collecting your maximum insurance benefits, we may ask for a copy of your insurance card at each visit. Co-payments will be collected at the time of sign in. Some insurance companies require prior authorizations / referrals for any visit. Please refer to your health care manual to find out if this applies to you. Usually, a prior authorization number is obtained through your primary care physician or insurance company.

Thank you for taking time to read this letter and complete the required forms. We look forward to seeing you!

www.hnaoc.com
26726 Crown Valley Parkway, Suite 200 • Mission Viejo, CA 92691 • 949-364-4361 • Fax 949-364-4495
24411 Health Center Drive, Suite 370 • Laguna Hills, CA 92653 • 949-581-3888 • Fax 949-581-3883
675 Camino de los Mares, Suite 420 • San Clemente, CA 92673 • 949-496-2307 • Fax 949-496-8688

HEAD & NECK ASSOCIATES OF ORANGE COUNTY

26726 Crown Valley Parkway Suite 200

Mission Viejo, Ca 92691

Driving Direction - From Freeway

Take the San Diego Freeway and

Exit Crown Valley Parkway

Go East on Crown Valley Parkway past

The Shops at Mission Viejo on the right

Make a right turn at Los Altos

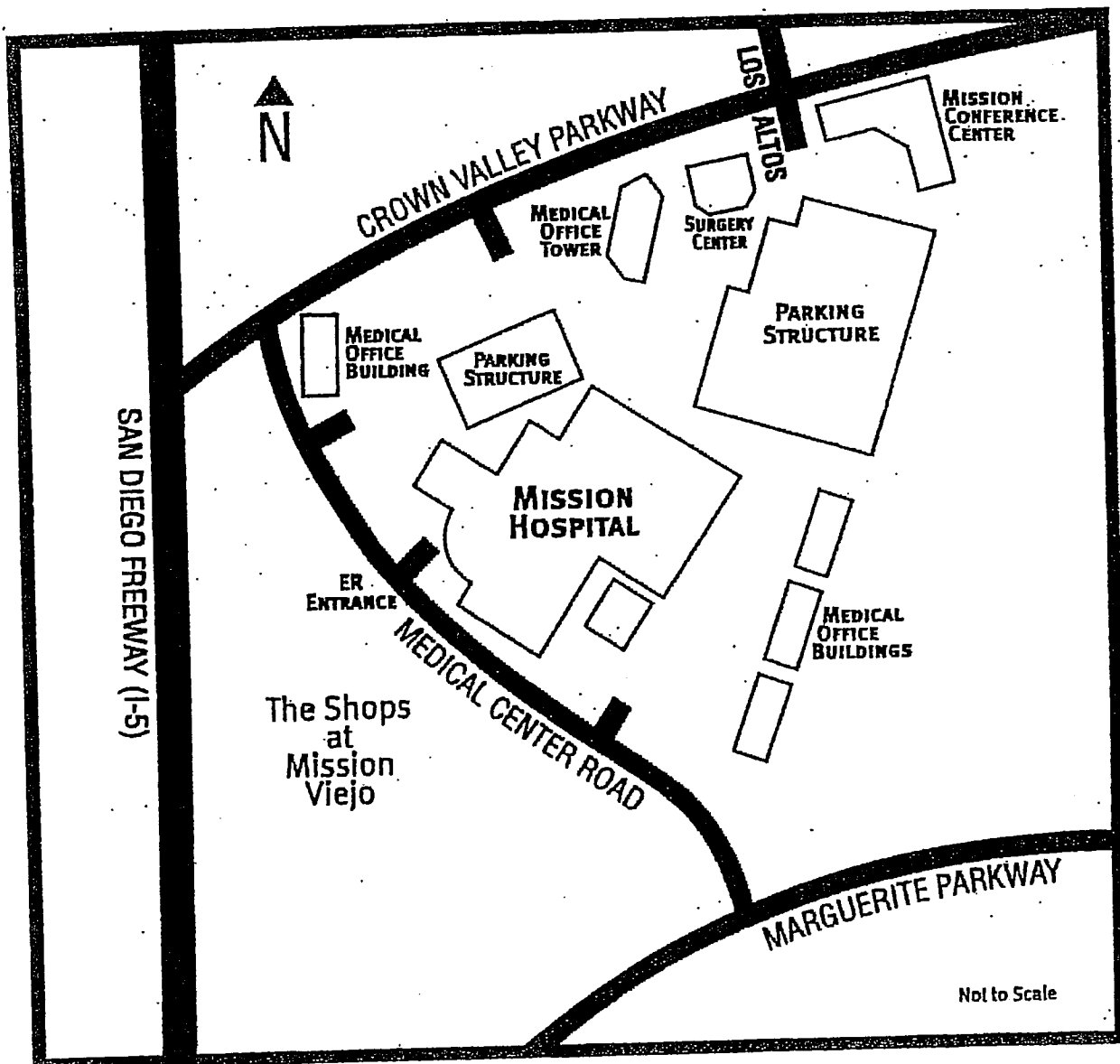
The Building is on the left side

Proceed straight ahead into the Parking Structure.

