



## WELCOME TO OUR PRACTICE

Date: \_\_\_\_\_

Dear \_\_\_\_\_:

We welcome you to our practice and appreciate the opportunity to be of service to you. Our staff is a group of well-qualified professionals who work as a team to provide you with the highest level of treatment in a professional and caring environment.

Your appointment is scheduled with Doctor \_\_\_\_\_ on \_\_\_\_\_.

We ask you to arrive at \_\_\_\_\_ to allow us time to update your information and copy your insurance card(s). One of our nursing staff will be taking a medical history at this time. ***Please bring a complete list of the medications you currently take, your allergies to medications, and your surgical history with year of surgery.***

**Referrals:** If your insurance is an HMO, a referral from your primary care physician (PCP) **is required** for you to be treated by our physicians. You are responsible for providing us with the referral before you are seen by our doctors. If you fail to provide us with a referral, you will be responsible for your charges.

**Minors:** All children under the age of 18 **must be accompanied by a parent or legal guardian**. If the parent or legal guardian is unable to accompany the minor child, we must have a note stating who will be accompanying the minor and permission from the parent/legal guardian authorizing this practice to treat the minor child.

**Cancellations:** We require at least a 24-hour notice should you need to change or cancel your appointment.

**Telephone Calls:** Should you have a problem, please do not hesitate to call. Our office staff has been trained to handle all situations. A message will be taken and then given to one of our physicians, who will review the chart and respond appropriately. Please remember to leave a phone number where you can be reached.

Should you need to contact us after hours, call 301-714-4375 and our answering service will forward your message to the physician on call. Please note that we share on-call coverage with Dr. Kirby Scott which means he may be returning your call.

**In the event of an extreme emergency, go directly to the Emergency Room.**

**Green Entrance, Robinwood Professional Center**

11110 Medical Campus Road, #126 Hagerstown, MD 21742

301-714-4375 (p) 301-714-4399 (f)

**Medicare:** We do participate with Medicare. We will file your claim for you and accept what Medicare **allows**. If you have a secondary carrier, we will submit any unpaid balance to it. All payments from Medicare and secondary carriers should be sent to our office. Please keep in mind that you may be responsible for any charges not covered by Medicare or the secondary insurance such as deductibles, co-payments, and co-insurances.

**Commercial Insurance:** We do participate with a number of insurance carriers. Please ask our staff if we participate with your particular insurance. If so, we will be glad to submit the charges for your visit and accept the insurance allowed amount for covered services. **Please keep in mind that you will be responsible for co-payments, deductibles and co-insurances.**

If you do not have insurance or have insurance with which we do not participate, we will expect your payment for services rendered at the time of your visit. You will receive two copies of the fee ticket to use when submitting your claim to your insurance company for reimbursement. If you are unable to pay at the time of service, you may make payment arrangements with our Billing Department prior to treatment. Please note that the charge for your visit depends on the level of service rendered to you. Prices may be higher if hearing tests or diagnostic/surgical procedures are required. Feel free to discuss charges with our physicians or staff prior to having these services. You may pay by cash, check, Visa, Mastercard or Discover.

**Surgeries:** If we participate with your insurance company, we will submit your surgery charges directly to your insurance company. Balances remaining after your insurance has paid are the responsibility of the patient. Please be aware that we bill only for our physicians. You will receive bills from the anesthesiologist and the facility, which may include pathology fees.

**Otolaryngologist-Head and Neck Surgeon-** is a Specialist in diagnosing and treating diseases and disorders of the ear, nose and throat. The practice of Otolaryngology specializes in:

- Sinus infections
- Allergies
- Ear infections/ear surgery
- Snoring disorders
- Sleep Apnea
- Nasal problems
- Head and neck surgery for cancer of the mouth, throat and voice box
- Tonsils and adenoids
- Loss of hearing
- Thyroid disorders
- Plastic surgery for facial reconstruction

**Additional Information:**

Our office is designated as non-smoking and **we ask you not to bring food or drink into the office.**

**In Conclusion:** We thank you for choosing our practice and we hope that this letter will give you a better understanding of the services we provide to our community.

