NW Surgical Associates
EAR, NOSE & THROAT DIVISION

☐ Dr. Ryan Stern
☐ Dr. David Johnson
☐ Dr. Dick Hoistad
☐ Dr. Joseph Bellairs

Dear New Patient,

We would like to take this opportunity to welcome you to our practice and to thank you for choosing our physicians to participate in your healthcare. We look forward to providing you with personalized, comprehensive healthcare.

As continuity and coordination of patient care is essential in meeting your healthcare needs, our physicians, and staff will work closely in a team approach to support your patient care.

We also request that you contact your primary care office or any provider you have seen regarding your Ear, Nose or Throat problems and have them send us a copy of your records.

You will also need to bring your health insurance identification card as well as a photo I.D, a complete list of all of your medications, any imaging reports and images on a disk, as well as any other information you find pertinent to your visit.

You will need to complete your new patient registration attached to this letter **and** the health history email prior to your appointment on _____ at_____ in our office at;

☐ Auburn
222 2nd Street NE
Auburn, WA 98002

☐ Federal Way
34612 6th Ave S, Suite 200
Federal Way, WA 98003

During your initial visit, we will be reviewing your health status and the attached forms contain information necessary to complete this process.

Once again, we would like to thank you for choosing us to be a part of your healthcare team. We look forward to working with you.

Sincerely,

The Physicians and Staff at Surgical Associates Northwest-ENT Division

222 2nd Street NE, Auburn, WA 98002
34612 6th Ave S, Federal Way, WA 98003
P: 253.833.4050
F: 253.735.5083

BEFORE YOUR APPOINTMENT

Please call your insurance company to verify your benefit coverage. Most insurance cards have the Customer Service phone number printed on them. If you do not have health insurance we request payment at the time of service.

If you chose to pay privately because you do not have insurance, understand that these visits cannot be back billed to insurance. Once notified of insurance coverage, we will be glad to bill your insurance for any future visits.

WHAT TO BRING TO YOUR APPOINTMENT

When you arrive to your appointment, please arrive 15 minutes early. We need this time to go over paperwork with you and to prepare your chart so that you can see the doctor at the appointment time allotted for you. **Unfortunately, if you arrive late, your appointment may be rescheduled.**

Enclosed forms – please fill them out completely in pen including details where requested.

Your insurance card (s) – this allows us to bill the correct insurance company. If you chose to pay privately because you do not have insurance or you do not have your insurance card, please see financial policy.

Referral (if applicable) – if you are unsure whether a referral is needed, please contact your insurance company.

Co-pay – we will collect your co-pay at the time of your visit. If you are unsure whether a co-pay is required for your visit, please contact your insurance company. We currently accept cash, personal check, debit cards, Visa, MasterCard, or Discover for payment.

Tests from other facilities – if you have had an MRI or CT of the Head, Neck, Brain, Sinus or Ears, please bring the films (CD-ROM ok) **and** the report to your appointment. This information can be critical in the outcome of your doctor's recommendations. Please be aware that your appointment may be rescheduled if these are not present for your appointment.

Hearing Tests – any hearing tests or vestibular testing results

If you or your child is scheduled to have a hearing test, please be aware that there must be someone to watch any other children/siblings during the exam.

HOURS

Our office hours are Monday – Friday 8am – 4:30 pm with lunch generally from 12:00 – 1:00pm.

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PATIENT INFORMATION (please fill in completely)

Patient Name_____**Birthdate**_____/_____/_____**Age**_____
(First, Middle, Last)

Social Security Number_____-_____-_____ **Gender:** ❑ **Male** ❑ **Female** ❑ **Other:** _____

Race: □**Asian** □**Black/African American** □**White** □**Native American** □**Native Hawaiian/Pacific Islander** □**Other**_____

Ethnicity: □**Hispanic/Latino** □**Not Hispanic/Latino** □**Declines to Provide**

Home Address_____ **Apt#**_____ **City**_____ **State**___ **Zip**_____

Email Address _____**Home Phone** _____**Cell Phone**_____

Preferred Method of Communication ❑ Text ❑ Cell Phone ❑ Home Phone ❑ Email **Ok to leave a detailed message?**❑ Yes ❑ No

Occupation: _____ **Employer:** _____

Marital status: ❑Single □Married ❑Divorced ❑Widowed/Widower □Other_____

Spouse or Significant Other Name_____ **Phone**_____

Spouse's Employer _____ **Spouse's Birthdate**_____

Emergency Contact Name:_____ **Phone:**_____

PARENT INFORMATION IF PATIENT IS A MINOR-OR IF INSURANCE IS STILL UNDER PARENT

Primary Parent: Name _____**Birthdate** _____/_____/_____ Age _____

Gender: ❑ **Male** ❑ **Female** ❑ **other:** _____**Social Security Number** _____-____-_____

Phone, if different from above (_____)_____ **Email, if different from above** _____

Employer _____ **Job Title** _____

Parents are: ❑Married/Partnered ❑Divorced/Separated ❑Deceased ❑other_____

Other Parent/Guardian's Name _____ **Work/Cell Phone** (_____)_____

Other Parent/Guardian's Social Security # _____-____-_____ **Date of Birth** _____/_____/_____ **Age** _____

Address, if different from above _____

REASON FOR VISIT

Reason for today's visit _____

How did you hear about us? (ex. TV, Radio, Internet, etc.) _____

Were you referred by another physician? ❑Yes ❑No if yes, **Physician's name** _____

Primary Care Physician_____ **Location**_____

MEDICAL INSURANCE

Primary Insurance Name_____
Subscriber Name_____
Subscriber Date of Birth _____
Subscriber No._____
Group No._____

Secondary Insurance Name _____
Subscriber Name_____
Subscriber Date of Birth _____
Subscriber No._____
Group No._____

Assignment Release & Financial Agreement: I Surgical Associates Northwest or my insurance company to release any information required for the claim. I authorize my insurance benefits to be paid directly to Surgical Associates Northwest for any service furnished me Surgical Associates Northwest, respectively. I have reviewed the office financial policies and am aware I am financially responsible for any balance due, including no show and late cancellation fees. If this account is referred to a collection agency or attorney for collection, I agree to pay all court costs, attorney's fees and costs of collection.