Building says Mission Conference Center on front door

Proceed to second floor. Suite is

Right off elevator.



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HEAD & NECK ASSOCIATES OF ORANGE COUNTY, INC.

(Please Print)

BREDENKAMP / CHO / CROCKETT / JAKOBSEN / SUPANCE / WOHLGEMUTH / WELLS ACCT # _____

PATIENT INFORMATION

NAME: _____
Last First MI Nickname

ADDRESS: _____
Street City State Zip Code

HOME PHONE: (____) _____ WORK OR CELL PHONE: (____) _____

BIRTHDATE: ____/____/____ EMPLOYER NAME: _____

PRIMARY CARE / REFERRING PHYSICIAN NAME: _____

SS#: ____/____/____ MARITAL STATUS: S ____ M ____ D ____ W ____ O ____

SEX: M ____ F ____ E-MAIL Address: _____

EMERGENCY CONTACT: _____ PHONE: (____) _____

PRIMARY LANGUAGE _____ RACE-(circle) AMERICAN INDIAN- ASIAN – CAUCASIAN
AFRICAN AMERICAN – NATIVE HAWAIIAN
OTHER PACIFIC ISLANDER - UNKNOWN

ETHNICITY (circle) HISPANIC/LATINO – NON HISPANIC/LATINO - UNKNOWN

SPOUSE AND / OR OTHER INSUREDS INFORMATION

NAME: _____
Last First MI Nickname

ADDRESS (IF DIFFERENT): _____
Street City State Zip Code

BIRTHDATE: ____/____/____ SS#: ____/____/____ RELATIONSHIP TO PT: _____

INSURANCE POLICY INFORMATION

PRIMARY INSURANCE CO: _____ Relationship to Patient: _____

INSURED'S NAME: _____ INSURED'S DATE of BIRTH: ____/____/____

ID #: _____ GROUP #: _____ INSURED'S EMPLOYER: _____

SECONDARY INSURANCE CO: _____ Relationship to Patient: _____

INSURED'S NAME: _____ INSURED'S DATE OF BIRTH: ____/____/____

ID#: _____ GROUP #: _____ INSURED'S EMPLOYER: _____

ASSIGNMENT OF BENEFITS / RELEASE OF INFORMATION

I assign and request payment of medical benefits be made to **HEAD AND NECK ASSOC OF ORANGE COUNTY, INC.** for medical services rendered. I authorize the release of medical information necessary to process my claim. **I have read the Financial Policies and understand that I am financially responsible for any non-covered services.**

Patient Signature

Date



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PATIENT CONTACT PREFERENCE

In accordance with the Health Insurance and Portability Act (HIPAA), we are required to institute specific confidentiality safeguards regarding your medical health information. It will be necessary for our office staff to contact you regarding scheduled appointments, possible surgery scheduling, lab diagnostic test results and other related matters such as insurance coverage and billing.

Many people have multiple communication devices such as cell phones, work or home voice mail / answering machine systems. Consequently, we require specific instructions as to how best to contact you. In addition, if you wish other members of your household or other designated persons to be authorized to receive this protected health information, you must indicate those individuals that are authorized to be made aware of such information.

Please rank in order of preference all phone numbers at which we may contact you to leave information about your appointment, surgical time or other related health information:

- Home Telephone: () _____ 1 2 3 (Circle)
- Cell Phone: () _____ 1 2 3 (Circle)
- Work Telephone: () _____ Ext: _____ 1 2 3 (Circle)

If you are not available, may we leave information or instructions with a family member or other authorized person? Yes No

Please PRINT the names and relationships of persons authorized to receive protected health information:

 Name Relationship

 Name Relationship

May we also contact you via e-mail? Y / N If yes, email address: _____

 Signature of Patient, Parent or Guardian Print Name of Patient

 Date



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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 guaranty 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.

