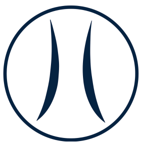


Patient Name: ___________________________ Date of Birth: ________ Date: _________

TEXAS SINUS, ALLERGY, SNORING & SLEEP INSTITUTE

KHETARPAL FACIAL PLASTICS

Umang Khetarpal, M.D.

How did you hear about us? ☐ Google ☐ Radio ☐ Facebook/Instagram ☐ ZocDoc ☐Insurance ☐ Referral

Who do we thank for referring you to us? ____________________________

Referring Physician: ____ Phone: ___________________________

Primary Care Physician: ____ Phone: ___________________________

Pharmacy Name & Address: ____ Phone: ___________________________

Patient Information

Last Name:____First Name:_________________________DOB: _____________

Address: ____ City/State/Zip Code:___________________________________

Home Telephone: ______________________ Work: _________________________ Cell: _____________________________

Social Security Number: ___________________________ Circle One: Single Married Divorced Widowed Other

Emergency Contact Name: ____ Relationship: ______________________

Phone Number: ________________________________

Email: ____ *We encourage our patients to register on our patient portal.

Complete for Minors

Father's Name: ____ Social Security: _____________________________

Mother's Name: ____Social Security: _____________________________

Insurance & Subscriber Information

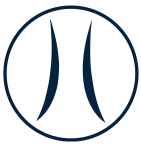
PLEASE PROVIDE INSURANCE CARDS TO THE FRONT DESK

Name of Insurance: ____ Member ID/Group:_____________________________

Name of Insured ____ Date of Birth: ________________________________

Name of Secondary Insurance: ______________________________ Member ID/Group:_____________________________

Name of Insured ____ Date of Birth: ________________________________



Patient Name: ________________________ Date of Birth: ________ Date: _________

No-Show / Cancellation Policy

Office Visit Cancellations:
Please be advised that failure to show for a visit or canceling an appointment less than 24 hours of scheduled arrival time will result in a **$50 no show/cancellation** fee added to your account

Allergy Test Cancellations:
Please be advised that failure to cancel an allergy test with 7 days notice will result in a **$200 no show/cancellation** fee added to your account.

Surgery Cancellation:
Please be advised that failure to cancel surgery within one week of surgery date will result in a **$500 cancellation fee** added to your account. If a medical reason is provided, a letter from your physician will be required to waive the fee.

Two no show appointments without a valid reason will result in termination of the doctor-patient relationship.

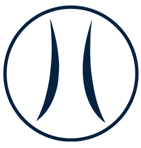
Patient Signature or Guardian's Name ___________________________________ Signature:_____________________

Authorization of Payment Release of Information

I hereby authorize payment of medical benefits to the provider for Professional Services rendered by Dr. Umang Khetarpal. I also promise to pay all charges incurred by me at Dr. Umang Khetarpal's request regardless of insurance coverage with the understanding that I will be refunded any money overpaid. I authorize release of information from my medical records to the following: My insurance company(ies), your billing agency, primary care/referring/consulting physicians and to some of your vendors.

Patient Signature or Guardian's Name ___________________________________ Signature:_____________________

Email: ____ Date: _______________________



Patient Name: ________________________ Date of Birth: ________ Date: _________

Legal Assignment of Benefits and Release of Medical and Plan Documents

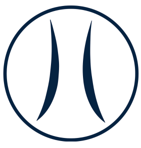
In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Southwest Ear, Nose & Throat Institute, Dr. Umang Khetarpal all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named provider to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Doctor and Practice stands in my beneficiary shoes for all transactions acting as the beneficiary and agent involved with health plan insurance and their agents for the processing of all claims, appeals as well as all transactions associated with the approval and payment of healthcare services. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and laboratory in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and lab's expenses.

This lifetime assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Signed: __________________________________

Date:____________________________________



Patient Name: ___________________________ Date of Birth: ________ Date: _________

Advanced Beneficiary Notice of Non-Coverage (ABN)

NOTE: If Medicare does not pay for **D.**_________________________below, you may have to pay. Medicare does not pay for everything, even some care that you or your healthcare provider have good reason to think you need. We expect Medicare may not pay for the **D.**_______________________below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Allergy Drops Ear Wax Removal	Not FDA Approved Not paid with office visit	$100/vial $100/cleaning

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D.____________listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: **Check only one box. We cannot choose a box for you.**
☐ OPTION 1. I want the D.________________listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare does not pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles. ☐ OPTION 2. I want the D.________________listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed. ☐ OPTION 3. I do not want the D.___________listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

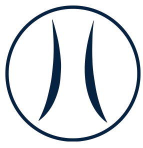
H. Additional Information: **This notice gives our opinion, not an official Medicare decision.** If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	**J. Date:**

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.