Sincerely,

Drs. Saylor, Wathne, Manilla and Stonebraker

**Green Entrance, Robinwood Professional Center**

11110 Medical Campus Road, #126 Hagerstown, MD 21742

301-714-4375 (p) 301-714-4399 (f)

CUMBERLAND VALLEY ENT CONSULTANTS/ALLERGY DEPARTMENT

Phone 301-714-4388 Fax 301-714-4387

**ALLERGY QUESTIONNAIRE**

Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Do you have any of the following: Nasal Congestion?

|                            |   |   |
|----------------------------|---|---|
| Frequent sneezing?         | Y | N |
| Watery Nasal Discharge?    | Y | N |
| Discolored Nasal Drainage? | Y | N |
| Nasal Burning?             | Y | N |
| Sinus/Facial Pain?         | Y | N |
| Itchy Nose?                | Y | N |
| Itchy Throat?              | Y | N |
| Itchy, Burning Eyes?       | Y | N |
| Watery Eyes?               | Y | N |
| Red Eyes?                  | Y | N |
| Post Nasal Drip?           | Y | N |
| Chronic Headaches?         | Y | N |
| Asthma?                    | Y | N |
| Chronic cough?             | Y | N |
| Shortness of breath?       | Y | N |
| Wheezing?                  | Y | N |
| Cough with exercise?       | Y | N |

When did symptoms begin? \_\_\_\_\_

Do you have a family history of allergy? \_\_\_\_\_

Do you have any history of sinus problems? \_\_\_\_\_

Circle which seasons are most difficult for you. **Summer** **Fall** **Winter** **Spring**

Do you have eczema or get other rashes? \_\_\_\_\_

Do you get hives? \_\_\_\_\_

Are you allergic to specific foods? Which? \_\_\_\_\_

Do you have any drug allergies? \_\_\_\_\_

Do you have excessive fatigue? \_\_\_\_\_

Excessive gas and indigestion? \_\_\_\_\_

Patient Name: \_\_\_\_\_

Account # \_\_\_\_\_

## ENVIRONMENT:

| Circle your type of home.                                                        | Apartment | Trailer             | Single Family | Duplex |
|----------------------------------------------------------------------------------|-----------|---------------------|---------------|--------|
| How old is your home?                                                            | _____     |                     |               |        |
| Are you worse in a particular room?                                              | _____     |                     |               |        |
| Do you have a wood stove or burn wood in a fireplace?                            |           |                     | Y             | N      |
| Do you have a basement?                                                          |           |                     | Y             | N      |
| Is your basement damp or dry?                                                    |           |                     | Y             | N      |
| Do you have standing water or leaks in or around your home?                      |           |                     | Y             | N      |
| Do you have carpet in your bedroom?                                              |           |                     | Y             | N      |
| Do you have curtains in your bedroom?                                            |           |                     | Y             | N      |
| Do you have a feather pillow?                                                    |           |                     | Y             | N      |
| Have allergy precautions been taken in the bedroom?                              |           |                     | Y             | N      |
| Do you get stuffy shortly after you go to bed?                                   |           |                     | Y             | N      |
| Does house cleaning make your symptoms worse?                                    |           |                     | Y             | N      |
| Do you have a library with many old books?                                       |           |                     | Y             | N      |
| Do you have a lot of antique furniture?                                          |           |                     | Y             | N      |
| Do you have a lot of difficult to dust knick-knacks?                             |           |                     | Y             | N      |
| Are your symptoms better when you go on vacation?                                |           |                     | Y             | N      |
| Do your symptoms flare-up in:                                                    |           | basement?           | Y             | N      |
|                                                                                  |           | around barns/farms? | Y             | N      |
|                                                                                  |           | in the woods?       | Y             | N      |
|                                                                                  |           | around lakes/marsh? | Y             | N      |
| Are your symptoms worse when you go outside in the AM?                           |           |                     | Y             | N      |
|                                                                                  |           | in the P.M?         | Y             | N      |
| Do your symptoms get worse when you do yard work?                                |           |                     | Y             | N      |
|                                                                                  |           | do gardening?       | Y             | N      |
| Do you have many house plants?                                                   |           |                     | Y             | N      |
| Please list indoor pets:                                                         | _____     |                     |               |        |
| Please list outdoor pets:                                                        | _____     |                     |               |        |
| Are there certain areas of the country where your symptoms are worse, or better? | _____     |                     |               |        |
| What type of work do you do?                                                     | _____     |                     |               |        |
| How many years have you been doing this type of work?                            | _____     |                     |               |        |
| What type of hobbies do you enjoy?                                               | _____     |                     |               |        |

## PLEASE ANSWER THE FOLLOWING QUESTIONS IF PATIENT IS A CHILD:

Was the patient premature of full term?(circle one)

|                                                |       |   |
|------------------------------------------------|-------|---|
| Was the patient a colicky baby?                | Y     | N |
| Breast fed?                                    | Y     | N |
| Bottle fed?                                    | Y     | N |
| Is the child in daycare?                       | Y     | N |
| Does the child have ADD or ADHD?               | Y     | N |
| At what age did the patient start solid foods? | _____ |   |
| Does anyone smoke around the child?            | _____ |   |



The following questionnaire is intended to help define your symptoms and provide valuable information and insights for your doctor. Answer the questions, rating to the best of your ability the problems you have experienced over the past two weeks.

