BELLINGHAM
EAR NOSE & THROAT

Thomas Stackhouse, MD • Joost Knops, MD • David Olson, MD • Andrew Verneuil, MD • Jason Lichtenberger, MD • Avram Hecht, MD

2940 Squalicum Parkway Suite 203, Bellingham, WA 98225 • Phone: 360 733-0640 • Fax: 360 733-1034

Welcome to Bellingham Ear Nose & Throat & Facial Plastic Surgery, Inc.

We would like to make your visit with us as smooth and easy as possible. We are asking you to fill out these papers in advance, using blue or black ink, and bring them with you to your first appointment. This will allow you time to fill them out completely in the comfort of your own home.

Health History: The physicians are committed to providing you with the highest quality care. In order to do this, it is important to know your medical history including all medications you are taking. Please make sure this is filled out as completely as possible.

Patient Registration: This is necessary to make sure that we can accurately track your medical care and properly bill you and your insurance company. Please bring all of your insurance cards as they need to be scanned into our computer system. We do ask you to verify this information at each visit.

If the patient is a minor, and these papers are not signed by the parent or guardian, we will have to reschedule the patient's appointment. Please also note that any child under age 16 must be accompanied by an adult.

Financial Policy: Our financial policy is explained in detail and we require that it be signed by the responsible party. If you have any questions, please call and speak to one of our billing representatives.

Perpetual Authorization: This form allows us to leave you a detailed phone message and/or to speak with a spouse, significant other, family member or caregiver regarding your Protected Health Information (PHI). If this is something you would like to participate in, please complete one or both sections of the PHI form enclosed. Please indicate the type of information you would like disclosed. Please note this form is valid and will **not** expire until cancelled by the patient or legally authorized individual.

Privacy Practices: Our notice of privacy practices is also enclosed and we will ask you to sign an acknowledgement at your first visit.

It is important to us to know how we are doing, so do not hesitate to contact us if you have any problems (or compliments). Our administrator's name is Patricia Tidmarsh and you may reach her at 360-733-0640.

DRIVING DIRECTIONS

2940 SQUALICUM PARKWAY #203, BELLINGHAM, WA 98225
PHONE (360) 733-0640

FROM 1-5 NORTHBOUND

TAKE EXIT 255. TURN LEFT ONTO SUNSET DRIVE, CROSS OVER THE FREE-WAY AND GO TO THE SECOND LIGHT ELLIS ST, TURN RIGHT ONTO ELLIS AND GO 2 BLOCKS TO SQUALICUM PARKWAY GETTING IN THE LEFT HAND LANE, (ST. JOSEPH'S ER IS STRAIGHT AHEAD) TURN LEFT ONTO SQUALICUM PARKWAY, WE ARE THE THIRD BUILDING ON THE LEFT SIDE. THE BUILDING NAME IS PARKWAY MEDICAL CENTER.
OUR OFFICE IS UP AND AROUND THE BACK OF THE BUILDING, SUITE 203.

FROM 1-5 SOUTHBOUND

TAKE EXIT 256 AND CONTINUE EAST TO THE STOPLIGHT WHICH IS MERIDIAN WHERE YOU TURN RIGHT ONTO MERIDIAN. GO TO THE NEXT STOPLIGHT AND TURN LEFT ONTO BIRCHWOOD. BIRCHWOOD TURNS INTO SQUALICUM PARKWAY AS YOU MAKE A SHARP RIGHT AND GO UP THE HILL TOWARD THE HOSPITAL.

FOLLOW THE ROAD AROUND A SWEEPING LEFT HAND CORNER. WHEN IT STRAIGHTENS OUT WE ARE THE SECOND BUILDING ON THE RIGHT. THE NAME OF THE BUILDING IS PARKWAY MEDICAL. OUR OFFICE IS UP AND AROUND THE BACK OF THE BUILDING, SUITE 203.

