TRI-COUNTY ENT, LLC

Dr. Jayde Steckowych

ALL INFORMATION IS KEPT CONFIDENTIAL

PLEASE PRINT- ALL FIELDS REQUIRED

PATIENT NAME ________________________ **SS#** ______-_____-______ **Date of Birth**______________

Street________________________ **Home Phone** (_______) ________________

City ______________ **State**_______ **Zip** __________ **Cell Phone** (______) ________________

☐ **Male** ☐ **Female** ☐ **Married** ☐ **Single** ☐ **Other** **Student:** ☐ **Yes** ☐ **No** **Employed:** ☐ **Yes** ☐ **No**

Employer ________________________

Employment Address ________________________

City ______________ **State**_______ **Zip**__________

Phone (_________) ________________

Primary Physician ________________________

Address ________________________

City ______________**State** _______**Zip**________

Phone (_________) ________________

Emergency Contact ________________ **Relationship** ____________ **Phone** (_______) ____________

Is there any Doctor, Family Member, or Friend to whom we have permission to speak or give test results?

Name________________________ **Relationship** ________________________

Person Responsible for this Account (*if different from above*)

Name________________________ SS#_______-_____-______ Date of Birth______________

Street________________________ Employer ________________________

City ______________ State_______ Zip __________ Address ________________________

Home Phone (________) ________________ Phone (________) ________________

Relationship to Patient: ☐Parent ☐Spouse ☐Other

PRIMARY INSURANCE COMPANY ________________________ **Referral Needed?** ☐ **Yes** ☐ **No**

Insured Name: ________________________**Specialist Copay:** $_____________

SS# _______-_____-_______ Date of Birth: ________________ Relationship to Patient: ☐ Self ☐ Parent ☐ Spouse ☐ Other

SECONDARY INSURANCE COMPANY________________________

Insured Name: ________________________

SS# _______-_____-_______ Date of Birth: ________________ Relationship to Patient: ☐ Self ☐ Parent ☐ Spouse ☐ Other

Please provide us with your Referral (if required by Insurance) and your Insurance Card (we will copy).

Tri-County ENT, LLC
Responsibility for Payment of Service

The responsibility of payment for services provided to you by Dr. Steckowych is your responsibility.

****Co-pays are expected at check-in****

Insurance Guidelines:
For your convenience we participate with most major insurance carriers, however we may not participate in your individual plan. Insurance coverage is an agreement between the insured and the carrier. It is the patient/subscriber's responsibility to ensure Dr. Steckowych's participation in their particular plan. If you have questions about this, contact your insurance carrier directly, as we are unable to ascertain the specifics of each patient's individual plan. ****WE DO NOT PARTICIPATE IN ANY MEDICAID PLANS WHATSOEVER****

PLEASE NOTE: If your plan has a yearly deductible that has not been satisfied (applies to in-network and out-of-network patients), you will be responsible for these charges. In some instances, your carrier may send payment directly to you, which must be forwarded to our office, along with any Explanation of Benefits (EOB), and all out-of-pocket responsibility as indicated on your EOB. Out-of-network payments are not accepted as payment in full, and this office reserves the right to expect full payment for the total charges billed. If your plan has a coinsurance component, you are required to remit this payment to the office within 30 days of being billed.

It is your responsibility to know and to advise us of your program's requirements in advance of any service provided to you. We will do our best to comply with any reasonable requirements that your program may have.

- Some Insurance Programs require that a specific facility be used for your x-rays, CT scans, MRI's, blood tests, or other tests as required by the Doctor.
- Some Insurance Programs require pre-authorizations and/or referrals while others do not.

If your insurance company requires a referral, it is *your responsibility* to make sure you have the referral to cover today's visit and keep track of the # of visits allowed and the expiration date. **Please note that if you require a referral for your visit or your current referral has expired, you will be required to make payment in full at the time of service or reschedule your appointment once you have obtained an active referral and presented it to our office. This applies to pre-authorizations as well. Visits that are denied for no referral or pre-authorization after submission to your insurance will be billed to you, and you will be responsible for payment to the office.**

If you are part of a Union Plan, reimbursement for services will be mailed directly to you. It is, therefore, required that payment be made at the time of service.

