Richmond Ear, Nose & Throat
www.RichmondENT.com

8700 Stony Point Parkway, Suite 110
Richmond, VA 23235
Tel: 804-330-5501
Fax: 804-272-4504

1800 Glenside Drive, Suite 120
Richmond, VA 23226
Tel: 804-288-8308
Fax: 804-249-7521

Welcome to Richmond Ear, Nose and Throat

We are delighted that you have chosen Richmond Ear, Nose and Throat (Richmond ENT) for your specialty care. Richmond ENT was founded in 2001 with a vision of becoming a premier subspecialty otolaryngology and facial plastic surgery practice. Originally incorporated as Advanced Otolaryngology, P.C., Richmond ENT has expanded to employ 4 physicians, 3 nurse practitioners, 2 audiologists, two hearing aid specialists, and a master esthetician.

We are committed to providing a level of service that exceeds your expectations. We schedule fewer patients per hour and try to spend more time with each patient so that we can better understand and explain your illness. We will provide you with our mobile telephone numbers so that you may contact us directly if you should have an emergency or feel that your questions were not fully answered during our office visit. We feel very blessed with the privilege of serving you and your family and pray that God may be glorified through the work that we do.

Instructions:

If you have not been seen this calendar year, please LOG IN to our patient portal to update or register on line and to ensure confidential access to your medical record. Print and sign pages 2-8 and bring these with you to your appointment. If you are unable to complete your registration on line, please print and complete all pages of this document before you leave home for your appointment, and arrive at least 15 minutes early, so that we can manually enter the data for you.

Don't forget:

- Insurance card
- Photo identification
- Referral, if required
- Cash, check or credit card
- Signed Patient Contract
- Signed Acknowledgement of Privacy Policy

Services we offer:

Richmond ENT – Ear, Nose & Throat	Richmond Sinus & Allergy – A Division of Richmond ENT	Richmond Skin & Laser – A Division of Richmond ENT	Richmond Facial Plastics – A Division of Richmond ENT	Richmond Hearing Aids – An Affiliate of Richmond ENT
Head/neck tumors	CT scans	Medical spa facials	Botox	Hearing Aid Fittings
Thyroid Surgery	Allergy tests	IPL Photofacials	Sculptra	Hearing Aid Repairs
Salivary Surgery	Nasal endoscopy	Tattoo Removal	Radiesse	0% Financing
Sleep apnea	Allergy shots/drops	Vein Removal	Face Lifts	45-day Returns
Tonsillectomy	Balloon Sinuplasty	Hair Removal	Nasal Surgery	3 year warranty
Ear Tubes	Sinus surgery	CO2 laser	Eyelid Surgery	Free batteries

Patient Contract

Consent to Treat

You authorize the physicians, nurse practitioners, audiologists and staff of Richmond ENT to render treatment to you or your dependent. You understand that medicine is not an exact science and that no warrantee can be given for any evaluation, diagnosis, treatment, or surgery. All medical and surgical treatments include risks. These risks include, but are not limited to, incorrect or missed diagnoses, improper treatments, unexpected drug reactions, and complications from surgery or anesthesia. We will do our best to inform you of specific risks whenever we feel that a reasonably prudent person would want to know those risks prior to making a choice. You are free to accept or reject any treatment plan offered by us. You hold us harmless from any liability arising out of your care.

Assignment of Benefits

It is YOUR RESPONSIBILITY to be familiar with all aspects of your insurance coverage and to follow all requirements of your coverage for maximum benefit.

By signing below, you authorize Advanced Otolaryngology, P.C. (doing business as Richmond ENT) to submit charges directly to your insurance companies and you authorize your insurance companies to make payments directly to Advanced Otolaryngology, P.C. You authorize release of medical information to the insurance companies so that the insurance company can verify that services were provided and that the services were medically necessary and appropriate under insurance company guidelines. You further authorize the exchange of medical records between Advanced Otolaryngology, P.C. and any referring or consulting physicians involved in your care.

Guarantee of Payment

You, as patient, parent, or guardian are personally responsible for guaranteeing payment for any healthcare services or products provided by Advanced Otolaryngology, P.C., doing business as Richmond ENT, Richmond Sinus and Allergy, Richmond Facial Plastics, or Richmond Skin and Laser. We will file insurance claim forms for participating plans if you provide us with accurate information in a timely manner. If you do not have required referrals, or we are outside your network of providers, you will be responsible for the entire bill and you may submit your own claims to the insurance company for reimbursement. If payment is denied because you are not covered under the plan, then you will be responsible for the entire balance.

