GREGORY A. HOGLE, D.O.
COLUMBINE OTOLARYNGOLOGY • HEAD AND NECK SURGERY

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# PATIENT REFERRAL WAIVER AGREEMENT

**** This may or may not apply to your insurance. It is your responsibility to know your insurance. ****

Because Dr. Hogle is a ***specialist***, some insurance policies require an authorization for your Primary Care Physician (PCP) to refer you. If your insurance policy requires authorized referrals, we need an authorization number and have a copy of the referral form mailed or faxed to this office prior to your appointment(s). If we do not have a copy of the referral form or you did not bring a copy with you, the following options are available:

1. You may call your insurance company to obtain the authorization number.
2. You may reschedule this appointment and bring your copy of the referral form or the authorization number with you to the next appointment.
3. You may keep this appointment today without either of the above but understand that your insurance company **MAY NOT PAY** for the charges related to your visit(s).
4. You understand that if you choose Option #3 and your insurance does not pay for your visit(s), you will be responsible for payment of **ALL CHARGES** related to that visit(s).

# APPOINTMENT CANCELLATION POLICIES

**OFFICE APPOINTMENTS:**

It is important, not only to you but to our office and other patients, that you keep your appointments with us and are on time. If you are unable to keep an office appointment at any time, we ask that you kindly give us a 24-hour notice. We do understand that it is not always possible, and we do understand busy schedules. However, there will be a $50 fee to patients who do not call and cancel. *This fee is not billable to insurance.*

Patients who arrive late to an appointment may be asked to reschedule. Habitual late and/or missed appointments may result in discontinuation of Dr. Hogle's services.

**SURGERY APPOINTMENTS:**

Surgery scheduling is very time consuming for our staff. Patients who cancel scheduled surgeries within five (5) days of a scheduled surgery will be assessed a cancellation fee of 10% of Dr. Hogle's total surgical fee or $100, whichever is higher. Surgical fees vary depending on the extent and complexity of the surgery. *This fee is not billable to insurance. This fee will not apply if our office cancels your surgery for any reason.*

_____
Printed Name

_____ _____
Signature of Patient or Authorized Representative Date

# Columbine Otolaryngology
## Patient Information

| | | | | |
|---|---|---|---|---|
| **Last Name** | **First Name** | | **MI** | **Nickname:** |
| **Date of Birth** _____/_____/_____ | **Age** | ❑ Male ❑ Female | **Circle title:** Mr. Mrs. Ms. Miss Dr. | **Social Security # (for insurance verification)** |
| **Home #** (_____)_____ | **Mobile #** (_____)_____ | | **Work #** (_____)_____Ext_____ | |
| **Street Address** | **Apt./Unit #** | **City** | **State** | **Zip** |
| **Mailing Address (if different)** | **Apt./Unit #** | **City** | **State** | **Zip** |
| **Marital Status:** ❑ Married ❑ Not Married | **Spouse(S)/Partner(P)/Significant Other(SO) Name** | **S/P/SO Birth Date** | **S/P/SO Phone #** (_____)_____ | |
| **Email Address (please print legibly):** | | **Your Preferred Pharmacy: (include street & city OR phone)** | | |
| **Race 1:** ❑ African American/Black ❑ Caucasian/White ❑ Decline ❑ American Indian/Alaskan ❑ Other Race | | **Ethnicity:** ❑ Hispanic or Latino ❑ Decline ❑ Not Hispanic or Latino | | |
| **Employment:** ❑ Employed Full Time ❑ Retired ❑ Employed Part Time ❑ Unemployed ❑ Student | **Occupation** | **Who referred you to us?** ❑ PCP ❑ Insurance ❑ Internet ❑ Family/Friend ❑ _____ | | |
| **Who is your Primary Care Physician (PCP)?** | **PCP Address & Phone:** | **List other family members seen here** | | |
| **May we leave a message or lab results (check each applicable #)?** ❑ Home ❑ Mobile ❑ Work ❑ S/P/SO #:_____ ❑ Other Person: _____Phone # (_____)_____ | | | | |
| **In case of emergency, notify:** | | | | |
| **Name** | **Phone #** (_____)_____ | **Relationship to Patient** | | |
| **Minor Patients:** | | | | |
| **Parent/Guardian Name** | **Date of Birth** | **Phone #** (_____)_____ | | |

**Payment**

- ❑ I am a Self-Pay patient and I will pay cash/check/credit card at the time of service.
- ❑ I will have you bill my insurance and pay my co-pay at the time of service.

