**Thank you for choosing Tygart Valley Medical Specialties, Inc. as your ENT, Allergy, Sleep and Hearing Specialist.
We welcome you to our practice!**

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| **Appointment Date:** | **\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_** |
| **Appointment Time:** | **\_\_\_\_\_\_\_\_\_\_\_AM/PM** |

Dear: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Please feel free to visit our new website at the following address: <https://www.wrshealth.com/live/patient_v2/index.php?patientView=1&id=2427106> and become aware of the ease and convenience of our electronic registration process online. Thank you for taking advantage of this and please take a look around the website and familiarize yourself with the various features. You will find links to information and answers to most commonly asked Ear, Nose, & Throat medical questions. You will also be able to be notified of upcoming appointments. Please call our office and register your email to access the Patient Portal. Your personal email address along with your date of birth will only be used to verify that you are a patient.

We are located at 911 Gorman Ave, Suite 201, Elkins, WV 26241. The building may be entered from the front or back. Please see enclosed map.

Come to the 2nd floor and look for the glass door marked Tygart Valley Medical Specialties. Please arrive 15 minutes early for your appointment to complete all paper work. If you arrive more than ***15 MINUTES*** late for your appointment, you will be asked to reschedule.

***If you have had any sort of testing performed in relation to your condition by another provider (such as CT scan, MRI, Audiogram, Lab-work, etc.) please bring a copy of the reports & CD of films to ensure we have your images and reports ready for the Provider to discuss during your visit.***

**PLEASE BRING** the following as they apply to your appointment, unless otherwise directed:

1. A list of all your current medications, with dosages and directions for use;
2. A list of your medication history pertinent to the symptoms you are experiencing (i.e.- antibiotics, nasal sprays, steroids, etc.);
3. Insurance and prescription cards;
4. Any forms to be completed for work, school, insurance, or sports;
5. A driver’s license or picture ID. (The appropriate ID is required to prevent insurance or financial fraud and may be asked for to verify your identity.)

FINANCIAL INFORMATION: It is your responsibility as a patient to be informed of your insurance benefits before your appointment. Please call your insurance company to verify that we are an in-network provider. **All insurance co-pays or payments for services not covered by insurance are due at the time of services**. We accept all major credit cards, debit cards, checks, and cash. For questions about referral authorization or your insurance co-pay, please call the number on your insurance card. PLEASE NOTE: You may be asked to pay your co-insurance amount for any procedures done on the day you are seen if they are not covered under the guidelines of your policy and included in your co-pay office visit.

A broken appointment is a loss to everyone. PLEASE inform us at least 24 hours in advance if you are unable to keep your appointment. Appointment reminders are a courtesy we attempt to provide. Our office serves the right to charge a $25.00 to $50.00 fee for missed appointments. (This fee is not covered by insurance.)

Thank you again for choosing Tygart Valley Medical Specialties, Inc. as your Otolaryngology, ENT, Allergy, Sleep Medicine, and Hearing Specialist. If you have any questions prior to your visit, please feel free to contact us at (304) 637-6302. We look forward to seeing you!

Sincerely,

Reception Services
Tygart Valley Medical Specialties, Inc.

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**



**Parking available behind the
Physician Professional Building.**

**Please follow signs to Suite 201.**

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| **PATIENT REGISTRATION Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Full Name:** |  |
| **Marital Status** | ❑-Single ❑-Married ❑-Divorced ❑-Widowed | **DOB:** |  |
| **Ethnicity** | ❑-White ❑-Black ❑-Hispanic ❑-Asian ❑-Other \_\_\_\_\_\_\_\_\_\_\_ | **Preferred Language:** |  |
| **Home Ph #:** |  | **Cell Ph #:**  |  |
| **Home** **(Mailing) Address:** |  | **Gender** | ❑-Male ❑-Female |
|  | **SSN:** |  |
| **Email:** |  |
|  |  |  |  |
| **Employment Status:** | ❑-Employed ❑-Not Employed ❑-Retired | **Occupation:** |  |
| **Employer:** |  | **Work Ph#:** |  |
| **May we leave messages at your home/work/cell phone numbers?** ❑-Yes ❑-No |
|  |  |  |  |
| **Preferred Pharmacy:** |  | **Pharmacy Location:** |  |
| **Primary Care Provider (PCP):** |  | **PCP Ph#:** |  |
|  |  |  |  |
| **Emergency Contacts/Responsible Party Information** |
|  | **Name:** |  | **Relationship:** |  |
| **Home Ph** |  | **Cell Ph** |  |
|  | **Name:** |  | **Relationship:** |  |
| **Home Ph** |  | **Cell Ph** |  |
|  |  |  |  |
| **Consent to Receive Information:(Please include family members, doctors, and specialists involved in your care.)*****\*\*\*NOTE: If the patient is under age of 18-parent must be included in this list as well\*\*\**** |
|  | **Name:** |  | **Relationship:** |  |
|  | **Name:** |  | **Relationship:** |  |
|  | **Name:** |  | **Relationship:** |  |
|  | **Name:** |  | **Relationship:** |  |
|  | **Name:** |  | **Relationship:** |  |