HMO Patients Require a Referral

If your insurance plan requires a referral before seeing a specialist, and if you are seen without a referral, your insurance company will deny the claim and you will be responsible for the entire fee. It is your responsibility to make sure that the referral process has been completed prior to your arrival at our office. Insurance companies will not issue referrals after the service has been received. If you feel that there has been an error in their processing of a claim, it is YOUR responsibility to contact your insurance company and your primary care physician to rectify this.

Non-Participating Provider

We participate with most Richmond insurance networks. We are delighted to see patients out of network, and will be happy to help you in filing your own insurance claim forms. You will be responsible for paying in full at the time of service and you may file with your insurance company for possible reimbursement under your out-of-network guidelines. Please check with your insurance company so that you understand your benefits outside of network providers. . If you have been seen in the emergency room and need continued outpatient management, it is your responsibility to make sure that we are on your list of preferred providers.

Non-Covered Services

Insurance companies do not pay for services that they consider cosmetic, investigational or otherwise not medically necessary for your health. Sublingual immunotherapy (allergy drops),the treatment of uncomplicated snoring, and any medical or surgical service that is intended purely to improve appearance of normally functioning body parts or to reverse the appearance of aging are NOT COVERED BY YOUR INSURANCE. Examples of common cosmetic procedures include botulinum toxin, Belotero, Radiesse, Sculptra, liposuction, facials, chemical peels, laser treatments, facelifts, eyelids, facial implants, earlobe repair and most rhinoplasties. These services will not be billed to the insurance company and payment is expected at or before delivery of the product or service. Other procedures may be excluded by the plan if they are considered experimental, of unproven benefit or not medically necessary under insurance guidelines. Occasionally rhinoplasty procedures are medically necessary. Procedures related to obstructive sleep apnea are usually covered, but uncomplicated snoring is not covered. Balloon Sinuplasty is considered investigational by Anthem BC/BS. We will do our best to determine in advance whether your insurance will cover certain services. If we fail to inform you in advance that a treatment is likely to be denied, then we will not hold you accountable for our charges. The following procedures are considered NOT MEDICALLY NECESSARY, and are not covered by any plan:

- Cosmetic procedures (not medically necessary)
- Snoring without obstruction (not medically necessary)
- Allergy drops (considered investigational)

Collection Policies

Payment is due at the time of service. If you have an outstanding balance on a return visit, you are expected to settle that balance before you are seen. There is a $50 charge for returned checks. Statements are mailed monthly for outstanding balances. If the balance due is not paid within 30 days, you agree that you will pay a 1.5% finance fee per month (annual interest rate 19.6%). If the balance due is not paid within 90 days, your account will be turned over to our collection attorney and you agree to pay attorney's fees of 25% of the amount then due plus any court costs incurred for collection of the past due balance. Short-term financing can be arranged through a bank upon request. Charity discounts are granted cheerfully upon proven financial need. Please speak to our billing manager immediately if you anticipate a financial hardship. For any form that needs to be completed and signed by a provider will incur a $25 fee to be paid upon request of the form.

Appointment Times

It is important that you arrive in sufficient time to update your patient information and be prepared for your office visit at the appointed time. If you arrive late, we will have to reschedule your appointment or work you in later in the day to avoid inconveniencing other patients who arrive on time. If you are a new patient or have new insurance information, you should allow at least 15 minutes to complete registration prior to your appointment. If you have preregistered online, or if you have been seen in the last year and have no insurance changes, you should arrive approximately 5 minutes prior to your appointment time. We recognize that our providers cannot guarantee to see every patient on time due to medical emergencies and our inability to accurately predict the complexity of each patient's office visit. We have found, however, that our providers often run behind because a previous patient arrived late. We apologize if you are kept waiting for your appointment, but we assure you that we will provide the same conscientious service to you that we provided the previous patient.

If you are more than 15 minutes late, expect to be rescheduled. If you are more than 30 minutes late, you will be charged a $25 cancellation fee. If you must reschedule, please call at least one business day in advance to avoid the $25 cancellation fee.

Consent for Chart Review

In a continuing effort to improve quality of care, Advanced Otolaryngology, P.C. may periodically review your or your dependent's medical record to evaluate the outcome of certain treatments. We may telephone you to see how you or your dependent is doing. This information may be entered into a computerized database for research purposes. Neither you nor your dependent will be identified in any publications resulting from this research, without your specific signed permission. The care that you receive will not be affected by your decision to participate or not to

participate in this research. Should you decide you do not wish to participate, please list this restriction on the Release of Protected Health Information (Page 8).

Privacy of Protected Health Information

Richmond ENT and Richmond Hearings Aids create and maintain health records regarding each visit or other important communications. This information is used to plan your care and treatment as well as to communicate among other health professionals involved in your care. This information may also be required to verify to your insurance company that billed services were actually provided. We will not share protected health information with anyone else except for you or the loved ones that you so choose. For more information, see the following Notice of Privacy Practices.