  I/we hereby authorize payment directly to Dr. Hogle's office of the group benefits otherwise payable by me. The estimate provided by this office is considered as a guideline until the insurance payment has been received. I understand that this office can make no guarantee of the insurance payment as estimated and that I am responsible for all costs of medical treatment. I also understand that if this office is not paid by my insurance company by the 61st day after treatment, or if I provide incorrect insurance information, I will be billed in full.

**Privacy Notice**

I have been given a copy of the Notice of Privacy Practices in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

**Collection/NSF Checks**

- There will be a $25.00 handling fee for any returned checks.
- In the case of default of payment (90+ days past due), an additional fee of $75 will be added to the account balance.

I have read, understand, and agree to all of the above information.

_____ Date_____

Patient Signature (Parent or Guardian if minor patient)

**Columbine Otolaryngology**
**Patient History Form**
(Please complete each line)

Name _____ DOB _____Date_____

Height _____ Weight _____ Age _____

Reason for today's visit?_____

Date of injury or accident _____ Worker's Comp _____ Auto _____

Other _____

Have you had any other treatment for this problem? ❑ Yes ❑ No If yes, please explain

_____

_____

Last flu vaccine (mo./yr.) _____/_____ Last pneumonia vaccine (mo./yr.) _____/_____

**Advanced Care Plan**: If age 65+, I have an Advanced Care Plan ❑ Yes ❑ No
If Yes, name of surrogate decision maker: _____

**Past/Current Medical History (please check all that apply)**

**Cardiovascular** ❒ None

❑ heart attack
❑ coronary artery disease
❑ blood clot
❑ stroke
❑ TIA (transient ischemic attack)
❑ high blood pressure
❑ brain aneurysm
❑ aortic aneurysm
❑ valve disease: mitral
❑ valve disease: aortic
❑ cardiac septal defect
❑ high cholesterol
❑ other: _____

**Blood Disease** ❒ None

❑ anemia
❑ low white blood cells
❑ low blood platelets
❑ abnormal red blood cell: thalassemia
❑ abnormal red blood cell: sickle cell
❑ bleeding problems
❑ clotting disorder
❑ other _____

**Chest** ❒ None

❑ pneumonia
❑ asthma
❑ emphysema
❑ COPD
❑ chronic bronchitis
❑ bronchospasm
❑ sarcoid
❑ pulmonary embolism (clot in lung)
❑ tuberculosis
❑ other: _____

**Gastrointestinal/Abdominal Disease** ❒ None

❑ heartburn
❑ GERD
❑ stomach ulcers
❑ esophagitis
❑ colitis, Crohn's disease
❑ bowel obstruction
❑ irritable bowel syndrome
❑ hepatitis A
❑ hepatitis B
❑ hepatitis C
❑ cirrhosis
❑ gall stones
❑ gastric bleeding
❑ intestinal bleeding
❑ kidney stones
❑ renal insufficiency
❑ renal failure
❑ pancreatitis
❑ liver insufficiency
❑ liver failure
❑ other _____

## Connective Tissue/Rheumatology Disorder

❒ None

❒ osteoarthritis
❒ rheumatoid arthritis
❑ lupus
❑ neurofibromatosis
❑ scleroderma
❑ other: _____

## Neurologic Disease

❒ None

❑ seizure disorder / convulsions
❑ multiple sclerosis
❑ brain aneurysm
❑ migraine
❑ Alzheimer's disease
❑ ALS (Lou Gehrig's disease)
❑ Depression or mental health issues_____
❑ other _____

## Malignant Disease (cancer)

❒ None

❑ skin: basal cell (common skin cancer)
❑ skin: squamous cell
❑ skin: melanoma_____
❑ lung _____
❑ laryngeal
❑ thyroid
❑ salivary gland
❑ other head/neck cancer: _____
❑ breast
❑ ovarian, uterine, cervical
❑ esophagus
❑ other _____
❑ stomach
❑ colon
❑ rectal
❑ brain _____
❑ renal: kidney
❑ renal: bladder
❑ lymphoma _____
❑ prostate
❑ leukemia____

## Infectious Disease

❒ None

❑ meningitis
❑ malaria
❑ HIV
❑ immune deficiency
❑ other _____
❑ sexually transmitted disease (STD):
  ❑ herpes
  ❑ HPV
  ❑ other _____