Signature of Patient or Legal Guardian_____ **Date**_____

Printed name (If other than Patient) _____ ***Relation:*** _____

PATIENT HEALTH HISTORY

In Order for ust o obtain a complete medical history, it is important for you to fill out this form to the best of your knowledge. Please fill out every item. It is important for your doctor to know you have carefully reviewed every area of this form, and provided complete and accurate information so that we may provide the best care possible.

Patient Name:_____Date of Birth:_____

Preferred Pharmacy name and Location:_____

☐ **Please check this box if you are NOT currently taking ANY medications.**

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

Name of Medication	Dosage	How Often Taken

ARE YOU ALLERGIC TO ANY MEDICATIONS? _____YES _____NO If yes, please list below;

Name of Medication	Type of Reaction

SURGERIES AND HOSPITALIZATIONS

Have you ever had any problems with Anesthesia (being numbed or put to sleep?) _____Yes _____No

If yes, please list the type of problem or reaction:_____

_____

_____

Please list any Surgeries you have had (including dates):

_____

_____

_____

Have you ever been hospitalized for non-surgical reasons? _____Yes _____ No

If yes, please list the reason for hospitalization:_____

_____

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Patient Name: _____

DOB: _____

Financial and No-Show Policy

No Show/Late Cancellation Policy

Definition of a "No-Show" Appointment
Surgical Associates, NW defines "No-show" appointment as any scheduled appointment in which the patient either:
-Does not arrive to the appointment
-Cancels with less than 24 hours' notice for office visits, 48 hours for testing, 7 days for surgery
-Arrives more than 15 minutes late and is consequently unable to be seen

Cancellation/No-Show Policy for Doctors Visits
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.
If an appointment is not cancelled at least 24 hours in advance for any appointment, you will be charged a one-hundred-dollar ($100.00) fee: This will not be covered by your insurance company.

Scheduled Appointments
We understand that delays can happen; however, we must try to keep the other patients and doctors on time. If a patient is 15 minutes past their scheduled time, we may have to reschedule the appointment.

Audio, Allergy Testing, CT
Due to the large block of time needed for these appointments, last-minute cancellations can cause problems and added expenses for the office.
If an Audio, Allergy test or CT is not cancelled at least 2 days (48 hours) in advance, you will be charged a two-hundred-fifty-dollar ($250.00) fee: This will not be covered by your insurance company.

Surgery
Due to the large block of time needed for surgery, last-minute cancellations can cause problems and added expenses for the office.
If surgery is not cancelled at least 7 days in advance, you will be charged a three hundred-dollar ($300.00) fee: This fee willnot be covered by your insurance company.

Consequences of "No-Show" Appointments
If you miss 3 or more appointments within a year, you may be dismissed from the Practice.

Returned Check Policy

A $35 fee will be charged for each check returned for insufficient funds, in addition to all bank fees incurred. This charge is not covered by your insurance and will be solely your responsibility. The fee will be treated as an unpaid balance and will be reported to a collection agency if unpaid. If you have more than 3 returned checks you may be dismissed from the practice.

Billing Options

If you chose to pay privately because you do not have insurance or you do not have your insurance card, payment will be due at time of service. Please note if you choose not to use your insurance, understand that these visits cannot be back billed to insurance and we will bill you as a private pay.

Copays & Co-Insurance
All Copays and Co-insurance are collected at the time of the visit. We are obligated by contract with your insurance company to collect copay, and Co-Insurance; these cannot be billed after the service is rendered.

Visits outside our office
If you are hospitalized during or following your procedure, you will be billed separately and independently for the care you receive from the hospital. Surgical Associates Northwest is not liable to pay for your hospitalization. Surgical Associates Northwest is not liable for any expenses related to revisionary procedures or your future care.

Signing below indicates that you understand these policies and agree to them.

Signature of Patient or Legal Guardian | Printed Name | Date

Acknowledgement Notice of Privacy Practices

NW Surgical Associates
EAR, NOSE & THROAT DIVISION

Patient's Name _____ D.O.B. _____

About our Privacy Practices
We keep a record of the health care services we provide you. You may ask to see and/or obtain a copy of that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our office.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information. Please review the posted Notice of Privacy Practices in our office before your appointment.

By my signature below I acknowledge the following.

- ☐ I give permission to have my information sent electronically and to be contacted via email.
- ☐ I give permission to be contacted via phone/text/email system with the information provided on my intake forms.
- ☐ Please do not disclose my information with anyone unless the law authorizes or compels you to do so.

  -OR-

- ☐ The person(s) (e.g. friends and/or family, caregivers) marked below may have access to my information:

_____
Printed Name Relationship

_____
Printed Name Relationship

_____
Patient Signature Date

-OR-

_____
Parent or legally authorized individual signature Date

_____
Printed name Relationship