Self Pay Policy (patients without insurance coverage):
All fees must be paid for at the time of service, no exceptions will be made to this policy.

PAST DUE BALANCE POLICY (APPLIES TO ALL PATIENTS)

ACCOUNTS WITH A PATIENT BALANCE OLDER THAN 60 DAYS WILL BE REFERRED TO COLLECTIONS. YOU WILL BE RESPONSIBLE FOR PAYMENT OF ALL CHARGES INCLUDING ANY COLLECTION FEES AND/OR ATTORNEY/COURT COSTS.

NO SHOW/CANCELLATION POLICY

DUE TO ESCALATING COSTS, YOU WILL BE CHARGED $40.00 FOR ANY APPOINTMENT NOT KEPT, OR NOT CANCELLED 24 HOURS PRIOR TO APPOINTMENT (NOT THE SAME DAY).

RETURNED CHECKS WILL BE CHARGED A $40 REPROCESSING FEE

I hereby acknowledge the responsibility for payment of service as explained above:
(Existing patients- this document supersedes prior Responsibility for Payment of Service documents currently on file)

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Patient Signature **Date**
(Parent/Guardian if patient is under 18 years old)

Tri-County ENT, LLC
Jayde M. Steckowych, M.D., FACS
21 Franklin Turnpike, Suite 2111
Mahwah, NJ 07430
(201)-642-4000

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

USE AND DISCLOSURES

- **Treatment**

Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

- **Payment**

Your health information may be used to seek payment from your health plan, from other sources of coverage, such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

- **Health Care Operations**

Your health information may be used, as necessary, to support the day-to-day activities and management of Tri-County ENT, LLC. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

- **Law Enforcement**

Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting.

- **Public Health Reporting**

Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

- **Other Uses and Disclosures Require Your Authorization**

Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke the authorization.

- **Additional Uses of Information**

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

- **Individual Rights**

You have certain rights under the federal privacy standards, which include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice.

- **Tri-County ENT Duties**

We are required by law to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices. We are also required to abide by the privacy policies and practices that are outlined in this notice.

- **Right to Revise Privacy Practices**

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required/by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

- **Requests to Inspect Protected Health Information**

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our office. Your request will be review and will generally be approved, unless there are legal or medical reasons to deny the request.

- **Complaints/Contact Person**

If you wish to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to our office, attention: Practice Manager.

- **Effective Date**

This Notice of Privacy Practices is effective as of April, 2003.

For additional information about HIPAA, you may contact:
The US Department of Health & Human Services
200 Independence Avenue SW Washington, DC 20201 Phone: 202-619-0257 Toll Free: 1-877-696-6775

MEDICARE LIFETIME SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made on my behalf to Tri-County ENT, LLC for services furnished me by the physician. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents, any information to determine these benefits payable for related service.

Patient Signature **Date**

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PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS/INFORMATION RELEASE

I, the undersigned, authorize payment of medical benefits to Tri-County ENT, LLC for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provide to me. This information will be used for the purpose of evaluating and administering claims of benefits.

Patient Signature **Date**
Parent or Guardian (if child is under 18 years old)

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This statement is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement. ***You may refuse to sign This Acknowledgement***

As part of HIPAA, we need to know if the doctor or staff can leave messages on your voicemail.
Please check one and sign:

□ DO NOT LEAVE A MESSAGE ______________________________
Signature

□ PERMISSION TO LEAVE A MESSAGE ______________________________
Signature

Phone # ______________________________

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FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign
Communication barriers prohibited obtaining the acknowledgement
An emergency situation prevented us from obtaining acknowledgement
Received at another Physician's Office
Other (Please Specify)

___________ Staff Initials

TRI-COUNTY ENT, LLC

Name ________________________________

Present Illness and Chief Complaint ________________________________

Date Symptom(s) began: __________________

Frequency: ☐ Constant ☐ Intermittent ☐ Occasional ☐ Rare ☐ Recurrent ☐ Other

Intensity of Symptom(s): ☐ Excruciating ☐ Severe ☐ Moderate ☐ Mild ☐ Other ____________________________