In order to properly evaluate our patients, it is often necessary for the physician to perform an in-office procedure such as, but not limited to:

fiberoptic laryngoscopy biopsies ultrasounds
fiberoptic nasal endoscopy hearing testing CT scans

These services are billed as an additional charge from the office visit and additional coinsurance and/or deductible amounts may apply. Although these services are done in the office, they are often labeled as "surgery" on your insurance company explanation of benefits. If you have any questions regarding the necessity of any of these services, please direct them to your physician at the time of service.

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 twenty-dollar service charged will be assessed to your account for any check returned by your bank.

Responsible party signature

Date

Patient name (Please Print)

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NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT

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).

Notify our office staff if you wish to retain a copy of the Notice of Privacy Practices.

Signature

Date

Patient Name

Relationship to Patient

www.hnaoc.com

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NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you as a patient of Head and Neck Associates may be used and disclosed, your rights as a patient and how you can access your health information. This notice is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Head and Neck Associates is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information as prescribed by HIPAA. These HIPAA guidelines are summarized below for your information and understanding.

Use and Disclosure of your Health Information

The following circumstances may require Head and Neck Associates to use or disclose your health information.

1. To comply with requests from public health authorities and health oversight agencies which are required by law to collect health information.
2. Law suits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Head and Neck Associates will only make such disclosures to a person or organization able to prevent the threat.
5. If you are a member of U.S. or foreign military forces, including veterans, and if required by the appropriate authorities.
6. To federal government officials for intelligence and national security activities required by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Worker's Compensation and similar programs.

Your Rights regarding your Health Information

1. You can request that Head and Neck Associates communicate with you about your health related issues in a particular manner or at a certain location. Therefore, you may ask to be contacted at home rather than work, via personal fax or cell telephone for appointment confirmations or related scheduling matters, for results of specific diagnostic tests, and such reasonable requests will be accommodated.
2. You can request a restriction regarding the use or disclosure of your health information for treatment, payment, or health care operations by Head and Neck Associates.
3. You have the right to request that Head and Neck Associates restrict our disclosure of your health information to only certain individuals involved in your care or the payment of your care, such as a family member or friend. However, Head and Neck Associates is not required to agree to your requests, but if we do agree, Head and Neck Associates is bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you.
4. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical and billing records, **with the exception of psychotherapy notes**. You must submit your request in writing to Head and Neck Associates, Attn: Beth Page, HIPAA Privacy Officer, at 26726 Crown Valley Pkwy., Suite 200, Mission Viejo, CA 92691. Obtain a request form from one of the Front Desk receptionists.
5. You may ask Head and Neck Associates to amend your health information if you believe it is incorrect or incomplete as long as the information is kept by or for Head and Neck Associates. To request an amendment, make your request in writing with a supporting reason for the amendment to your health information to Head and Neck Associates, Attn: Beth Page, HIPAA Privacy Officer, at 26726 Crown Valley Pkwy., Suite 200, Mission Viejo, CA 92691. Obtain a request form from one of the Front Desk receptionists.
6. You are entitled to receive a copy of the Notice of Privacy Practices by asking the Front Desk receptionist to make you a photocopy.
7. If you believe your privacy rights have been violated, you may file a complaint with Head and Neck Associates or with the Secretary of the Department of Health and Human Services. Any complaint filed with Head and Neck Associates must be submitted in writing. You will not be penalized for filing a complaint. Obtain the proper form to file a complaint from one of our Front Desk receptionists or Medical Assistants.
8. Head and Neck Associates will obtain your written authorization for uses and disclosures that are not identified by this Notice of Privacy Practices or permitted by law.

If you have any questions regarding this Notice of Privacy Practices or Head and Neck Associates' health information privacy policies, please contact Beth Page, HIPAA Privacy Officer at Head and Neck Associates, 26726 Crown Valley Pkwy., Suite 200, Mission Viejo, CA 92691.

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Date: _____

**HEAD AND NECK ASSOCIATES OF ORANGE COUNTY
ADULT MEDICAL QUESTIONNAIRE**

Name: _____ Age: _____ Date of birth: _____

Primary Care Doctor: _____

Doctor who referred you: _____

Other physicians caring for you: _____

Are your symptoms a work related injury: **Yes/no** Date of injury: _____

Are you pregnant? **Yes/no**

Reason for Visit: _____

• **PAST MEDICAL HISTORY**
(Have you been diagnosed with or treated for any of the following diseases?)