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Tygart Valley Medical Specialties, Inc. (herein referred to as TVMS) appreciates the confidence you have shown in choosing us to provide for your healthcare needs. The following are our general policies. Please review this information and sign where indicated. Thank you!**

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| **PATIENT FINANCIAL POLICIES: I have read the policies below regarding my financial responsibilities to TVMS for providing services to me or the above-named patient. I authorize my insurer to pay any benefits directly to TVMS, the full and entire amount of the bill incurred by me or the patient. Patient Initials: \_\_\_\_\_\_\_\_** |
| * I understand and authorize TVMS to directly bill and receive payment from my insurance company, Medicare, Medicaid, and/or other persons liable to pay my bill, and I assign my right to receive payment from any unavailable resource to TVMS. I understand that for the purposes of payment an electronic inquiry may be performed via my insurance company’s website to verify eligibility and obtain benefits. I understand that a voluntary customer report transaction may be obtained for purposes of collecting my medical debt and I understand I may be contacted by TVMS and/or its affiliates on any phone provided, which may include the use of a prerecorded/artificial voice message and/or an automatic dialing device or by text message or email in connection with any communications made to me or related to my accounts. I understand that I will receive a separate billing for the services from these agencies.
* I understand that it is my responsibility to provide TVMS with current, accurate billing information at the time of check in and to notify TVMS of any changes in this information.
* I understand that it is my responsibility to pay my co-pay at the time services are rendered. I understand that this is a contractual agreement that I have with my health plan and that TVMS also has a contractual agreement with my health plan to collect co-pays at the time of service.
* I understand that I will be billed for any amounts due by me including co-insurance amounts, co-pays, and deductibles and that I have a financial responsibility to pay these amounts.
* I understand that insurance claims pending which exceed the agreed upon time limit for payment with respect to the terms of my insurance company’s contract with my provider are my responsibility to pay.
* I understand that if any charges billed to me are still outstanding after 90 days from the date services were rendered, my account may be referred to a collection, including but not limited to, ***Thirty Three Percent Collection*** agency fees plus attorney fees and court costs. In the event that my account is in default, I agree to pay interest at the rate of 18% per annum from and after the date of treatment. I hereby waive the benefit of my homestead exemption as to this debt.
* I understand it is my responsibility to obtain a referral (if required by my insurance). If this referral is not obtained, then all charges will be the responsibility of the guarantor.
* I understand there is a $35.00 fee not covered by insurance for any check returned from my bank.
* I understand that if I do not cancel my appointment 24 hours prior to my scheduled appointment time, or if I do not show for my appointment, there may be a $25.00 to $50.00 fee not covered by insurance. If I cancel/no show for three (3) appointments, I may be released from care. If I am released, I may be notified in writing by TVMS.

**EXTERNAL SERVICES DISCLAIMER:*** Please be advised TVMS, INC outsources certain services such as:( Allergy Pro, Alletess) and other services. In the event, you require these services you may receive a separate bill from that respective company. **PLEASE NOTE:** These services are independent of TVMS and therefore, any billing questions will be referred to such company.
 |
| **I have been made aware of the above-mentioned policy and understand my financial obligations as outline in the patient rights and responsibilities. Patient Initials: \_\_\_\_\_\_\_\_**  |
| **Consent for Treatment & Authorization for Release of Information Patient Initials: \_\_\_\_\_\_\_\_\_** |
| * I hereby authorize TVMS through its appropriate personnel, to perform or have performed upon me, or the above-named patient appropriate assessment and treatment procedures.
* I generally consent to be treated by TVMS, which may include telemedicine consultation, if requested for my attending physician; however, I understand it is my right to refuse any specific procedure or treatment when it is offered.
* I authorize TVMS to release my medical records or other information relating to my care (including information related to psychiatric, substance abuse, or HIV testing) to any person, company or agency that may need them for treatment, payment or other healthcare operations. I grant permission for the release of relevant physician office information to TVMS from the referring/consulting provider for services rendered.
* I understand that in the course of treatment, there is a possibility that TVMS staff may become exposed to my blood or bodily fluids. State Law requires a sample of my blood be tested for the presence of infectious diseases. The result of the test will be released to me and the exposed worker.
* I authorize TVMS to freely dispose of any specimens or tissues taken from my body during my visit.
* I understand that TVMS discourages patients from bringing valuables with them to their visit. I will not hold TVMS responsible for any loss or damage to any valuables I keep with me while in the office or testing site, including money, jewelry, documents, dentures, glasses, or other valuables. I understand that cell phone use while a patient is strongly discouraged and I will not hold TVMS responsible should my cell phone become lost or damaged.
* I further authorize TMVS to release any and all medical information on myself or the above-named patient to my insurance company to process my claim and hereby authorize a copy of my medical information be sent to my primary care provider as well as any attending or consulting providers.
 |
| **Acknowledgement of Receipt of Privacy Notice Patient Initials: \_\_\_\_\_\_\_\_\_** |
| I understand that this provider’s office may release information from my medical record and billing records in accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPPA) and statutory regulation of the State of West Virginia. My signature below acknowledges that I have received a copy of the Federal Notice of Privacy Practices in person at my appointment. |