Bellingham Ear Nose & Throat 2940 Squalicum Pkwy #203 Bellingham, WA 98225

Patient Name: _____ Date: _____

Date of Birth: ____/____/____ Age: _____ Height: ____ ft ____ in Weight: _____ lbs

Gender: ____ M ____ F ____ Other Pronouns (identifies as): _____

Primary Care Provider: _____ Referring Provider: _____

Reason for Visit: _____ How long have you had your symptoms: _____

Current Medications (Please list medication NAME and DOSAGE below):	
1	7
2	8
3	9
4	10
5	11
6	12

_____ **No Medications**

Drug Allergies (please list):
1
2
3
4
5
6

_____ **No Known Drug Allergies**

Past Medical History:

____ Allergies: seasonal / year-round
____ Anxiety
____ Asthma
____ Cancer (specify): _____
____ COPD / Emphysema / Bronchitis
____ Depression
____ Diabetes
____ Eye disease (specify): _____
____ Heart Attack (date): _____
____ High Blood Pressure
____ Migraines
____ Non-Migraine Headaches
____ Other Psychiatric Illness (specify): _____
____ Sleep Apnea
____ Stroke (date): _____

Past Surgical History/Hospitalizations:	Approximate Date	Other Significant Medical Problems:	Date:

Family History {Check all that apply to your blood relatives):

____ Asthma ____ Anesthetic Reactions ____ Bleeding Problems ____ Cancer ____ Hearing loss ____ Heart Disease

Social History:

Marital Status: S M D W Other Children: ____ Yes, How Many? ____ Occupation: _____

Tobacco Use: None ____ Smoker, how many packs per day? _____ For how long? _____ ____ Former Smoker
Alcohol Use: None ____ Yes, how many drinks per week? _____ For how long? _____

Bleeding Problem: _____Yes _____No HIV: ____ Yes ____ NO Hepatitis: ____ Yes ____ No Type: _____

Doctor Notes (Reserved Use)

Patient Name: _____ **Date of Birth:** ___/___/___ **Date:** _____

Review of Systems: (current or recent symptoms, check appropriately)

Name	System	Yes	No
Increased infections	Allergic/Immunologic	☐	☐
Chest pain	Cardiovascular	☐	☐
Shortness of breath	Cardiovascular	☐	☐
Increased heart rate	Cardiovascular	☐	☐
Fatigue	Constitutional/Symptom	☐	☐
Fever	Constitutional/Symptom	☐	☐
Night sweats	Constitutional/Symptom	☐	☐
Weight loss	Constitutional/Symptom	☐	☐
Dry Skin	Endocrine	☐	☐
Increased thirst	Endocrine	☐	☐
Difficulty swallowing	ENT and Mouth	☐	☐
Hearing loss	ENT and Mouth	☐	☐
Hoarseness	ENT and Mouth	☐	☐
Nasal obstruction	ENT and Mouth	☐	☐
Painful swallowing of food	ENT and Mouth	☐	☐
Post nasal drip	ENT and Mouth	☐	☐
Double vision	Eyes	☐	☐
Overflow of tears onto cheek	Eyes	☐	☐
Abdominal Pain	Gastrointestinal	☐	☐
Heartburn	Gastrointestinal	☐	☐
Painful urination	Genitourinary	☐	☐
Bruising	Hematologic/Lymphatic	☐	☐
Clotting disorder	Hematologic/lymphatic	☐	☐
Increased bleeding	Hematologic/Lymphatic	☐	☐
Rash	Integumentary	☐	☐
Neck mass	Musculoskeletal	☐	☐
Neck pain	Musculoskeletal	☐	☐
Musculoskeletal pain	Musculoskeletal	☐	☐
Headache	Neurological	☐	☐
Tremor	Neurological	☐	☐
Anxiety	Psychiatric	☐	☐
Depression	Psychiatric	☐	☐
Cough	Resplratory	☐	☐
Shortness of breath	Respiratory	☐	☐
Wheeze	Respiratory	☐	☐

Alerts: (check appropriately)

	Yes	No
Allergy to adhesive	☐	☐
Allergy to latex	☐	☐
Allergy to shellfish/iodine	☐	☐
Mechanical valve	☐	☐
Pregnant or planning pregnancy	☐	☐
Under pain management	☐	☐

Bellingham Ear Nose & Throat 2940 Squalicum Pkwy #203 Bellingham, WA 98225

Mr Mrs Ms Miss:_____
Last First Middle

Birthdate: ____-____-_____ Gender: _____M _____F _____ Other Pronouns (Identifies as): _____

Marital Status: S M W D Sep Social Security#: _____-_____-_____

Race_____ Ethnicity: _____ Language Spoken: _____

Mailing Address:_____
Street City State Zip Code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