Patient Name: \_\_\_\_\_

Patient Phone: \_\_\_\_\_

Date: \_\_\_\_\_

## Sino-Nasal Outcome Test (SNOT-20)

| 1. Consider how severe the problem is when you experience it and how frequently it happens, please rate each item below on how "bad" it is by circling the number that corresponds with how you feel.<br><br>2. Please mark the most important items affecting your health (maximum of 5 items). |                                   | No problem | Very mild problem | Mild or slight problem | Moderate problem | Severe problem | Problem as bad as it can be |  | 5 most important items |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|------------|-------------------|------------------------|------------------|----------------|-----------------------------|--|------------------------|
| 1.                                                                                                                                                                                                                                                                                               | Need to blow nose                 | 0          | 1                 | 2                      | 3                | 4              | 5                           |  | <input type="radio"/>  |
| 2.                                                                                                                                                                                                                                                                                               | Sneezing                          | 0          | 1                 | 2                      | 3                | 4              | 5                           |  | <input type="radio"/>  |
| 3.                                                                                                                                                                                                                                                                                               | Runny nose                        | 0          | 1                 | 2                      | 3                | 4              | 5                           |  | <input type="radio"/>  |
| 4.                                                                                                                                                                                                                                                                                               | Cough                             | 0          | 1                 | 2                      | 3                | 4              | 5                           |  | <input type="radio"/>  |
| 5.                                                                                                                                                                                                                                                                                               | Post-nasal discharge              | 0          | 1                 | 2                      | 3                | 4              | 5                           |  | <input type="radio"/>  |
| 6.                                                                                                                                                                                                                                                                                               | Thick nasal discharge             | 0          | 1                 | 2                      | 3                | 4              | 5                           |  | <input type="radio"/>  |
| 7.                                                                                                                                                                                                                                                                                               | Ear fullness                      | 0          | 1                 | 2                      | 3                | 4              | 5                           |  | <input type="radio"/>  |
| 8.                                                                                                                                                                                                                                                                                               | Dizziness                         | 0          | 1                 | 2                      | 3                | 4              | 5                           |  | <input type="radio"/>  |
| 9.                                                                                                                                                                                                                                                                                               | Ear pain                          | 0          | 1                 | 2                      | 3                | 4              | 5                           |  | <input type="radio"/>  |
| 10.                                                                                                                                                                                                                                                                                              | Facial pain / pressure            | 0          | 1                 | 2                      | 3                | 4              | 5                           |  | <input type="radio"/>  |
| 11.                                                                                                                                                                                                                                                                                              | Difficulty falling asleep         | 0          | 1                 | 2                      | 3                | 4              | 5                           |  | <input type="radio"/>  |
| 12.                                                                                                                                                                                                                                                                                              | Wake up at night                  | 0          | 1                 | 2                      | 3                | 4              | 5                           |  | <input type="radio"/>  |
| 13.                                                                                                                                                                                                                                                                                              | Lack of sleep                     | 0          | 1                 | 2                      | 3                | 4              | 5                           |  | <input type="radio"/>  |
| 14.                                                                                                                                                                                                                                                                                              | Wake up tired                     | 0          | 1                 | 2                      | 3                | 4              | 5                           |  | <input type="radio"/>  |
| 15.                                                                                                                                                                                                                                                                                              | Fatigue                           | 0          | 1                 | 2                      | 3                | 4              | 5                           |  | <input type="radio"/>  |
| 16.                                                                                                                                                                                                                                                                                              | Reduced productivity              | 0          | 1                 | 2                      | 3                | 4              | 5                           |  | <input type="radio"/>  |
| 17.                                                                                                                                                                                                                                                                                              | Reduced concentration             | 0          | 1                 | 2                      | 3                | 4              | 5                           |  | <input type="radio"/>  |
| 18.                                                                                                                                                                                                                                                                                              | Frustrated / restless / irritable | 0          | 1                 | 2                      | 3                | 4              | 5                           |  | <input type="radio"/>  |
| 19.                                                                                                                                                                                                                                                                                              | Sad                               | 0          | 1                 | 2                      | 3                | 4              | 5                           |  | <input type="radio"/>  |
| 20.                                                                                                                                                                                                                                                                                              | Embarrassed                       | 0          | 1                 | 2                      | 3                | 4              | 5                           |  | <input type="radio"/>  |