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| --- | --- |
| **Patient Signature or Legal Representative/Agency Signature:** | **Date:** |
| **Legal Rep/Agency’s Relationship to Patient****❑-Parent****❑- Having Medical Power of Attorney****❑- Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Reason Patient is Unable to Sign:** **❑-Patient is minor under 18 years of age.****❑-Patient is mentally or physically unable to understand to sign.****❑-Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **Review of Systems: Please mark your health problems** |
| **General Health** | ❑-None ❑-Fever ❑-Chills ❑-Sweats ❑-Anorexia ❑-Fatigue ❑-Malaise ❑-Sleepiness ❑- Sleep Problems ❑-Weight loss ❑-Weight gain ❑-Speech Delay  |
| **Ears** | ❑-None ❑-Itching ❑-pain ❑-fullness/pressure ❑- Hearing loss ❑-Wax ❑-Ringing in ears ❑-Drainage |
| **Nose & Sinus** | ❑-None ❑-Obstruction ❑-Congestion ❑-Post-nasal drip ❑-Headache ❑-Facial pain ❑-Bleeding ❑-Runny nose ❑-Cough ❑-Seasonal allergies ❑-Recurrent sinus infections  |
| **Throat & Mouth** | ❑-None ❑-Soreness ❑-pain ❑-Swallowing problems ❑-Voice problems ❑-Bad breath ❑-Snoring ❑-Heartburn/Reflux ❑-Foreign body sensation ❑-Tumor  |
| **Skin** | ❑-None ❑-Rash ❑-Itching ❑-Ulcer/growths ❑-Excess scarring ❑-Bleeding problems ❑-Dryness ❑-Suspicious lesions  |
| **Allergic/Immunologic** | ❑-None ❑-Uticaria (Hives) ❑-Hay fever ❑-Persistent infections ❑-HIV exposure ❑-Previous allergy testing or immunotherapy |
| **Neurologic** | ❑-None ❑-Paralysis ❑-Weakness ❑-Paresthesias ❑-Seizures ❑-Syncope (fainting) ❑-Tremors ❑-Vertigo |
| **Vestibular (Balance)** | ❑-None ❑-Imbalance ❑-Visual problems ❑-Joint problems ❑-Spinning sensation ❑-Dizziness ❑-Falling ❑-Strength issues  |
| **Eyes** | ❑-None ❑-Eye pain ❑-Vision loss ❑-Excessive tears ❑-Blurring ❑-Discharge ❑- Irritation ❑-Double Vision ❑-Photophobia  |
| **Neck** | ❑-None ❑-Lump/mass ❑-Thyroid problems ❑-Pain ❑-Tenderness  |
| **Respiratory** | ❑-None ❑-Cough ❑-Dyspnea (Difficulty breathing) ❑-Excessive Sputum ❑-Wheezing ❑-Hemoptysis (Coughing up Blood)  |