Patient Name: ________________________ Date of Birth: ________ Date: _________

Medical Questionnaire

Reason for Visit (Please list all snoring, ear, nose, and throat issues): ______________________________________

____

Length of time of condition: ____

Medications taken: (Please list medications that have been prescribed, or other over the counter medications used and the length of time used. I.e. flonase 2x day, 1 year). List additional medications on back of form:

Medication	Dosage	Length of Time	Medication	Dosage	Length of Time
________	________	________	________	________	________
________	________	________	________	________	________
________	________	________	________	________	________

Are you allergic to any medications? Yes / No If yes, list here: ____

Personal Medical History:

- ☐ Acid Reflux
- ☐ Allergy Problems
- ☐ Artery/Vein Problems
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Headaches
- ☐ Hearing Impairment
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Hypertension
- ☐ Liver Disease
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Other: ___________

Hospitalizations/Significant Injuries: ____

____

Surgeries/Procedures (If none, write 'N/A'): ____

____

Family Medical History:

Father:	Alive/Deceased	Issues: High blood pressure, stroke, cancer, diabetes, other: _______________
Mother:	Alive/Deceased	Issues: High blood pressure, stroke, cancer, diabetes, other: _______________
Brother(s):	Alive/Deceased	Issues: High blood pressure, stroke, cancer, diabetes, other: _______________
Sister(s):	Alive/Deceased	Issues: High blood pressure, stroke, cancer, diabetes, other: _______________

Social History:

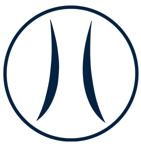
Do you smoke? Yes / No If yes, number per day: ______ How many years? __________

Marital Status: Married / Single / Divorced / Widowed / Other:

Do you drink alcohol? Yes / No Daily/Socially ______________ How many drinks per day? __________

Have you ever used recreational drugs? Yes / No

What is your profession/work? _______________



Patient Name: ________________________ Date of Birth: ________ Date: _________

COVID Questionnaire

In the past 3 weeks:

Have you been in contact with someone that has or has had Covid-19?	Yes	No
Have you been treated for Covid-19?	Yes	No
Have you traveled outside the city or internationally?	Yes	No

In the past 1-2 weeks, have you had any of the following symptoms?:

Malaise	Yes	No
Fever	Yes	No
Cough	Yes	No
Shortness of Breath	Yes	No
Chest Pain	Yes	No
Headache	Yes	No
Loss of smell or taste	Yes	No
Diarrhea	Yes	No
Blood Clot	Yes	No

COVID Release of Liability

Given the circumstances surrounding the spread of Covid-19 and the data available thus far, we want you to understand that 80- 85% of all Covid-19 infected patients are either without symptoms or mildly symptomatic. This means that they may not recognize that they have had Covid-19 or are currently infected with Covid-19. These symptoms may be as subtle as runny nose, mild sore throat or occasional cough, mild malaise or smell changes without any fever or shortness of breath or significant cough. The last three are cardinal symptoms of Covid-19 but may be absent in early Covid-19 or in asymptomatic or mild Covid-19. Given that background, some patients will not have fever on screening and are negative on the screening questionnaire, there is potential exposure to Covid-19 in our office. We maintain safe distancing and cleaning protocols in our office as per guidelines including patients and employees wearing masks.

By signing this form, you agree to release this office and Dr. Umang Khetarpal of any liability from getting infected by Covid-19 in our office

____

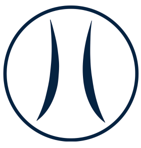
Patient Name (Printed)

______________________________ ____________

Patient Signature Date

______________________________ ____________

Parent or Legal Guardian Signature Date



Patient Name: ___________________________ Date of Birth: ________ Date: _________

Release of Information

I authorize the release of records to the following individual(s):

Name:___________________ Date of Birth: __________ Phone Number: ___________

Name:___________________ Date of Birth: __________ Phone Number: ___________

Name:___________________ Date of Birth: __________ Phone Number: ___________

☐ I do **NOT** authorize the release of my information

____
Patient Name (Printed)

____ ____________________
Patient Signature Date

____ ____________________
Parent or Legal Guardian Signature Date