Angina or Heart Attack	Yes/no	Glaucoma/Cataracts	Yes/no
Anesthesia complications	Yes/no	Headaches	Yes/no
Asthma	Yes/no	High Blood Pressure	Yes/no
Bladder disease	Yes/no	Immune suppression/ HIV	Yes/no
Bleeding Problems	Yes/no	Irregular Heart Beat	Yes/no
Blood Transfusions	Yes/no	Liver problems/Hepatitis	Yes/no
Congestive Heart Failure	Yes/no	Sleep Apnea	Yes/no
Cancer	Yes/no	Snoring	Yes/no
Diabetes Mellitus	Yes/no	Stroke	Yes/no
Emphysema	Yes/no	Thyroid disease	Yes/no
Epilepsy	Yes/no	Ulcers or Reflux (GERD)	Yes/no

SURGERIES AND HOSPITALIZATIONS

List all previous surgeries/hospitalizations, and approximate dates:

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |

CURRENT MEDICATIONS WITH DOSAGES

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Do you take any "blood thinners? **Yes/no**

Do you take aspirin containing medications? **Yes/no**

ALLERGIES TO DRUGS**YES (list if YES) / NO**

1. _____
2. _____
3. _____

ENVIRONMENTAL ALLERGIES**YES (list if YES) / NO**

1. _____
2. _____
3. _____

• REVIEW OF SYSTEMS – PAST 30 DAYS

(Circle Yes or No. If Yes, put a Check next to any illnesses, problems, or symptoms you have had in the past 30 days)

Yes/No: EYES

- Change in Vision
- Pain
- Blurred or double vision
- Glaucoma

Yes/No: CONSTITUTIONAL SYMPTOMS

- Fevers, Chills, or Night sweats
- Recent Weight change
- Skin problems

Yes/No: RESPIRATORY

- Cough
- Spitting up blood
- Wheezing

Yes/No: MUSCULOSKELETAL

- Joint pain/stiffness
- Muscle pain/cramps/weakness
- Back pain

Yes/ No: GENITORUINARY

- Flank pain
- Problems with urination
- Abnormal urine color

Yes/ No: CARDIOVASCULAR

- Chest pain
- Palpitations
- Shortness of breath, walking or lying flat
- Swelling of feet, ankles or hands

Yes/ No:**EARS/NOSE/MOUTH/THROAT**

- Hearing loss
- Hearing noises in your ear(s)
- Earaches or drainage
- Nosebleeds
- Trouble swallowing
- Sinusitis
- Sore throat
- Snoring
- Voice changes
- Oral bleeding
- Difficulty and or pain with swallowing

Yes/ No: GASTROINTESTINAL

- Problems with bowel movements
- Nausea or vomiting
- Rectal bleeding, blood in stool, vomiting blood
- Abdominal pain or heartburn

Yes/ No: HEMATOLOGIC/LYMPHATIC

- Slow to heal after cut
- Bleeding or bruising tendency

Yes/No: NEUROLOGICAL

- Headaches
- Numbness or tingling sensations
- Tremors
- Head injury
- Fainting or loss of consciousness

Yes/No: OTHER SYMPTOMS

- Memory loss or confusion
- Nervousness
- Depression
- Insomnia

• **FAMILY HEALTH HISTORY**

	<u>Father</u>	<u>Mother</u>
Alive	Yes/No	Yes/No
Age or Age at death	_____	_____
Angina or Heart Attack	Yes/No	Yes/No
Diabetes Mellitus	Yes/No	Yes/No
Congestive Heart Failure	Yes/No	Yes/No
High Blood Pressure	Yes/No	Yes/No
Adverse Anesthetic Reactions	Yes/No	Yes/No
Liver Problems/Hepatitis	Yes/No	Yes/No
Bleeding Disorders	Yes/No	Yes/No

HABITS

- Do you now smoke? (circle cigars/cigarettes) Yes No
 How many years _____ Packs per day? _____
- Have you ever smoked? Yes No
 How long ago? _____ For how many years? _____
 How many packs per day (average)? _____
- Have you ever used chew or snuff? Yes No
- Do you drink alcohol? Yes No
 How many drinks per day (average)? _____
 When did you last drink? _____
- Have you used illicit drugs (including marijuana, heroin, cocaine, LSD, crack)? Yes No
 If yes, circle which ones.
- Do you exercise on a regular basis? Yes No
 Type of exercise? _____ How often? _____

Besides the information that will be entered in the following pages, is there anything else or other information that you would like us to know? _____

Reviewed by MA _____

Reviewed by MD _____