If patient is a minor, parent/guardian:_____
Last First Middle

Mailing Address if different from above: _____
Street City State Zip Code

Preferred Phone Number: _____ Relationship to Patient: _____

Emergency Contact: _____
Full Name Contact Number Relationship to Patient

Primary Insurance Company: _____ Eff Date: _____ Copay $ _____

Subscriber's Name_____ Date of Birth: _____-____-_____

Subscriber's ID: _____ _____ Group#: _____ Relationship to Insured: _____

Secondary Insurance Company: _____ _____ Eff Date: _____ Copay $ _____

Subscriber's Name: _____ Date of Birth: _____-____-_____

Subscriber's ID: _____ Group#: _____ Relationship to Insured: _____

Were you injured on the job? _____ Auto? _____ Other? _____ Date of Injury/Accident: _____-____-_____

Insurance Company: _____ Claim #: _____ Policy #: _____

Claims Adjuster Name/Phone#: _____

PLEASE READ CAREFULLY:

I hereby authorize payment directly to this medical office for the Medicare and/or Group Insurance benefits otherwise payable to me. I authorize release to the Centers for Medicare or Medicaid services and/or to Group Insurances any medical information needed to determine payments for related services. I understand that I am financially responsible for all charges and costs related to my medical treatment. All payments are due at the time of service unless prior arrangements have been made with the medical office. I certify that all of the above information is correct and accurate and I acknowledge receipt of the **Medical Record Privacy Policy**.

Signature: _____ Date: _____
patient/parent/guardian

BELLINGHAM EAR, NOSE & THROAT & FACIAL PLASTIC SURGERY INC
FINANCIAL POLICY

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your responsibility.

- All patients must complete our Patient Information forms before seeing the doctor. These must be updated at least once a year.
- **FULL PAYMENT IS DUE AT THE TIME OF SERVICE** unless you have a current and eligible medical insurance card. If this is not possible, discuss your financial situation with our business office. We will assist you in setting up an acceptable payment plan.
- **COPAYS ARE ALWAYS DUE AT THE TIME OF VISIT.**
- WE ACCEPT CASH, CHECKS AND VISA, MasterCard, DISCOVER, AMERICAN EXPRESS and CARE CREDIT.

MINORS ACCOMPANIED BY AN ADULT
The adult accompanying a minor, his/her/their parent, or guardian is responsible for full payment at the time of service unless we are provided with a current medical insurance card.

INSURANCE
Bellingham ENT is contracted with the following commercial insurance companies: AETNA, CHPW, CIGNA, Department of Indian Health, FIRST CHOICE, GREAT WEST, HMA, HUMANA, KAISER, MOLINA, MULTIPLAN, PREMERA BC, REGENCE BS, and UNITED HEALTHCARE. We also accept the following government plans: Apple Health (Washington Medicaid), Labor and Industries, Medicare, Railroad Medicare, Tricare, and VA. For patients with any of these listed insurances, we bill the carrier direct, accept the contracted rate and bill the patient for any co-payment, deductible and/or co-insurance amounts due and not previously paid. We will bill all other insurance companies one time only as a courtesy, but the patient is ultimately responsible for payment. The patient must provide current, complete and accurate information. We will bill your secondary only if the correct insurance information is provided at the time of service.

If your insurance company has not paid the FULL BALANCE within 45 days, you will be expected to begin making payments on any balance due. If your insurance company pays more than the balance due, we will refund the check to the issuing party.

We require payment prior to ENT surgeries not covered by insurance with financial arrangements for the balance made with our business office. Cosmetic procedures must be paid in full 7 days prior to the procedure.

Insurance is a contract between you and your insurance company and you are responsible for payment as well as settling any disputes. If we are contracted with your insurance we will handle your claims according to our contract. We do not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc., other than to supply factual information as necessary. **YOU ARE RESPONSIBLE FOR TIMELY PAYMENT OF YOUR ACCOUNT**. Accounts exceeding 90 days will be considered delinquent.

DELINQUENT ACCOUNTS will be referred to an outside collection agency. An account that is referred to collection may result in termination of medical services from our clinic.

If you pay by check and that check is returned for non-sufficient funds (NSF) we will charge an additional $25.00 to your account. If this happens, you will be asked to remit the amount of the check plus the service charge in cash within 10 days. If your account has not been cleared by then, we will refer it for collection action.
Repeated failure to keep scheduled appointments or NSF checks may also result in the termination of medical care from our clinic.
Thank you for understanding our Financial Policy. Please let us know if you have any questions.

OWNERSHIP DISCLOSURE: Whatcom Surgery Center is a division of Bellingham Ear Nose & Throat and should you have a procedure or surgery there, please be advised that Drs. Stackhouse, Knops, Olson, Verneuil, Lichtenberger and Hecht have a financial Interest in Whatcom Surgery Center.