# CUMBERLAND VALLEY EAR, NOSE, & THROAT CONSULTANTS

A. Christopher Manilla, DO  
Angela C. Stonebraker, MD

Megan Willwerth, CRNP  
Michael Cochran, DNP

## PATIENT SELF HISTORY SHEET

Name: \_\_\_\_\_ SEX: **MALE / FEMALE** Last 4 SS# \_\_\_\_\_

**Who Referred  
you to CVENT?**  
(choose one)

☐ Family Dr Name: \_\_\_\_\_

☐ UC Dr Name \_\_\_\_\_

☐ ER Dr Name: \_\_\_\_\_

☐ Self Referred

Main Reason for today's visit: (**Describe in ONE Sentence**): \_\_\_\_\_

Location (Where is the problem?): \_\_\_\_\_

Date symptom(s) began: \_\_\_\_\_

Frequency of Symptoms: ☐ Constant ☐ Intermittent ☐ Occasional ☐ Rare

Intensity of Symptoms: ☐ Mild ☐ Moderate ☐ Severe

How did symptoms start? ☐ Gradual ☐ Suddenly

Associated Symptom(s): \_\_\_\_\_

Have you taken any medications for this problem? ☐ No ☐ Yes, if so please list: \_\_\_\_\_

Have you had any Labs, X-Ray, CT, MRI or Ultrasounds for this problem? ☐ No ☐ Yes, if so what test(s) & where \_\_\_\_\_

### **PAST/PRESENT MEDICAL HISTORY:**

Please check any ongoing medical conditions that you have already been diagnosed by doctors, including serious illness of the past. **DO NOT** check any problems which have not yet been addressed by a doctor.

- |                                                     |                                                        |                                                     |                                               |
|-----------------------------------------------------|--------------------------------------------------------|-----------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> No Past/Present Medical Hx | <input type="checkbox"/> COPD                          | <input type="checkbox"/> Heart Failure (Congestive) | <input type="checkbox"/> Osteoporosis         |
| <input type="checkbox"/> Acid Reflux                | <input type="checkbox"/> Coronary Artery Disease       | <input type="checkbox"/> Heart Attack(Year:_____)   | <input type="checkbox"/> Panic Disorder       |
| <input type="checkbox"/> Alcoholism                 | <input type="checkbox"/> Degenerative Disc Disease     | <input type="checkbox"/> Hepatitis                  | <input type="checkbox"/> Prostate Enlargement |
| <input type="checkbox"/> Alzheimer's Disease        | <input type="checkbox"/> Depression                    | (Circle:) A B C                                     | <input type="checkbox"/> Seasonal Allergies   |
| <input type="checkbox"/> Anemia                     | <input type="checkbox"/> Diabetes Type I(Insulin Dep)  | <input type="checkbox"/> High Blood Pressure        | <input type="checkbox"/> Seizure Disorder     |
| <input type="checkbox"/> Anxiety                    | <input type="checkbox"/> Diabetes Type II(Non-Insulin) | <input type="checkbox"/> High Cholesterol           | <input type="checkbox"/> Sleep Apnea          |
| <input type="checkbox"/> Arthritis/ Rheumatoid      | <input type="checkbox"/> Drug Abuse                    | <input type="checkbox"/> High Triglycerides         | <input type="checkbox"/> Stomach Ulcers       |
| <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Eczema                        | <input type="checkbox"/> HIV                        | <input type="checkbox"/> Stroke (Year:_____)  |
| <input type="checkbox"/> Atrial Fibrillation        | <input type="checkbox"/> Emphysema                     | <input type="checkbox"/> Kidney Disease             | <input type="checkbox"/> Thyroid Problems     |
| <input type="checkbox"/> Bipolar Disorder           | <input type="checkbox"/> Fibromyalgia                  | <input type="checkbox"/> Macular Degeneration       | <input type="checkbox"/> TIA (Year: _____)    |
| <input type="checkbox"/> Cancer (Year:_____)        | <input type="checkbox"/> Glaucoma                      | <input type="checkbox"/> Migraine/Headaches         | <input type="checkbox"/> Other: _____         |
| Type: _____                                         | <input type="checkbox"/> Hearing Loss                  | <input type="checkbox"/> Obesity                    | _____                                         |

**ALLERGIES:**

**Latex Allergy:** \_\_\_\_\_ No \_\_\_\_\_ Yes (if yes, list reaction) \_\_\_\_\_

**Drug Allergies:** \_\_\_\_\_ No \_\_\_\_\_ Yes (if yes, list **drug** and type of **reaction** below)

|       |       |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**IMMUNIZATIONS:**

Have you received an Influenza Vaccine this year? ☐ No ☐ Yes (Date: \_\_\_\_\_)

Have you ever received a Pneumonia Vaccine? ☐ No ☐ Yes (Date: \_\_\_\_\_)

**SOCIAL HISTORY:**

**Do you smoke or use tobacco products?** ☐ No ☐ Yes

**Do you drink alcohol beverages** ☐ No ☐ Yes

**Employment:**

☐ Full Time ☐ Part Time ☐ Disabled ☐ Retired ☐ Student ☐ Unemployed

Occupation: \_\_\_\_\_

**SURGICAL HISTORY:**

Please check **ANY** surgeries you have had in your lifetime.

