Jin S. Lim, M.D.

Diplomate of American Board of Otolaryngology

7001 Heritage Village Plaza, Suite 170
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Telephone: (703) 468-2205
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EAR, NOSE & THROAT ASSOCIATES

Patient Information (Child)

PATIENT'S LEGAL NAME (Last, First, MI)		DATE OF BIRTH SEX(M/F)
ADDRESS		SSN OR ID#
CITY	STATE ZIP	HOME PHONE
PARENT NAME (MOTHER/FATHER)	STREET ADDRESS (IF DIFFERENT)	CITY STATE ZIP
HOME PHONE	WORK PHONE	CELL PHONE
PARENT NAME (MOTHER/FATHER)	STREET ADDRESS (IF DIFFERENT)	CITY STATE ZIP
HOME PHONE	WORK PHONE	CELL PHONE
EMERGENCY CONTACT	EMERGENCY CONTACT PHONE #	EMERGENCY CONTACT RELATIONSHIP

Guarantor Information (person responsible for the bill)

NAME (Last, First, MI)		DATE OF BIRTH
ADDRESS		SEX(M/F)
CITY	STATE ZIP	SSN OR ID#
HOME PHONE	CELL PHONE	EMAIL
EMPLOYER	OCCUPATION	WORK PHONE

Insurance Information

PRIMARY INSURANCE	**SECONDARY INSURANCE**
POLICY ID# GROUP #	POLICY ID# GROUP #
GROUP NAME	GROUP NAME:
POLICY HOLDER SOCIAL SECURITY #	POLICY HOLDER SOCIAL SECUIRTY #
DATE OF BIRTH RELATIONSHIP	DATE OF BIRTH RELATIONSHIP

Patient Authorization

- I authorize Ear, Nose & Throat Associates, PC to provide medical treatment to myself and or my dependent.
- I request that payment of authorized Medicare, Medicaid, or applicable private insurance benefits be paid directly to Ear, Nose & Throat Associates, PC for services provided under their care.
- I authorize Ear, Nose & Throat Associates, PC to release necessary medical information to my insurance company, its agents, or any third party payor in order for payable benefits for these services to be determined.
- I understand that co-pays are due at the time of service. I understand that Ear, Nose & Throat Associates, PC will file my insurance claims as a courtesy; however, I am ultimately responsible for full payment of all charges. I further understand if my account is referred to a collection agency or attorney I will be responsible for all expenses and up to 33.33% of collection costs.
- I have read these statements and I understand my responsibilities. A copy of this authorization will be considered as valid as the original.

SIGNATURE OF RESONSIBLE PARTY_____ **DATE**_____
PRINTED NAME OF RESONSIBLE PARTY_____ **RELATIONSHIP**_____

Ear, Nose & Throat Associates, PC
Jin S. Lim, MD
Rebecca M. Beckman, AuD

PATIENT HISTORY

Name:_____ **Age**:____ **Date of Birth**:_____ **Race:**_____
Referring Physician:_____ **Primary Care Physician**:_____
Pharmacy of Choice (name & location):_____
Reason for your visit: _____

PLEASE ANSWER ALL QUESTIONS AS THOROUGHLY AS POSSIBLE

1. Are you allergic to any medications? ☐ Yes ☐ No
If so, please list all drug allergies: _____ _____ _____

2. Are you currently taking any medications? ☐ Yes ☐ No
If so, please list all current medications: _____ _____ _____
_____ _____ _____

3. Do you have any existing medical conditions? ☐ Yes ☐ No
If so, please list ALL: _____ _____ _____
_____ _____ _____

4. Have you ever had a surgical procedure? ☐ Yes ☐ No
If so, please list and date ALL: _____ _____ _____

5. Does anyone in your family have any of the following? ☐ None ☐ Do not know
☐ Allergies ☐ Asthma ☐ Hearing Loss ☐ Throat Cancer ☐ Diabetes ☐ Heart Disease
☐ Anesthesia Difficulty ☐ Bleeding Problems ☐ Other _____

6. Are your immunization records up to date? ☐ Yes ☐ No

7. Are you a:
☐ Never smoker
☐ Current every day smoker: _____packs per day for _____ years
☐ Current some day smoker: _____packs per day for _____ years
☐ Former smoker: Date quit: _____

8. Do you drink alcohol? ☐ Yes ☐ No
If yes, frequency is: ☐ Socially ☐ Minimally ☐ Infrequently ☐ Frequently

9. Any illicit drug use? ☐ Yes ☐ No Type _____

Patient Signature:_____ Date: _____

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REVIEW OF SYSTEMS

Name:_____ **Date of Birth**:_____

Are you experiencing any of the following?