I HAVE READ AND FULLY UNDERSTAND THE BELLINGHAM EAR NOSE & THROAT & FACIAL PLASTIC SURGERY INC FINANCIAL POLICY

Signature, Responsible Party

Date

Please print full name

Updated 5/2021

BELLINGHAM
EAR NOSE & THROAT

Perpetual Authorization to Share Protected Health Information (PHI)

Allows our office to discuss your healthcare information with the person(s) you list below

Patient Name: _____

Date of birth: _____ Previous Name: _____

I authorize Bellingham Ear Nose & Throat to leave detailed messages for the above-named patient with the individual(s) listed below at the phone number specified:

Name	Phone
Name	Phone

I authorize Bellingham Ear Nose and Throat (including all clinics, office, and ancillary services) to share limited protected health information about my condition and care with the individual(s) listed below, who are involved in my ongoing care.

Name (spouse, family member, caregiver) (print)	Phone Number	Relationship
Name (spouse, family member, caregiver) (print)	Phone Number	Relationship

You may include information specific to the following (check all that apply):

☐	**Complete Health Record**	☐	**Radiology and Diagnostic Imaging Reports**
☐	**Pathology Reports**	☐	**Photographs, Videos, Digital or Other Images**
☐	**HIV (AIDS virus)**	☐	**Mental Health or Illness**
☐	**Sexually Transmitted Diseases**	☐	**Drug and/or alcohol use**
☐	**Other (please specify):**		

Minors: A minor patient's signature is required in order to disclose information related to reproductive care (at any age), sexually transmitted disease (age 14 and older), HIV/AIDS (age 14 and older), drug and/or alcohol abuse (age 13 and older), and mental health or illness (age 13 and older)

***Note:** This form is valid until cancelled by the patient or legally authorized individual. **This form does not authorize release of any medical records.**

Patient or legally authorized individual signature _____ Date _____

Printed name (*if signed on behalf of the patient*) _____ Relationship (parent, legal guardian etc.) _____

Minor patient's signature, if applicable _____ Date _____

☐ **Cancel this authorization**

Patient Signature: _____ Date: _____

05/21/2021

BELLINGHAM
EAR NOSE & THROAT
Thomas Stackhouse, MD Joost Knops, MD David Olson, MD Andrew Verneuil, MD
Jason Lichtenberger, MD Avram Hecht, MD Chris Stacey, PA-C

Notice of Privacy Practices - BELLINGHAM EAR NOSE & THROAT & FACIAL PLASTIC SURGERY, INC. and its divisions.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Bellingham Ear Nose & Throat, Hearing Health Clinic and LIFE Aesthetic Center respects your privacy. We understand that your personal health information is very sensitive. The law protects the privacy of the health information we create and obtain in providing care and services to you. Your protected health information includes your symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relating to these services.

We will not use or disclose your health information to others without your authorization, except as described in this Notice, or as required by law.

Your health information rights

The health and billing records we create and store are the property of Bellingham Ear Nose & Throat. The protected health information in it, however, generally belongs to you. You have a right to:

- ☐ Receive, read, and ask questions about this Notice.
- ☐ Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request unless the request is to restrict disclosure of your protected health information to a health plan for payment or health care operations and the protected health information is about a service or treatment for which you paid directly.
- ☐ Request and receive from us a paper copy of the most current Notice of Privacy Practices ("Notice").
- ☐ Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing. We have a form available for this type of request.
- ☐ Have us review a denial of access to your health information-except in certain circumstances.
- ☐ Ask us to change your health information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records.
- ☐ When you request, we will give you a list of certain disclosures of your health information. The list will not include disclosures for treatment, payment, or health care operations. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.
- ☐ Ask that your health information be given to you by another means or at another location. Please sign, date, and give us your request in writing.
- ☐ Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

For help with these rights during normal business hours, please contact:
Patricia Tidmarsh, Practice Administrator, 2940 Squalicum Pkwy#203, Bellingham, WA 98225
360-733-0640

Our responsibilities

We are required to:

- ☐ Keep your protected health information private.
- ☐ Give you this Notice.
- ☐ Follow the terms of this Notice.

We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it or by visiting our Bellingham Ear Nose & Throat medical records department to pick one up.

To ask for help or complain.
If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact:
Patricia Tidmarsh, Practice Administrator, 2940 Squalicum Pkwy #203, Bellingham, WA 98225
360-733-0640

If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint to ***Patricia Tidmarsh, Practice Administrator*** at *Bellingham Ear Nose & Throat*. You may also file a complaint with the Department of Health and Human Services Office for Civil Rights (OCR).