Notice of financial interest

Richmond Hearing Aids (RHA) is an affiliated retail company that provides hearing aid services within the Richmond ENT office suite. Richmond Hearing Aids is owned and operated by the physicians at Richmond ENT. RHA contracts with Richmond ENT for office space and employees. For your privacy, each company maintains separate medical records. If you are a patient of Richmond ENT and also a customer of Richmond Hearing Aids, your provider will have access to both records when necessary for diagnosis, treatment or other operations related to your health care. Hearing aids are available elsewhere in the community, and we will be happy to coordinate care with any dispenser of your choosing.

Dr. Armstrong is also an investor in Medarva Stony Point Surgery Center ("SPSC"). Surgical services are also available at other facilities in the community.

By signing below, you indicate that you understand and agree to the policies in this document

_____ _____

Patient, Parent, or Guardian Signature Date

M. Armstrong, Jr. M.D. October 1, 2016

Michael Armstrong, Jr., M.D.
President, Richmond Hearing Aids, Inc.
President, Advanced Otolaryngology, P.C.
Doing business as Richmond ENT, Richmond Sinus and Allergy, Richmond Facial Plastics, and Richmond Skin and Laser

Notice of Privacy Practices

Advanced Otolaryngology P.C., doing business as Richmond ENT, and its affiliate Richmond Hearing Aids, Inc. are dedicated to maintaining the privacy of your medical information.

We May Use and Disclose Your Medical Information in the following ways:

The following categories describe the different ways in which we may use and disclose your medical information. Except for the purposes described below, we will use and disclose Health Information only with your permission. You may revoke such permission at any time by writing to our practice manager

Treatment: We can use your health information and share it with other professionals who are treating you. For example, a doctor treating you for an injury asks another doctor about your overall health condition.

Bill for your services: We can use and share your health information to bill and get payment from health plans or other entities. For example, we give information about you to your health insurance plan so it will pay for your services.

Run our organization: We can use and share your health information to run our practice, improve your care, and contact you when necessary. For example, we use health information about you to manage your treatment and services.

Other Uses and Disclosures of Your Medical 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. We can share health information about you for certain situations such as:

Help with public health and safety issues:

- 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:

- 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:

- In response to a court or administrative order
- 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. You may change your mind at any time. Let us know in writing if you change your mind.

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 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.
• 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 (for example, home or office phone) or to send mail to a different address. We will comply with all reasonable requests.
Get a list of those with whom we’ve shared information:
• You can ask for a list (accounting) of the times we’ve shared your health information for 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 health care 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
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 health care 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 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 complain if you feel we have violated your rights by contacting us using the information on this page.
• We will not retaliate against you for filing a complaint.
• 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 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

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, talk to 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
• Include your information in a hospital directory

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

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

• Marketing purposes
• Sale of your 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.

Changes to 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, in our office, and on our web site.

For questions about this notice, contact:

Rose M. Guthrie, Practice Manager

1-804-330-5501 x 318

For more information and a short video explaining your rights, see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Release of Protected Health Information

With whom may we discuss your care or share your medical records?

Richmond ENT maintains a web-based portal for secure transmission of your confidential health information. We strongly recommend that you contact us only through the web portal. Should you choose to contact us through a cellular phone or email account, be aware that these methods are not as private as you may think, and may be read or overheard by others. Please indicate below if you would like us to communicate confidential health information in the following ways:

- Home voice mail ☐Y ☐ N
- Personal email ☐Y ☐ N
- Mobile voice mail ☐Y ☐ N
- Mobile text message ☐Y ☐ N

Additional Contact Information (optional):

1) Name: _____ Phone: _____

   Relationship: _____ Email: _____
   - This contact is a parent, guardian or has power of attorney for healthcare: ☐Y ☐ N
   - Confidential health information may be discussed with this person: ☐Y ☐ N
   - Confidential health messages may be left on this phone or Email: ☐Y ☐ N

2) Name: _____ Phone: _____

   Relationship: _____ Email: _____
   - This contact is a parent, guardian or has power of attorney for healthcare: ☐Y ☐ N
   - Confidential health information may be discussed with this person: ☐Y ☐ N
   - Confidential health messages may be left on this phone or Email: ☐Y ☐ N