- |                                              |                                                 |                                                       |                                            |
|----------------------------------------------|-------------------------------------------------|-------------------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> No Previous Surgery | <input type="checkbox"/> Appendectomy           | <input type="checkbox"/> Gallbladder                  | <input type="checkbox"/> Oral Surgery      |
| <input type="checkbox"/> Adenoidectomy       | <input type="checkbox"/> Back Surgery (Disc)    | <input type="checkbox"/> Hernia Repair                | <input type="checkbox"/> Ovarian Cyst      |
| <input type="checkbox"/> Ear Drum Repair     | <input type="checkbox"/> Breast Biopsy          | <input type="checkbox"/> Hip Replacement              | <input type="checkbox"/> Prostate – Biopsy |
| <input type="checkbox"/> Ear Tubes           | <input type="checkbox"/> Cardiac Pacemaker      | <input type="checkbox"/> Hysterectomy                 | <input type="checkbox"/> Prostatectomy     |
| <input type="checkbox"/> Mastoidectomy       | <input type="checkbox"/> Cardiac Stenting       | <input type="checkbox"/> Knee Arthroscopy             | <input type="checkbox"/> Skin Biopsy       |
| <input type="checkbox"/> Septoplasty         | <input type="checkbox"/> Carotid Endarterectomy | <input type="checkbox"/> Knee Replacement             | <input type="checkbox"/> Splenectomy       |
| <input type="checkbox"/> Sinus Surgery:      | <input type="checkbox"/> Cataract               | <input type="checkbox"/> Lobectomy                    | <input type="checkbox"/> Thyroidectomy     |
| Year & Where _____                           | <input type="checkbox"/> Colectomy              | <input type="checkbox"/> Lumpectomy                   | <input type="checkbox"/> Other: _____      |
| <input type="checkbox"/> Tonsillectomy       | <input type="checkbox"/> Coronary Artery Bypass | <input type="checkbox"/> Mastectomy                   | _____                                      |
|                                              | Year: _____                                     | <input type="checkbox"/> Nephrectomy (kidney removed) | _____                                      |
|                                              | <input type="checkbox"/> Defibrillator          | <input type="checkbox"/> Oophorectomy                 | _____                                      |

**MEDICATIONS:**

Please list all MEDICATIONS including supplements, herbals, CBD products and/or medical marijuana usage.

|       |       |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**PHARMACIES:**

Please list your preferred pharmacy.

|                     | Pharmacy Name | Street Name | City, State |
|---------------------|---------------|-------------|-------------|
| Local Pharmacy      | _____         | _____       | _____       |
| Mail Order Pharmacy | _____         | _____       | _____       |

**Have you ever used recreational/illicit drugs?**

Marijuana ☐ Never ☐ Currently ☐ Previously  
 Heroin ☐ Never ☐ Currently ☐ Previously  
 Cocaine ☐ Never ☐ Currently ☐ Previously

**Marital Status:**

☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

**Employment:**

☐ Full Time ☐ Part Time ☐ Disabled ☐ Retired ☐ Student ☐ Unemployed

Occupation: \_\_\_\_\_

**Do you have animals in your home?** ☐ No ☐ Yes If yes, what type? \_\_\_\_\_

**Is Daycare used?** ☐ No ☐ Yes

**SURGICAL HISTORY:**

Please check ANY surgeries you have had in your lifetime.