We respect your right to file a complaint with us or with the OCR. If you complain, we will not retaliate against you.

How we may use and disclose your protected health information.

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways we may use and disclose your protected health information. For each category, we will explain what we mean and give some

examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose health information will fall within one of the categories.

Examples of uses and disclosures of protected health information for treatment, payment, and health care operations:

For treatment:

- ☐ Information obtained by a nurse, physician, or other member of our health care team will be recorded in your medical record and used by members of our health care team to help decide what care may be right for you.
- ☐ We may also provide information to health care providers outside our practice who are providing you care or for a referral. This will help them stay informed about your care.

For payment:

- ☐ We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses, procedures performed, or recommended care.
- ☐ We bill you or the person you tell us is responsible for paying for your care if it is not covered by your health insurance plan.

For health care operations:

- ☐ We may use your medical records to assess quality and improve services.
- ☐ We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- ☐ We may use and disclose your information to conduct or arrange for services, including:
  - ☐ Medical quality review by your health plan,
  - ☐ Accounting, legal, risk management, and insurance services; and
  - ☐ Audit functions, including fraud and abuse detection and compliance programs

Statements about certain uses and disclosures.

- ☐ We may contact you to remind you about appointments.
- ☐ We may use and disclose your health information to give you information about treatment alternatives or other health-related benefits and services.
- ☐ We may contact you to raise funds. If we contact you for fund-raising, we will also provide you with a way to opt out of receiving fund-raising requests in the future.

Some of the other ways that we may use or disclose your protected health information without your authorization are as follows:

- ☐ **Required by law:** We must make any disclosure required by state, federal, or local law.
- ☐ **Business Associates:** We contract with individuals and entities to perform jobs for us or to provide certain types of services that may require them to create, maintain, use, and/or disclose your health information. We may disclose your health information to a business associate, but only after they agree in writing to safeguard your health information. Examples include billing services, accountants, and others who perform health care operations for us.
- ☐ **Notification of family and others:** Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital.
- ☐ **Public health and safety purposes:** As permitted or required by law, we may disclose protected health information:
  - ☐ To prevent or reduce a serious, immediate threat to the health or safety of a person or the public.
  - ☐ To public health or legal authorities:
  - ☐ To protect public health and safety.
    - ☐ To prevent or control disease, injury, or disability.
    - ☐ To report Vital statistics such as births or deaths.
    - ☐ To report suspected abuse or neglect to public authorities.
- ☐ **Coroners, medical examiners. and funeral directors:** We may disclose protected health information to funeral directors and coroners consistent with applicable law to allow them to carry out their duties.
- ☐ **Organ-procurement organizations:** Consistent with applicable law, we may disclose protected health information to organ-procurement organizations (tissue donation and transplant) or persons who obtain, store, or transplant organs.
- ☐ **Food and Drug Administration (FDA):** For problems with food, supplements, and products, we may disclose protected health information to the FDA or entities subject to the jurisdiction of the FDA.
- ☐ **Workplace injury or illness:** Washington State law requires the disclosure of protected health information to the Department of Labor and Industries, the employer, and the payer (including a self-insured payer) for workers' compensation and for crime victims' claims. We also may disclose protected health information for work-related conditions that could affect employee health; for example, an employer may ask us to assess health risks on a job site.
- ☐ **Correctional institutions:** If you are in jail or prison, we may disclose your protected health information as necessary for your health and the health and safety of others.
- ☐ **Law enforcement:** We may disclose protected health information to law enforcement officials as required by law, such as reports of certain types of injuries or victims of a crime, or when we receive a warrant, subpoena, court order, or other legal process.
- ☐ **Government health and safety oversight activities:** We may disclose protected health information to an oversight agency that may be conducting an investigation. For example, we may share health information with the Department of Health.
- ☐ **Disaster relief:** We may share protected health information with disaster relief agencies to assist in notification of your condition to family or others.
- ☐ **Military, Veteran, and Department of State:** We may disclose protected health information to the military authorities of U.S. and foreign military personnel; for example, the law may require us to provide information necessary to a military mission.
- ☐ **Lawsuits and disputes:** We are permitted to disclose protected health information in the course of judicial/administrative proceedings at your request, or as directed by a subpoena or court order.
- ☐ **National Security:** We are permitted to release protected health information to federal officials for national security purposes authorized by law.
- ☐ **De-identifying information:** We may use your protected health information by removing any information that could be used to identify you.