Acknowledgment of Privacy Policy

You have been given the opportunity to read our Notice of Privacy Practices. By signing below, you authorize us to request your confidential health information from any physician, nurse practitioner, pharmacy, audiologist, laboratory, radiology, pathology, hospital, or other medical facility in order to coordinate your care. You agree that we may share your confidential health information with your insurance company, physician, nurse practitioner, pharmacy, audiologist, laboratory, radiology, pathology, hospital, or other medical facility, as necessary to coordinate your treatment, obtain payment or carry out ordinary business operations related to your care. If there are any of these medical professionals from whom you wish to REQUEST or WITHHOLD specific medical information, please describe:

REQUEST or WITHHOLD information from: _____

_____

_____ _____ _____

Patient's full Name Patient, Parent, or Guardian Signature Date

M. Armstrong, Jr. M.D. October 1, 2016

Michael Armstrong, Jr., M.D.
President, Richmond Hearing Aids, Inc.
President, Advanced Otolaryngology, P.C.
Doing business as Richmond ENT, Richmond Sinus and Allergy,
Richmond Facial Plastics, and Richmond Skin and Laser

Personal Information

Patient Name: _____ SS#: _____ Date of birth: ___/___/___

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____Work Phone: _____ Mobile Phone: _____

Personal Email: _____ Preferred Language: ___ English ___ Other: _____

Check all that apply: [ ] Male [ ] Female [ ] Married [ ] Single [ ] Widowed

[ ] White/Caucasian [ ] Black/African-American [ ] Hispanic/Latino [ ] Native American [ ] Asian

[ ] Employed [ ] Unemployed [ ] Disabled [ ] Retired [ ] Student [ ] Homemaker [ ] Other: _____

School / Employer: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Insurance Information

First Insurance Co.: _____ Phone Number: _____

Insurance ID#: _____Group Number: _____

Guarantor/Subscriber's Name: _____ SS#: _____Date of birth: ___/___/___
Relationship to insured: [ ] self [ ] parent [ ] spouse [ ] other:

Second Insurance Co.: _____Phone Number: _____

Insurance ID#: _____Group Number: _____

Guarantor/Subscriber's Name: _____ SS#: _____Date of birth: ___/___/___
Relationship to insured: [ ] self [ ] parent [ ] spouse [ ] other:

1) Referring Doctor: _____ Phone: _____

   Address: _____ Fax: _____
   Did this physician request that you obtain our opinion? Yes / No

2) Primary Doctor: _____ Phone: _____

   Address: _____ Fax: _____

_____ _____ _____
Patient's full Name Patient, Parent, or Guardian Signature Date

New Patient Medical History

Patient's full name: _____ Birth date: _____ Today's date: _____

Please circle any recent medical problems:

Allergies or asthma	Anesthesia problems	Acid Reflux	FAMILY HISTORY:
Cosmetic concerns	Chronic illnesses	Liver disease	
Hearing loss or ringing	Cancer	Kidney disease	Anesthesia difficulty
Dizziness or vertigo	Hospitalization	Joint pain or arthritis	Allergies or asthma
Ear pain or drainage	Skin problems	Pregnancy	Diabetes
Nasal congestion	Headaches or migraine	Breastfeeding	Heart disease
Nasal drainage	Glaucoma or cataracts	Diabetes	High blood pressure
Sinus pain or pressure	Neck pain or swelling	Thyroid	Bleeding or hemophilia
Mouth or lip sores	Swollen glands	Stroke or seizure	Hearing loss
Sore throat or tonsillitis	Difficulty breathing	Anxiety or depression	Tobacco use in home
Snoring or sleep apnea	High blood pressure	Hepatitis or HIV	Throat Cancer
Hoarseness	Heart disease	Bleeding or bruising	
Swallowing difficulty	Chest pain	Blood thinners	

Other Past Medical and Surgical History: Specify the date and treating physician if known.

_____ _____ _____
_____ _____ _____
_____ _____ _____

Medications: [_] (See attached list)
Please list all current medications, contraceptives, vitamins and herbal supplements.

_____ _____ _____
_____ _____ _____
_____ _____ _____

Drug Allergies – please describe reaction

_____ _____
_____ _____

Social History (circle all that apply):

Habits	Activities:	Home Support	Spiritual Support
Never Smoker	Student	Single	Christian
Occasional smoker	Homemaker	Married	Jewish
Current smoker	Occupation:	Live with family	Muslim
Former smoker	Unemployed	Live roommates	Hindu
Other tobacco:	Exercise:	Live alone	Other:
Other drug use:	Hobbies:	Other:	Unsure

What is the **main** reason for today's visit? _____

Who is your primary doctor? _____ Who may we thank for this referral? _____

What is your preferred pharmacy? _____ Location of pharmacy? _____

[_] You may write additional details on the back of this page

Signatures: _____ Patient, Parent, or Guardian _____ Nurse or provider _____ Date