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| **ALL Past or Present Medical Conditions** | **ALL Surgeries and the Year(S) Performed:** |
| **Condition** | **Personal** | **Family** | **Surgery** | **Year(s)** |
| Alcoholism | ❑ | ❑ | Adenoidectomy |  |
| Allergic Rhinitis | ❑ | ❑ | Balloon Sinuplasty |  |
| Anemia | ❑ | ❑ | Endoscopic Sinus Surgery |  |
| Anxiety | ❑ | ❑ | Mastoidectomy (Right)(Left)(Bilateral) |  |
| Arthritis | ❑ | ❑ | Neck Dissection |  |
| Asthma | ❑ | ❑ | Septoplasty |  |
| Atrial Fibrillation | ❑ | ❑ | Thyroidectomy (Right)(Left)(Bilateral) |  |
| Bronchitis | ❑ | ❑ | Turbinoplasty |  |
| Cancer: Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ❑ | ❑ | Ventilation tubes (Right)(Left)(Bilateral) |  |
| Chest Pain | ❑ | ❑ | **General Surgeries:** |  |
| Circulatory System Disorder | ❑ | ❑ | Appendectomy |  |
| Congestive Heart Failure | ❑ | ❑ | Gallbladder |  |
| Depression | ❑ | ❑ | Stomach Surgery |  |
| Diabetes: Type I or II | ❑ | ❑ | **Heart Surgeries:** |  |
| Ear infection | ❑ | ❑ | Artery Bypass |  |
| Emphysema | ❑ | ❑ | Heart Catherization |  |
| Esophageal Reflux (Heartburn) | ❑ | ❑ | Heart Bypass |  |
| Gout | ❑ | ❑ | Stents |  |
| Grave’s Disease | ❑ | ❑ | Valve replacement |  |
| Headache | ❑ | ❑ | **Orthopedic Surgeries:**  |  |
| Hearing loss | ❑ | ❑ | Bone fracture repair |  |
| Heart Attack | ❑ | ❑ | Carpal tunnel repair (Right)(Left)(Bilateral) |  |
| Heart Murmur | ❑ | ❑ | Herniated disc surgery |  |
| Herniated Disc | ❑ | ❑ | Hip replacement (Right)(Left)(Bilateral) |  |
| High Blood Pressure | ❑ | ❑ | Knee replacement (Right)(Left)(Bilateral) |  |
| High Cholesterol/Lipids | ❑ | ❑ | Knee arthroscopy (Right)(Left)(Bilateral) |  |
| Hyper/Hypothyroidism | ❑ | ❑ | Shoulder (Right)(Left)(Bilateral) |  |
| Insomnia | ❑ | ❑ | **Opthalmic Surgeries:**  |  |
| Irritable Bowel Syndrome | ❑ | ❑ | Cataract surgery (Right)(Left)(Bilateral) |  |
| Kidney Failure | ❑ | ❑ | **Dental Surgeries:** |  |
| Liver Failure | ❑ | ❑ | Wisdom Teeth Removal |  |
| Migraine | ❑ | ❑ | Dental Extractions |  |
| Obstructive Sleep Apnea | ❑ | ❑ | **Gynecological Surgeries:**  |  |
| Osteoporosis | ❑ | ❑ | Breast (Reduction)(Enlargement)(Cancer) |  |
| Pneumonia | ❑ | ❑ | Cesarean Section |  |
| Restless Leg Syndrome | ❑ | ❑ | Hysterectomy |  |
| Sinusitis | ❑ | ❑ | Novasure Ablation |  |
| Stroke | ❑ | ❑ | **Cancer Surgery (Type)** |  |

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Height: \_\_\_\_\_\_\_\_\_\_\_\_feet, \_\_\_\_\_\_\_\_\_\_\_\_\_ inches Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ lbs.**

**Are your immunizations up to date: ❑-Yes ❑-No**

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| **Tobacco Use History** | **Alcohol Use History** |
| Check all that applies: | Do you drink alcohol? | ❑-Yes ❑-No |
| ❑-Current Every Day SmokerNumber of pack per day : \_\_\_\_\_\_\_ Number of cigarettes per day \_\_\_\_\_\_\_Number of years \_\_\_\_\_\_\_. ❑-Current Some Day Smoker❑-Former SmokerDate quit : \_\_\_\_\_\_\_Number of packs per day before quit : \_\_\_\_\_\_\_Number of years before patient quit : \_\_\_\_\_\_\_.❑-Never smoker❑-Smokeless Tobacco User | Type: | ❑-Beer/Wine ❑-Liquor |
| Frequency | ❑-Socially ❑-Minimally ❑-Infrequently ❑-Frequently |
| **Drug Use History** |
| Do you use drugs? | ❑-Current use ❑-Past use ❑-Never |
| Type of Drug: | ❑-Marijuana ❑-Hallucinogens ❑-Opiates ❑-Barbituates ❑-Cocaine ❑-Amphetimines ❑-Other: \_\_\_\_\_\_\_\_\_ |
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| **PLEASE LIST ALL MEDICATIONS YOU ARE TAKING(Include prescriptions, over-the-counter medications, and herbal supplements)****IF NO CURRENT MEDICATIONS – CHECK HERE-** *❑-NO CURRENT MEDICATIONS* |
| **Name of Medication:** | **Dose:** | **Frequency:** |
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| **PLEASE LIST ALL OF YOUR ALLERGIESIF NO KNOWN DRUG ALLERGIES – CHECK HERE-** *❑-NO KNOWN DRUG ALLERGIES* |
| **Allergic To:** | **Reaction:** | **Severity (Check one):** |
|  |  | ❑-Low ❑-High ❑-Life Threatening |
|  |  | ❑-Low ❑-High ❑-Life Threatening |
|  |  | ❑-Low ❑-High ❑-Life Threatening |
|  |  | ❑-Low ❑-High ❑-Life Threatening |
|  |  | ❑-Low ❑-High ❑-Life Threatening |