



Jin S. Lim, M.D.

Diplomate of American Board of Otolaryngology

Gainesville Office
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8650 Sudley Road, Suite 303
Manassas, VA 20110

Telephone: (703) 468-2205

Fax: (703) 468-2216

EAR, NOSE & THROAT
ASSOCIATES

Patient Information (Adult)

PATIENT'S LEGAL NAME (Last, First, MI)		DATE OF BIRTH	SEX(M/F)
ADDRESS		SSN OR ID#	
CITY	STATE	ZIP	HOME PHONE
MARITAL STATUS	EMAIL		CELL PHONE
EMPLOYER	OCCUPATION		WORK PHONE
EMERGENCY CONTACT	EMERGENCY CONTACT PHONE #		EMERGENCY CONTACT RELATIONSHIP

Guarantor Information (person responsible for the bill)

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

Insurance Information

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

Patient Authorization

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

SIGNATURE _____

DATE _____



Ear, Nose & Throat Associates, PC

Jin S. Lim, MD

Rebecca M. Beckman, AuD

PATIENT HISTORY

Name: _____ Age: _____ Date of Birth: _____ Race: _____

Referring Physician: _____ Primary Care Physician: _____

Pharmacy of Choice (name & location): _____

Reason for your visit: _____

PLEASE ANSWER ALL QUESTIONS AS THOROUGHLY AS POSSIBLE

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

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

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

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

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

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

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

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

9. Any illicit drug use? Yes No Type _____

Patient Signature: _____

Date: _____



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Rebecca M. Beckman, AuD

REVIEW OF SYSTEMS

Name: _____

Date of Birth: _____

Are you experiencing any of the following?

<u>General</u>	<input type="checkbox"/> Pregnant	<input type="checkbox"/> Fever
<input type="checkbox"/> Chills/sweats	<input type="checkbox"/> Fatigue/malaise	<input type="checkbox"/> Sleep problems
<input type="checkbox"/> Weight gain	<input type="checkbox"/> Weight loss	<input type="checkbox"/> Hoarse voice
<input type="checkbox"/> Speech delay	<input type="checkbox"/> Unusual bleeding	

<u>Ears</u>	<input type="checkbox"/> Ear pain	<input type="checkbox"/> Hearing loss
<input type="checkbox"/> Tinnitus/ringing noise	<input type="checkbox"/> Ear fullness/pressure	<input type="checkbox"/> Ear itching
<input type="checkbox"/> Ear wax	<input type="checkbox"/> Ear drainage	

<u>Nose</u>	<input type="checkbox"/> Nasal obstruction	<input type="checkbox"/> Nasal congestion
<input type="checkbox"/> Runny nose	<input type="checkbox"/> Post nasal drip	<input type="checkbox"/> Nose bleed
<input type="checkbox"/> Facial pain	<input type="checkbox"/> Seasonal allergies	

<u>Throat</u>		
<input type="checkbox"/> Snoring	<input type="checkbox"/> Foreign body sensation	<input type="checkbox"/> Hoarseness
<input type="checkbox"/> Heartburn	<input type="checkbox"/> Throat pain/soreness	<input type="checkbox"/> Swallowing difficulty

<u>Skin</u>	<input type="checkbox"/> Suspicious lesions	<input type="checkbox"/> Excess scarring/keloids
<input type="checkbox"/> Rash	<input type="checkbox"/> Itching	<input type="checkbox"/> Ulcers/growths

<u>Allergy/Immunology</u>	<input type="checkbox"/> Eczema	
<input type="checkbox"/> Hives	<input type="checkbox"/> Hay fever	<input type="checkbox"/> HIV exposure

<u>Neurological</u>	<input type="checkbox"/> Numbness	<input type="checkbox"/> Muscle weakness/paralysis
<input type="checkbox"/> Headache	<input type="checkbox"/> Fainting/blackouts	<input type="checkbox"/> Seizures

<u>Balance/Vestibular</u>	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Vertigo
<input type="checkbox"/> Feeling lightheaded	<input type="checkbox"/> Imbalance but not vertigo	<input type="checkbox"/> Motion-provoked dizziness
<input type="checkbox"/> Dizziness that is positional	<input type="checkbox"/> Joint problem/arthritis	<input type="checkbox"/> Falling episodes

<u>Eyes</u>	<input type="checkbox"/> Eye pain	<input type="checkbox"/> Vision change
<input type="checkbox"/> Double vision	<input type="checkbox"/> Discharge	<input type="checkbox"/> Light sensitivity
<input type="checkbox"/> Itching/irritation	<input type="checkbox"/> Excessive tears	<input type="checkbox"/> Dry eyes

<u>Neck</u>		
<input type="checkbox"/> Lump/mass	<input type="checkbox"/> Thyroid problem	<input type="checkbox"/> Neck pain

<u>Respiratory</u>	<input type="checkbox"/> Cough (productive)	<input type="checkbox"/> Cough (dry)
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Sleep apnea	<input type="checkbox"/> Shortness of breath

Patient Signature _____ Date _____



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

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

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

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

AUTHORIZATION FORM FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

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

	<u>In Person</u>	<u>By Phone</u>
Spouse Name: _____	<input type="checkbox"/>	<input type="checkbox"/>
Parent(s) Name: _____	<input type="checkbox"/>	<input type="checkbox"/>
Sibling(s) Name: _____	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

(name) (relationship)

Expiration Date of Authorization: ___/___/___ OR until otherwise specified

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

(Printed name of Patient)	(Date)
(Signature of Patient or Patient’s Representative)	(Date)
(Printed Name of Patient’s Representative)	(Relationship)



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

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

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

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

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

Patient Name

Patient (or Representative) Signature

Date