|                                                                        |                                                                |                                                                   |                                                                |
|------------------------------------------------------------------------|----------------------------------------------------------------|-------------------------------------------------------------------|----------------------------------------------------------------|
| <input type="checkbox"/> No Previous Surgery                           | <input type="checkbox"/> Coronary Artery Bypass<br>Year: _____ | <input type="checkbox"/> Lobectomy (removal of lung/ all or part) | <input type="checkbox"/> Prostatectomy                         |
| <input type="checkbox"/> Adenoidectomy                                 | <input type="checkbox"/> Defibrillator (Placement)             | <input type="checkbox"/> Lumpectomy                               | <input type="checkbox"/> Septoplasty                           |
| <input type="checkbox"/> Appendectomy                                  | <input type="checkbox"/> Ear Drum Repair                       | <input type="checkbox"/> Mastectomy                               | <input type="checkbox"/> Sinus Surgery:<br>Year & Where: _____ |
| <input type="checkbox"/> Back Surgery (Disc)                           | <input type="checkbox"/> Ear Tubes                             | <input type="checkbox"/> Mastoidectomy                            | <input type="checkbox"/> Skin Biopsy                           |
| <input type="checkbox"/> Breast Biopsy                                 | <input type="checkbox"/> Gallbladder                           | <input type="checkbox"/> Nephrectomy (kidney removal)             | <input type="checkbox"/> Splenectomy                           |
| <input type="checkbox"/> Cardiac Pacemaker                             | <input type="checkbox"/> Herniorrhaphy (Hernia)                | <input type="checkbox"/> Oophorectomy                             | <input type="checkbox"/> Thyroidectomy                         |
| <input type="checkbox"/> Cardiac Stenting                              | <input type="checkbox"/> Hip Replacement                       | <input type="checkbox"/> Oral Surgery                             | <input type="checkbox"/> Tonsillectomy                         |
| <input type="checkbox"/> Carotid Endarterectomy                        | <input type="checkbox"/> Hysterectomy                          | <input type="checkbox"/> Ovarian Cyst                             | <input type="checkbox"/> Other: _____                          |
| <input type="checkbox"/> Cataract                                      | <input type="checkbox"/> Knee Arthroscopy                      | <input type="checkbox"/> Prostate – Biopsy                        | _____                                                          |
| <input type="checkbox"/> Colectomy (Partial/Complete Removal of Colon) | <input type="checkbox"/> Knee Replacement                      |                                                                   | _____                                                          |

**MEDICATIONS:**

Please list all MEDICATIONS including supplements, herbals, CBD products and/or medical marijuana usage.

|       |       |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**REVIEW OF SYSTEMS:**

|                                                                                                                                                                                                                       |                                                                                                                                                                                         |                                                                                                                                                                                                                 |                                                                                                                                                                           |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>GENERAL</b><br><input type="checkbox"/> Fever<br><input type="checkbox"/> Chills<br><input type="checkbox"/> Night Sweats<br><input type="checkbox"/> Weight Gain/ Loss<br><input type="checkbox"/> None           | <b>SKIN</b><br><input type="checkbox"/> Skin Rashes<br><input type="checkbox"/> Itchy Skin<br><input type="checkbox"/> Bruising<br><input type="checkbox"/> None                        | <b>HEENT</b><br><input type="checkbox"/> Headaches<br><input type="checkbox"/> Voice Changes<br><input type="checkbox"/> Blindness<br><input type="checkbox"/> None                                             | <b>NECK</b><br><input type="checkbox"/> Swollen Glands<br><input type="checkbox"/> Neck Mass<br><input type="checkbox"/> None                                             |
| <b>RESPIRATORY</b><br><input type="checkbox"/> Cough<br><input type="checkbox"/> Shortness of Breath<br><input type="checkbox"/> Wheezing<br><input type="checkbox"/> None                                            | <b>CARDIOVASCULAR</b><br><input type="checkbox"/> Irregular Heartbeats<br><input type="checkbox"/> Chest Pains<br><input type="checkbox"/> Blood Clots<br><input type="checkbox"/> None | <b>GASTRO-INTESTINAL</b><br><input type="checkbox"/> Abdominal Pain<br><input type="checkbox"/> Nausea<br><input type="checkbox"/> Vomiting<br><input type="checkbox"/> Reflux<br><input type="checkbox"/> None | <b>NEUROLOGICAL</b><br><input type="checkbox"/> Seizures<br><input type="checkbox"/> Fainting<br><input type="checkbox"/> Disorientation<br><input type="checkbox"/> None |
| <b>PSYCHIATRIC</b><br><input type="checkbox"/> Anxiety<br><input type="checkbox"/> Excessive Stress<br><input type="checkbox"/> Panic Attacks<br><input type="checkbox"/> Depression<br><input type="checkbox"/> None | <b>ENDOCRINE</b><br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Thyroid Problems<br><input type="checkbox"/> Excessive Urination<br><input type="checkbox"/> None     |                                                                                                                                                                                                                 |                                                                                                                                                                           |



## Notice of Privacy Practices

### Cumberland Valley ENT Consultants

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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.**

#### **Your Rights**

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

#### **You have the right to:**

##### **Get an electronic or paper copy of your medical record**

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

##### **Ask us to correct your medical record**

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

##### **Request confidential communications**

- You can ask us to contact you in a specific way about your medical information (for example, home or office phone) or to send your medical information to a different address.
- We will say, “yes” to all reasonable requests.

##### **Ask us to limit what we use or share**

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or healthcare item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

##### **Get a list of those with whom we’ve shared information**

- You can ask for a list (accounting) of the times we’ve shared (disclosed) your health information, for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and healthcare operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

##### **Get a copy of this privacy notice**

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

##### **Choose someone to act for you**

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

##### **File a complaint if you feel your rights are violated**

You can file a complaint with us if you feel we have violated your rights by contacting our Privacy Officer.

