



RIESBERG INSTITUTE

PATIENT INFORMATION

First Name _____ MI _____ Last Name _____
DOB _____ Age _____ Email Address _____
Address _____ City _____ State _____ Zip _____
SSN _____ Marital Status _____ Sex _____
Daytime Phone _____ Evening Phone _____ Cell Phone _____
Primary Care Physician _____ Referred by _____
Employer _____
Employer Address _____ City _____ State _____ Zip _____
Person Responsible for Account _____ SSN _____ DOB _____ Age _____
Responsible Person's Employer _____ Phone _____
Child's Caretaker (if not above) _____ Relationship _____
Spouse of Parent's Name (if applicable) _____

THE RIESBERG INSTITUTE FINANCIAL POLICY

OUR FINANCIAL POLICY: The Riesberg Institute is very concerned about the cost of your healthcare and has spent considerable time in setting our fees. We want to assure that the charges accurately reflect the complexity of care rendered and the skill and expertise required for your case.

INSURANCE USUAL AND CUSTOMARY: If an insurance company indicated that our fees are above the "usual and customary", please understand that most fees are above the rate which insurance companies choose to pay. We use many sources to determine the appropriateness of our fees. We cannot allow the payment or allowance of insurance companies to set the amount that we charge for services.

OUR POLICY: Our policy requires payment of co-payments and any deductibles at the time of service. If there is any balance owed after all insurance companies have made their payments, we will bill you for the remaining amount. All insurance information must be given to the office no later than 15 days after appointment or you could be responsible for the entire amount for the office visit and/or procedures.

PATIENT RESPONSIBILITIES: 1.) I understand that my insurance coverage is based on a legal contract between myself and my insurance company. 2.) I understand that I (as patient) am responsible for understanding and reading the conditions, coverage, terms, and limitations of my insurance policy. 3.) I understand that the legal contract of my insurance policy requires me to be responsible for payment of valid and legitimate fees and charges as follows: All outstanding deductibles, co-payments, non-covered procedures and services that are performed, and outstanding valid charges and fees after insurance companies have made their payments.

HMO AND PPO MEMBERS: If you are a member of an HMO or PPO in which we participate, your deductible or co-payment is required at the time of service. You are also responsible to see that we have a current referral on hand if your insurance carrier requires one. If we do not have this referral at the time of visit, your insurance company may hold you responsible for all charges. You may also be sent back to your primary care physician prior to being treated to obtain a current referral. Our agreement is with YOU and NOT your insurance company. You have chosen your insurance coverage. Although we will assist you in submitting your claim to your carrier, you are ultimately responsible for the services you receive. Payment to our office is not contingent or dependent on your insurance carrier. In your interest, we are pleased to accept Mastercard and Visa for your charges. Returned checks will receive a \$25 overdraft charge. A 5% monthly billing fee will be added to all account balances outstanding beyond 30 days from the date of service. A \$200 fee will be applied to any rescheduled surgery. Refer to our surgical rescheduling policy for specific information. We require 24 hours advance notice to avoid a \$50 appointment rescheduling fee. Please contact our billing office to make payment arrangements at (850) 476-0700.



CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPTIONS

- I consent to the use of disclosure of my protected health information (PHI) by The Riesberg Institute for the purpose of diagnosis or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operation of The Riesberg Institute.
- I understand that diagnosis or treatment of me by The Riesberg Institute may be conditioned upon my consent as evidenced by my signature on this document.
- I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or health care operations of the practice. The Riesberg Institute is not required to agree to the restriction that I may request, however, if The Riesberg Institute agrees to a restriction that I request, the restriction is binding on The Riesberg Institute.
- I have the right to revoke this consent in writing at any time, except to the extent that The Riesberg Institute has taken action in reliance on this consent.
- My PHI means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This PHI relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.
- I understand I have a right to review The Riesberg Institute's Notice of Privacy Practices as been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my PHI information that will occur in my treatment, payment of my bills, or in the performance of health care operation of The Riesberg Institute.
- The Notice of Privacy Practices for The Riesberg Institute is also provided at 4900 N. Davis Hwy, Pensacola, FL 32503. This Notice of Privacy Practices also describes my rights and duties of The Riesberg Institute with respect to my protected health information.
- The Riesberg Institute reserves the right to change the Privacy Practices. You can get a copy by calling the office and requesting a revised copy to be sent in the mail, or by asking for one at the time of your next appointment.
- Signing below, I state that I also understand that I have the right to revoke this consent, provided that I do so in writing, except to the extent that The Riesberg Institute has already used or disclosed the information in reliance on this consent.