## Endocrine Disease

❒ None

❑ hyperthyroid
❑ hypothyroid
❑ hyperparathyroid
❑ hypoparathyroid
❑ other _____
❑ pituitary disorder
❑ adrenal disorder
❑ diabetes, Type I
❑ diabetes, Type II

## Head & Neck

❒ None

- ❒ chronic ear infection
- ❒ chronic mastoid infection
- ❒ chronic sinusitis
- ❒ nasal/sinus polyps
- ❒ seasonal allergic rhinitis
- ❒ salivary gland tumor
- ❒ congenital cyst of neck/in front of ear
- ❒ obstructive sleep apnea (OSA)
- ❒ vocal fold nodule /polyp
- ❒ vocal fold paralysis
- ❒ thyroid nodule(s)
- ❒ other: _____

## Past Surgical History

❒ None

| Surgery Type | Surgery Description | Year |
|---|---|---|
| ❒ ear, mastoid | | |
| ❒ nasal | | |
| ❒ sinus | | |
| ❒ removal of tonsils & adenoids | | |
| ❒ tonsillectomy only | | |
| ❒ adenoidectomy only | | |
| ❒ palate surgery | | |
| ❒ larynx (voice box) | | |
| ❒ tracheostomy | | |
| ❒ eye | | |
| ❒ lung | | |
| ❒ heart | | |
| ❒ vascular | | |
| ❒ GI, bowel, appendix | | |
| ❒ hysterectomy, removal ovary(ies) | | |
| ❒ prostate | | |
| ❒ kidney | | |
| ❒ spine/disc | | |
| ❒ bone, joint | | |
| ❒ brain | | |
| ❒ other | | |

## Current Medications

❒ None

Please include all medications which you take regularly and occasionally (include vitamins, supplements, herbs, pain medications, birth control)

| Medication | Dose | Frequency | | For Treatment of: |
|---|---|---|---|---|
| | | # Times | daily/weekly | |
| | | | | |
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Are you pregnant? ❑ Yes ❑ No ❑ N/A  Are you trying to get pregnant? ❑ Yes ❑ No ❑ N/A

## Social History

Do you currently smoke cigarettes? ❑ Yes ❑ No ❑ Never smoked
How many packs a day? _____
Age started? _____

Have you quit smoking cigarettes? When? _____ (**Congratulations !)**
How many packs a day? _____
Age started? _____
Age stopped? _____

Have you chewed tobacco? ❑ Yes ❑ No
❑ Never
❑ Former
❑ Current
How many cans per day?_____
Age started? _____
Age stopped? _____

Do you drink alcoholic beverages? ❑ Former ❑ Yes ❑ No
Average drinks per week _____

Have you used "street" drugs? ❑ Yes ❑ No
Type _____
Quantity:_____
Age started:_____
Age stopped:_____

Have you ever taken steroids? ❑ Yes ❑ No
When?_____
Reason _____

## Family History:

❒ None

Medical problems of parents/brothers/sisters, such as cancer, heart disease, arthritis, high blood pressure, diabetes, bleeding problems, trouble with anesthesia:

| **Relative** (mother, father, etc.) | **Medical Problem** | **Onset Age** |
|---|---|---|
| | | |
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## Drug/Food Allergies (please circle ALL reactions that apply)

❒ None

**DRUGS:**

❑ Penicillin/Amoxicillin: (itching, rash/hives, breathing difficulty, facial swelling, nausea/GI upset)
❑ Sulfa: (itching, rash/hives, breathing difficulty, facial swelling, nausea/GI upset)
❑ Iodine: (itching, rash/hives, breathing difficulty, facial swelling, nausea/GI upset)
❑ Codeine: (itching, rash/hives, breathing difficulty, facial swelling, nausea/GI upset)
❑ _____ (itching, rash/hives, breathing difficulty, facial swelling, nausea/GI upset)
❑ _____ (itching, rash/hives, breathing difficulty, facial swelling, nausea/GI upset)

**FOODS:**

❑ Milk/dairy: (itching, rash/hives, breathing difficulty, facial swelling, nausea/GI upset)
❑ gluten (itching, rash/hives, breathing difficulty, facial swelling, nausea/GI upset)
❑ _____ (itching, rash/hives, breathing difficulty, facial swelling, nausea/GI upset)
❑ _____ (itching, rash/hives, breathing difficulty, facial swelling, nausea/GI upset)