- To file a complaint with our organization, please submit your request in writing to the Privacy Officer (**Sundae Meyer**), (11110 Medical Campus Rd, Suite 126, Hagerstown, MD 21742).
- You can file a complaint with the U.S. Department of Health and Human Services’ Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, by calling 877-696-6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/)
- We will not retaliate against you for filing a complaint.

##### **Your Choices**

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, contact us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

*If you are not able to tell us your preference - for example, if you are unconscious, we may share your information if we believe it is in your best interest to do so. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these following cases, we **never** share your information unless you give us written permission:

- Marketing purposes
- Sale of your protected health information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again. We will honor your request to not contact you again.

#### **Our Uses and Disclosures**

**We typically use or share your health information in the following ways:**

##### **Treatment**

We can use your health information and share it with other professionals who are treating you.

*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

##### **Run our organization**

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

*Example: We use health information about you to manage your treatment and services.*

##### **Bill for your services**

We can use and share your health information to bill and get payment from health plans or other entities.

*Example: We give information about you to your health insurance plan so it will pay for your services.*

#### **How else can we use or share your health information?**

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research.

We have to meet many conditions in the law before we can share your information for these purposes.

#### **Help with public health and safety issues**

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

#### **Do research**

We can use or share your information for health research.

#### **Comply with the law**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

#### **Respond to organ and tissue donation requests**

We can share health information about you with organ procurement organizations.

#### **Work with a medical examiner or funeral director**

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

#### **Address workers' compensation, law enforcement, and other government requests**

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

#### **Respond to lawsuits and legal actions**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

#### **Our Responsibilities**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

- **We will never share any substance abuse treatment records without your written permission.**

#### **Changes to the Terms of this Notice**

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our website, or we can mail a copy to you.

# CUMBERLAND VALLEY ENT CONSULTANTS AND/OR HEARING CARE CENTER

## HIPAA Compliant Information Form

Date \_\_\_\_\_ (Please complete front & back, and sign form)

For Office Use Only

Chart # \_\_\_\_\_

Doctor \_\_\_\_\_

Updated \_\_\_\_\_

Initials \_\_\_\_\_

Please PRINT clearly

### PATIENT INFORMATION

Name (Last): \_\_\_\_\_ (First): \_\_\_\_\_ (MI): \_\_\_\_\_

Sex: \_\_\_ M \_\_\_ F Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ SS #: \_\_\_\_\_

Marital Status: S \_\_\_ M \_\_\_ Other \_\_\_\_\_ P.O. Box: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Billing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Please share your email address. Patient/Guardian email address is: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Address: \_\_\_\_\_

Family Doctor (Full Name): \_\_\_\_\_ Referring Doctor (Full Name): \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Please list an alternate person to whom we may release medical information if you are unable to be reached. (Example: spouse, parent, etc.)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

### INFORMATION REQUIRED BY THE FEDERAL GOVERNMENT

Preferred Language: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Race:

\_\_\_ American Indian or Alaska Native \_\_\_ Asian \_\_\_ Black or African American

\_\_\_ More than one race \_\_\_ Native Hawaiian \_\_\_ Other Pacific Islander

\_\_\_ White \_\_\_ Refuse to report

Ethnicity:

\_\_\_ Hispanic or Latino \_\_\_ Not Hispanic or Latino \_\_\_ Refuse to Report

### PARENT / LEGAL GUARDIAN (For children under age 18)

Name (Last): \_\_\_\_\_ (First): \_\_\_\_\_ (MI): \_\_\_\_\_

P.O. Box: \_\_\_\_\_ Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Legal Custodian: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**\*Please provide us with a copy of legal documentation\***

The person(s) listed above are authorized to receive medical information for this patient: YES or NO (Please Circle)

**\*\*\*Note: The parent who brings a child to the office for medical treatment is responsible AT THE TIME OF SERVICE for co-payment, deductibles, and account balances. If our provider is not a participating provider with your insurance company, payment in full is required at the time of service.**

See Reverse Side →

**CUMBERLAND VALLEY ENT CONSULTANTS AND/OR  
HEARING CARE CENTER**

**HIPAA Compliant Information Form**

Page 2

For Office Use Only  
Chart # \_\_\_\_\_  
Doctor \_\_\_\_\_  
Updated \_\_\_\_\_  
Initials \_\_\_\_\_

**Patient Name** \_\_\_\_\_ **Date** \_\_\_\_\_

**POWER OF ATTORNEY (For Adults) (If Applicable)**

Name (Last): \_\_\_\_\_ (First): \_\_\_\_\_ (MI): \_\_\_\_\_  
P.O. Box: \_\_\_\_\_ Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Relation to patient: \_\_\_\_\_ **\*Please provide us with a copy of legal documentation\***