Signature of Patient or Personal Representative

Date

Printed Name of Patient or Personal Representative

Description of Personal Representative's Authority

ACKNOWLEDGEMENT OF REVISED NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received the revised Notice of Privacy Practices statement dated January 01, 2012 of the Riesberg Institute.

Signature

Date



PATIENT MEDICAL HISTORY

Patient Name _____ Date of Visit _____

What are we seeing you for today? _____

List any allergies or reactions to medication/anesthetics: _____

List any previous ear, nose, or throat surgeries, and date performed: _____

List any hospitalization or other surgery and date: _____

PERSONAL/SOCIAL HABITS

Do you smoke or have you ever smoked? Yes No

If so, how much and how long? _____ Year stopped? _____

Do you now or have you ever used smokeless tobacco? Yes No

If so, how much and how long? _____ Year stopped? _____

Do you drink Alcohol? Yes No How much per day? _____

Do you or have you used any recreational drugs? Yes No

If so, what type? _____

Do you take blood thinners other than aspirin? Yes No

If so, what type? _____

Type of work? _____ Retired Yes No Disabled Yes No

Are you a student? Yes No Grade in School? _____



MEDICAL QUESTIONNAIRE

Patient Name _____ Date of Visit _____

PLEASE CIRCLE ALL THAT APPLY

Ears Decreased Hearing: YES NO Dizziness: YES NO Frequent Ear Infections: YES NO
Ringing in Ear: YES NO

Nose Snoring/Sleep Apnea: YES NO Difficulty Breathing Through Nose: YES NO
Sinus Pressure: YES NO

Throat Recurrent Sore Throats: YES NO Difficulty Swallowing: YES NO
Hoarseness: YES NO Difficulty with Singing Voice: YES NO

Allergy History of allergies: YES NO Allergy Shots: YES NO

Endocrine Diabetes: YES NO Thyroid Trouble: YES NO

Cardiovascular Irregular Pulse: YES NO High Blood Pressure: YES NO
Previous Heart Attack: YES NO

Hematological Previous Transfusion: YES NO Easy Bruising: YES NO HIV+: YES NO

Gastrointestinal Heartburn/Reflux: YES NO Vomiting Blood: YES NO Ulcer: YES NO
History of Hepatitis: YES NO

Respiratory Frequent Cough: YES NO Asthma: YES NO Emphysema: YES NO
Coughing Blood: YES NO

Neurological Previous Head Injury: YES NO Previous Stroke: YES NO Migraines: YES NO
Seizures: YES NO

Psychiatric Anxiety: YES NO Depression: YES NO

Other History of Cancer: YES NO Weight Loss: YES NO Frequent Fever: YES NO
Are You Pregnant: YES NO

Other Conditions/Family History (please list) Use back if necessary:



RIESBERG INSTITUTE

CANCELLATION AND NO-SHOW FEE ACKNOWLEDGEMENT

Effective January 1, 2012, there will be a \$50 fee charged for all **SAME DAY** appointment cancellations and no-shows.

Patient Signature

Date

Printed Name



AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

Patient Name _____

Date of Birth _____ Phone Number: _____

Obtain From:

Name _____

Address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____

Release To:

The Riesberg Institute

4900 N. Davis Hwy

Pensacola, FL 32503

Phone: 850-476-0700

Fax: 850-476-4300

Authorization: I hereby give The Riesberg Institute permission to disclose my individually identifiable health information as listed below. I understand that once this information is disclosed, it may no longer be protected by The Riesberg Institute. I understand that this authorization is voluntary, that further treatment cannot be conditioned upon my signing this authorization, and that there may be a cost to copy the records.