MEDICAL HISTORY

Medications – List all medications you are currently taking. Include ALL Over the Counter & Vitamins

Drug Name	Dosage (mg)	Frequency	Current	Discontinued	Date Started/Stopped
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

Allergies – List your allergies including any medications that caused an allergic reaction

Allergies	Allergic Reaction	Allergies	Allergic Reaction
1. Latex: ☐ Yes ☐ No		6.	
2.		7.	
3.		8	
4.		9.	
5.		10.	

Family History – Please complete as accurately as possible

Relative	Health Status √ Excel	Good	Fair	Poor	Age if Living	Age At Death	Cause of Death	Illnesses (see Illness List, Next Section)
Mother								
Father								
Maternal Grandmother								
Maternal Grandfather								
Maternal Aunt								
Maternal Uncle								
Paternal Grandmother								
Paternal Grandfather								
Paternal Aunt								
Paternal Uncle								
Brother								
Brother								
Sister								
Sister								

Illnesses - Please check off any illnesses you have ever had and approximate date.

Illness	Mo/Yr	Illness	Mo/Yr	Illness	Mo/Yr
□ Accident		□ Fibromyalgia		□ Migraine Headaches	
□ Airway Obstruction		□ Foreign body -ear		□ Mitral Valve Prolapse	
□ Alcoholism		□ Foreign body -nose		□ Mononucleosis	
□ Allergies		□ Foreign body - throat		□ Multiple Myeloma	
□ Anemia		□ Gallstones		□ Multiple Sclerosis	
□ Angina		□ Gastric Ulcers		□ Mumps	
□ Anxiety Disorder		□ German Measles		□ Nasal Fracture	
□ Arthritis		□ Gonorrhea		□ Nose Bleeds	
□ Asthma		□ Gout		□ Osteoarthritis	
□ Bronchitis		□ Grave's Disease		□ Osteoporosis	
□ Cancer of brain		□ Hay Fever		□ Paralysis	
□ Cancer of Throat		□ Hearing Loss		□ Parasites	
□ Cancer of Breast		□ Heart Attack		□ Phlebitis	
□ Cancer of Liver		□ Heart Disease		□ Pleurisy/Pleuritis	
□ Cancer of Colon		□ Heart Failure		□ Pneumonia	
□ Cancer of Stomach		□ Heart Murmur		□ Polio	
□ Cancer of Pancreas		□ Hemorrhoids		□ Polyps	
□ Cancer of Prostate		□ Hepatitis		□ Prostate Problems	
□ Cancer of Lymph Node		□ Hiatal Hernia		□ Rheumatic Fever	
□ Cancer of Blood		□ High Cholesterol		□ Rheumatoid Arthritis	
□ Cancer of		□ Hypertension		□ Scarlet Fever	
□ Cataracts		□ Hypoglycemia		□ Seizure Disorder	
□ Chicken Pox		□ Inguinal Hernia		□ Sickle Cell Anemia	
□ Choking		□ Jaundice		□ Sinusitis	
□ Cholecystitis		□ Jaw Pain		□ Stroke	
□ Cirrhosis		□ Kidney Disease		□ Syphilis	
□ Clotting Disorder		□ Kidney Stones		□ Thyroid Disorder	
□ COPD		□ Leg Ulcers		□ Hashimoto's Thyroiditis	
□ Crohn’s Disease		□ Leukemia		□ Non Toxic Nodular Goiter	
□ Depression		□ Liver Disease		□ Tonsillitis	
□ Diabetes		□ Lung Disease		□ Tuberculosis	
□ Dysentery		□ Lupus		□ Varicose Veins	
□ Ear Infections		□ Lymphoma		□ Vocal Cord Polyps	
□ Emphysema		□ Measles			
□ Epilepsy		□ Mental Illness			

Other: ____

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Surgeries - indicate approximate date