**PRIMARY INSURANCE INFORMATION**

Insurance Company: \_\_\_\_\_ Effective Date: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Subscriber's Name: \_\_\_\_\_ Sex: \_\_\_M\_\_\_F Subscriber's Date of Birth: \_\_\_\_\_  
(First) (MI) (Last)  
Subscriber's SS #: \_\_\_\_\_ Patient's Relationship to Subscriber: \_\_\_\_\_  
Subscriber's Employer: \_\_\_\_\_ Employer's Phone #: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION**

Insurance Company: \_\_\_\_\_ Effective Date: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Subscriber's Name: \_\_\_\_\_ Sex: \_\_\_M\_\_\_F Subscriber's Date of Birth: \_\_\_\_\_  
(First) (MI) (Last)  
Subscriber's SS #: \_\_\_\_\_ Patient's Relationship to Subscriber: \_\_\_\_\_  
Subscriber's Employer: \_\_\_\_\_ Employer's Phone #: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_

**\*Please inform us if you have a third insurance.**

If this is Workers' Comp. or accident related, please inform us and provide us with the proper paperwork.

Date of Injury: \_\_\_\_\_ Insurance Company: \_\_\_\_\_  
Contact Person: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Claim Number: \_\_\_\_\_

I certify that the information on this form is current and accurate to the best of my knowledge.

(SEAL) \_\_\_\_\_  
Signature of Patient/Parent/Guardian Relationship Date

CUMBERLAND VALLEY ENT CONSULTANTS  
HEARING CARE CENTER  
11110 Medical Campus Road, Suite 126  
Hagerstown, MD 21742  
301-714-4375

For Office Use Only

Chart# \_\_\_\_\_  
Updated \_\_\_\_\_  
Initials \_\_\_\_\_

**FINANCIAL AGREEMENT, AUTHORIZATION FOR TREATMENT  
AND NOTICE OF PRIVACY PRACTICES' RECEIPT**

- Patient is responsible for payment at the time of service when: **1)** patient is a self-pay; **2)** patient has a nonparticipating insurance company; or **3)** patient has an HMO and comes without the referral specified by the insurance company.
- We file all claims to insurance companies in which we participate. You may use the fee ticket to file your insurance claims when we do not participate with your insurance company.
- There is a \$5.00 charge for replacement of a lost receipt
- Patient is responsible for any service that is not covered by his/her insurance as well as any co-pays, deductibles, and co-insurance.
- As part of your routine ENT exam, we may perform some common procedures on you. These may include hearing tests and an examination of the nose, sinuses or throat with various telescopes. An important part of your entire ENT exam, these tests and procedures aid your doctor in determining the proper treatment for your condition. Based on the contract you have with your insurance company, the endoscopic procedures may be categorized as surgical procedures even though they are part of your exam. Patient is responsible to contact insurance company with questions regarding benefits and co-payment obligations for office surgical procedures.
- **Copays are due at the time of service.**
- It is the patient's responsibility to provide our office with a written referral when required by his/her insurance plan.
- Patient is responsible to make sure laboratory studies, x-rays, scans, pre and post-operative testing are performed at a facility participating with patient's insurance.
- I agree to pay all charges promptly.
- A \$35 returned-check fee will be assessed to the patient's account for each check returned to our office for non-sufficient funds
- If my account is assigned to a collection agency, I agree to pay a 25% collection agency fee, court costs and attorney fees.

I hereby authorize Cumberland Valley ENT Consultants to furnish information, including records from other health care providers, to my insurance company, authorized agency, or health care provider specified concerning my medical care. I agree to pay all charges promptly upon presentation thereof. I hereby assign and transfer any medical benefits due me to Cumberland Valley ENT Consultants for the services provided to me by this medical practice. I permit a copy of this authorization to be used in place of the original. Regulations pertaining to Medicare Assignment of Benefits apply, as applicable. I acknowledge the information I have supplied is correct.

I hereby authorize Cumberland Valley ENT Consultants to treat me as needed. Also, I acknowledge receipt of the Notice of Privacy Practices.

\_\_\_\_\_  
Date (SEAL) \_\_\_\_\_  
Signature

I, parent or legal guardian, do hereby authorize Cumberland Valley ENT Consultants to treat \_\_\_\_\_, being \_\_\_\_\_ years of age and a minor. I understand that I am fully responsible for this minor's medical charges and agree to pay all charges for services rendered by the above-named medical practice. Also, I acknowledge receipt of the Notice of Privacy Practices.

\_\_\_\_\_  
Date (SEAL) \_\_\_\_\_  
Signature  
(Parent or Legal Guardian)

\_\_\_\_\_  
Printed name of parent or guardian Relationship to patient