INFORMATION TO BE RELEASED (CHECK ALL THAT APPLY)

Date of service/range (mm/dd/yy): From: _____ To: _____

- Clinic Notes Operative Report Radiology Reports Lab Reports

Other: _____

I understand that I can revoke this authorization to release my medical records at any time, except for the information that has already been released according to this authorization. I do understand that this consent will expire after 180 days from the date of my signature unless I provide notice in writing that it should be revoked. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. A copy of facsimile of this form is considered as valid as the original.

Signature of Patient or Legally Authorized Representative

Date of Signature

Printed Name of Signed on Behalf of the Patient

Relationship to patient, if applicable



IDENTITY AND PAYMENT PROTECTION SECURITY

If I need to make financial arrangements, I can call the Riesberg Institute and they will work with me, in a sincere attempt to avoid collection agencies or liens placed on unpaid accounts. I understand that if I remain delinquent in my balance due, despite the good faith attempt to make a fair payment plan through my credit card, or debit card, that my account at that time would be sent to a collection's agency.

A collection agency may take over delinquent accounts. If our account is placed with a collection agency, you will be responsible for all costs of collection. Timely payment will prevent consequences to your credit rating.

I authorize Dr. Riesberg to store my credit card or debit card information in full compliance of the payment care industry (PCI) Data Security Standard and Federal Red Flag Rules to safeguard against identity theft.

I authorize Dr. Riesberg to charge this credit card or debit card for any deductible, co-payment, co-insurance, non-covered, or outstanding balances, which are all fair-trade balances due for services or products I have received.

I agree to pay a \$50.00 fee if charges are denied or contested unless I pay in full within 24 hours of being notified. I agree to pay all fees and penalties due to denied or contested charges deemed valid, including charge back fees.

If the Riesberg Institute owes me money, I authorize Dr. Riesberg to apply the amount as a credit on to my debit or credit card.

If you have any questions about our financial policy or your insurance reimbursement, please feel free to discuss them with any staff member.

Patient/Responsible Party Signature

Date

I.D.: _____

SINO-NASAL OUTCOME TEST (SNOT-20)

DATE: _____

Below you will find a list of symptoms and social/emotional consequences of your rhinosinusitis. We would like to know more about these problems and would appreciate your answering the following questions to the best of your ability. There are no right or wrong answers, and only you can provide us with this information. Please rate your problems as they have been over the past two weeks. Thank you for your participation. Do not hesitate to ask for assistance if necessary.

1. Considering 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 using this scale: →

	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 a good night's 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"/>

2. Please mark the most important items affecting your health (maximum of 5 items) _____ ↑

THE CENTER OF BETTER HEARING
Audiology and Hearing Aids
at
THE RIESBERG INSTITUTE

Hearing Health Questionnaire

The onset of hearing loss is usually very gradual. It may take place over 25-30 years, or it may happen more rapidly if you are exposed to loud noises at work or through hobbies. Because it usually occurs slowly, you may not even be aware that you have a problem until someone brings it to your attention. Here is a simple test you can take to determine if you have a hearing loss.

1. Do others complain that you watch television with the volume too high? Yes No
2. Do you frequently have to ask others to repeat themselves? Yes No
3. Do you have difficulty understanding what is being said
when in groups or noisy situations? Yes No
4. Do you have to sit up front in meetings, church or other social
gatherings in order to hear a speaker's words? Yes No
5. Do you have difficulty understanding women or young children? Yes No
6. Do you have trouble knowing where sounds come from? Yes No
7. Are you unable to understand when someone talks to you from
another room? Yes No
8. Have others told you that you don't seem to hear them? Yes No
9. Do you avoid family gatherings or social situations because you
"can't understand"? Yes No
10. Do you have ringing, buzzing, or other noises (tinnitus) in your ears? Yes No

If you have answered yes to even one of these questions, you should have your hearing evaluated by an audiologist and take steps now to educate yourself about lifestyle changes you can make to slow the progression of hearing loss.