Surgery	Mo/Yr	Surgery	Mo/ Yr	Surgery	Mo/Yr
□ Adenoids and Tonsils		□ Breast Biopsy for Malignancy R		□ Hysterectomy	
□ Tonsillectomy		□ Breast Biopsy for Benign R		□ Hysterectomy with Ovaries	
□ Sinus Surgery		□ Breast Biopsy for Malignancy L		□ Colonoscopy	
□ Septoplasty		□ Breast Biopsy for Benign L		□ Colon Resection	
□ Ear Ventilation Tubes		□ Appendectomy		□ Cholecystectomy (Gallbladder)	
□ Mastoidectomy		□ Repair Hernia R Inguinal		□ Arthroscopy R Knee	
□ Wisdom Teeth Extraction		□ Repair Hernia L Inguinal		□ Arthroscopy L Knee	
□ Coronary Bypass		□ Repair Abdominal Hernia		□ OTHER	
□ Coronary Stenting		□ Abdominal Aneurysm		□ OTHER	

Social History - please be honest

# Children		
Marital Status	□ Married □ Single □ Widow/Widower □ Separated □ Divorced □ Child	
Occupation		
Mental Work	□ Light □ Moderate □ Heavy	**Hours/Day:**
Physical Work	□ Light □ Moderate □ Heavy	**Hours/Day:**
Type of Exercise/Sports	□ Walking □ Aerobics □ Biking □ Other ________________	
Level of Intensity-	□ Light □ Moderate □ Heavy	**Hours/Day:** **# Times/Week:**
Alcohol Consumption	□ Beer □ Liquor □ Wine □ NONE	**# per week**
Tobacco	□ NONE	
	# Packs/Day	# Years
	# Cigarettes/Day	# Years
	# Cigars	# Years
Caffeine	# Cups / Day	**Other Source Caffeine:**
Aspirin	□ NONE □ #/Day:	
Height	**Weight**	

Review of Systems – Check only the ONES you NOW have or have had RECENTLY.

General	Skin	Head	Eyes	Ears
□ Weakness	□ Skin Color Changes	□ Headaches	□ Blurred Vision	□ Hearing Loss
□ Fatigue	□ Skin Rashes	□ Head Injuries	□ Eye Redness	□ Ringing
□ Fever	□ Itchy Skin	□ Head Lesions	□ Glasses for Reading	□ Ear Discharge
□ Chills	□ Skin Sores	□ Head/Facial Swelling	□ Glasses for Distance	□ Earache
□ Night Sweats	□ Psoriasis		□ Glasses for Reading and Distance	□ Itchy ears
□ Fainting	□ Eczema		□ Itchy Eyes	□ Loss of Balance
□ Loss of Appetite			□ Burning Eyes	□ Dizziness
			□ Eye Swelling	□ Room Spins
			□ Eye Pain	□ Ear Blockage/Obstruction
			□ Dry Eyes	□ Ear Infections
			□ Tearing	□ Ear Lesions/Deformity
□ NONE	□ NONE	□ NONE	□ NONE	□ NONE

Nose	Mouth	Throat	Neck	Speech/Behavior
□ Loss of Smell	□ Bleeding Gums	□ Sore Throat	□ Neck Enlargement	□ Unclear Speech
□ Nose Bleeds	□ Oral Sores	□ Bad Tonsils/Tonsillitis	□ Neck Stiffness	□ Tongue Tied
□ Nasal Pain	□ Dental Problems	□ Hoarseness	□ Neck Soreness/Pain	□ Developmental Delays
□ Nasal Discharge	□ Mouth/Jaw Pain	□ Hard to Swallow	□ Neck Lumps	□ Sleep Abnormalities
□ Nasal Obstruction	□ Bad Breath	□ Recurrent Infections	□ Neck Masses	□ Hyperactivity
□ Nasal Congestion	□ Loss of Taste	□ Oral White Spots		□ Attention Deficit
□ Snoring	□ Dry Mouth	□ Throat Clearing		□ Auditory Processing Problems
□ Post Nasal Drip	□ Oral Ulcers	□ NONE	□ NONE	□ NONE