General	☐ Pregnant	☐ Fever
☐ Chills/sweats	☐ Fatigue/malaise	☐ Sleep problems
☐ Weight gain	☐ Weight loss	☐ Hoarse voice
☐ Speech delay	☐ Unusual bleeding	

Ears	☐ Ear pain	☐ Hearing loss
☐ Tinnitus/ringing noise	☐ Ear fullness/pressure	☐ Ear itching
☐ Ear wax	☐ Ear drainage	

Nose	☐ Nasal obstruction	☐ Nasal congestion
☐ Runny nose	☐ Post nasal drip	☐ Nose bleed
☐ Facial pain	☐ Seasonal allergies	

Throat		
☐ Snoring	☐ Foreign body sensation	☐ Hoarseness
☐ Heartburn	☐ Throat pain/soreness	☐ Swallowing difficulty

Skin	☐ Suspicious lesions	☐ Excess scarring/keloids
☐ Rash	☐ Itching	☐ Ulcers/growths

Allergy/Immunology	☐ Eczema	
☐ Hives	☐ Hay fever	☐ HIV exposure

Neurological	☐ Numbness	☐ Muscle weakness/paralysis
☐ Headache	☐ Fainting/blackouts	☐ Seizures

Balance/Vestibular	☐ Dizziness	☐ Vertigo
☐ Feeling lightheaded	☐ Imbalance but not vertigo	☐ Motion-provoked dizziness
☐ Dizziness that is positional	☐ Joint problem/arthritis	☐ Falling episodes

Eyes	☐ Eye pain	☐ Vision change
☐ Double vision	☐ Discharge	☐ Light sensitivity
☐ Itching/irriation	☐ Excessive tears	☐ Dry eyes

Neck		
☐ Lump/mass	☐ Thyroid problem	☐ Neck pain

Respiratory	☐ Cough (productive)	☐ Cough (dry)
☐ Wheezing	☐ Sleep apnea	☐ Shortness of breath

Patient Signature _____ Date_____

Ear, Nose & Throat Associates, PC

Jin S. Lim, MD Rebecca M. Beckman, AuD

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of the "Notice of Privacy Practices" for Ear, Nose & Throat Associates, PC. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy. This notice is available in our office.

I understand that I may access my medical records at any time and that I may copy and/or inspect my protected health information (PHI) to be used or disclosed in accordance with Ear, Nose & Throat Associates' policy. I understand that Ear, Nose & Throat Associates, PC may charge me for copies of such records, or completion of medical record forms, however a fee schedule will be provided to me.

I understand that Ear, Nose & Throat Associates, PC has the right to deny me access to my records in certain circumstances, in accordance with the law; however, in such instance they will provide me with a denial in writing.

AUTHORIZATION FORM FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how we may use and disclose PHI about you. It has been explained to the patient that disclosures may be made to family and friends related to the patient's health. It has also been explained that we will only disclose information relevant to current treatment. Our patient has agreed that we will only disclose health care information to (list all that apply):

	In Person	**By Phone**
Spouse Name:_____	☐	☐
Parent(s) Name: _____	☐	☐
Sibling(s) Name:_____	☐	☐
Other:_____	☐	☐
(name) (relationship)		

Expiration Date of Authorization: ____/____/____ OR ☐ until otherwise specified

I, _____, authorize the use or disclosure of my PHI as specified in the Notice of Privacy Practices for Ear, Nose & Throat Associates, PC. I understand the purpose of the authorized use of disclosure of PHI is for the use within Ear, Nose & Throat Associates, PC or for authorized disclosure from another entity that is subject to the privacy rule to Ear, Nose & Throat Associates, PC for treatment, payment or health care operation purposes. I also understand that if the organization authorized to receive my PHI is not a health plan or health care provider, that organization may disclose my PHI. In the event that this happens, I understand that my information may no longer be protected under the federal privacy rule and regulations. I understand that this authorization is voluntary and may be revoked at any time. I understand that I may ask questions of Ear, Nose & Throat Associates, PC, if I do not understand any information contained in the Notice of Privacy Practices.

_____ _____

(Printed name of Patient) (Date)

_____ _____

(Signature of Patient or Patient's Representative) (Date)

_____ _____

(Printed Name of Patient's Representative) (Relationship)

EAR, NOSE & THROAT
ASSOCIATES

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Ear, Nose & Throat Associates, PC
Cancellation/No Show Policy

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

Therefore, if an appointment is not canceled at least 24 hours in advance, you will be charged a fifty dollar ($50) fee; this will NOT be covered by your insurance policy. If you fail to cancel your appointment at least 24 hours in advance a second time, you will be charged a seventy-five dollar ($75) fee. This allows the staff to fill the slot with another patient. IF you must cancel your appointment, please call the office at 703-468-2205.

Exceptions to this policy will be made only for emergencies and conflicts beyond your control.

I have read this policy and understand that failure to cancel my appointment at least 24 hours in advance may result in additional fees as described above.

_____
Patient Name

_____ _____