Lungs	Heart	Gastrointestinal	Genitourinary	Environmental Exposure
□ Cough	□ Murmur	□ Abdominal Pain	□ Urinary Urgency	□ Allergy Testing NO
□ Phlegm	□ Palpitations	□ Nausea	□ Urinary Incontinence	□ Allergy Testing YES
□ Coughed Blood	□ Rapid Heart beat	□ Vomiting	□ Urinary Straining	□ Allergy to Dogs
□ Shortness of Breath	□ Swollen Extremities	□ Diarrhea	□ Flank Pain	□ Allergy to Cats
□ Wheezing	□ Cold Extremities	□ Constipation	□ Frequent Urination	□ Allergy to Dust Mites
□ Pain in Lungs	□ Chest Tightness/Pressure	□ Abdominal Bloating	□ Urinary Stones	□ Allergy to Mold
□ Chest Congestion	□ Chest Pain	□ Belching	□ Urinary Burning	□ Allergy to Tree / Pollen
□ Inhalant Exposure	□ Varicose Veins	□ Heartburn	□ Bed Wetting	□ Allergy to Ragweed
	□ Blood Clots	□ Indigestion	□ Bloody Urine	□ Carpeting
	□ Blue Extremities	□ Hemorrhoids	□ Small Stream	□ Dust Gathering Clutter
	□ Elevated Blood Press	□ Hiatal Hernia	□ Urinary Dribbling	□ Sealed Mattress
		□ Ulcers	□ Cloudy Urine	□ Pet(s) in Room
		□ Gallbladder Trouble	□ Urination at Night	□ Forced Hot Air
			□ Urinary Hesitancy	□ Baseboard Heat
			□ PSA =	□ Radiator
				□ Gas Heat
				□ Electric Heat
□ NONE	□ NONE	□ NONE	□ NONE	□ OTHER

Musculoskeletal	Location of pain or Stiffness	Neurological	Psychiatric	Endocrine
□ Muscular Pain		□ Seizures	□ Hyperventilation	□ Weight Loss
□ Muscle Weakness		□ Loss of Facial Expression	□ Alcohol Abuse	□ Weight Gain
□ Muscular Cramps		□ Paralysis	□ Drug Use	□ Voice Changes
□ Muscle Twitching		□ Vertigo/Ataxia	□ Depression	□ Low Blood Sugar
□ Joint Stiffness		□ Slurred Speech	□ Anxiety	□ High Blood Sugar =
□ Joint Pains		□ Tingling/Burning/ Numbness	□ Phobias	
□ Joint Swelling		□ Disorientation	□ Nervousness	
□ Injuries		□ Tremor/ Hands Shaking	□ Memory Loss	
□ Curvature of Spine		□ Headache		
□ Back Pain				
□ Hot Joint				
□ Osteoporosis				
□ NONE		□ NONE	□ NONE	□ NONE

Gynecologic Exam (For Women Only)

Check if you currently have:		Mo/Yr		Mo/Yr
□ Breakthrough Bleeding	Last Pap Test		Date LMP	
□ Menstrual Cramps	Last Mammogram		Duration of Cycle	
□ Postmenopausal Bleeding				
□ Vaginal Discharge		**No.**	**Menstrual Flow**	□ Light □ Normal □ Heavy □ None
□ Vaginal Itching	No.of Pregnancies			
□ Labial Sores	No. Full Term		# Days of Flow	
□ Labial Lumps/Nodules	No. Premature		Age First Menses	
□ Irregular Menses	No. Ab Induced		Age Menopause	
□ Hot Flashes	No. Miscarriage		**Contraception**	□ Pill □ Condom □ IUD □ Diaphram □ Sponge □ Tubal Ligation □ Hysterectomy
□ Pain between Menses	No. Ectopics			
□ Other:	No. Multiple Births			
	No. Living Children			
	No. Still Births			

If Patient is a Child

No. Months Gestation		
Breast Fed	□ Yes □ No	
Birth Problems	□ Yes □ No	Describe if yes:
Respirator	□ Yes □ No	
Problems with Mother	□ Yes □ No	
Problems with Delivery	□ Yes □ No	