Anchorage Location:
3841 Piper Street Suite T-230 Anchorage, AK 99508
Phone (907) 279-8800, Fax (907) 279-8810
www.ACENTAlaska.com

Homer Location:
South Peninsula Specialty Clinic
4201 Bartlett St. Suite 201 Homer, Alaska 99603
Phone (907) 235-0310

PLEASE READ COMPLETELY

Welcome to ACENT. We appreciate you choosing us for your comprehensive ENT care. Our Board Certified Otolaryngologists provide state-of-the-art care for a wide range of ENT, Hearing, and Cosmetic needs. We use the most advanced therapeutic and diagnostic modalities available to provide you with the very best care.

ACENT is conveniently located off Piper Street in the Providence Alaska Medical Center Campus. You will find our clinic on the second floor of the T- Tower between the elevators and the Sky Bridge that leads to the main Providence Hospital. Visit our website at www.ACENTAlaska.com for more information about our providers, staff, and services lines including Hearing at ACENT and FACES Medical Spa at ACENT.

In a sincere effort to maintain patient satisfaction while honoring the need to maximize effectiveness and efficiency of our work processes, we have implemented procedures which we hope will let us provide you with the best quality medical care we can.

New Patients/First Appointment

*** We encourage all patients to complete or update all paperwork by utilizing our Patient Portal located on our website. Our staff can easily email you information about your upcoming appointment along with a hyperlink and the needed security code to access the portal.***

- **Please arrive 15 minutes prior to your appointment and bring the following with you:**
- **Completed Patient Registration Form (or complete in the office)**
- **Completed Patient History Form (or complete in the office)**
- **Current list of medications**
- **Insurance Card/Billing Information**
- **Current Photo Identification**
- **A list of questions you may have**
- **Copay (Patients are responsible for their copay at time of checkout)**

A current identification photo will be taken at your initial visit for your patient record in addition to helping us meet privacy and verification requirements. At your initial visit your provider will review your medical history and may discuss with you any needed diagnostic testing that may be required to help in your diagnosis or treatment. In the specialty field of Otolaryngology, CT, Referrals for Audiology, Allergist or Oncologist, Pathology or MRI, may be suggested and are continual throughout your care. Any diagnostic testing or procedure is an additional charge to your office visit. Diagnostic test results will be reviewed during your follow up appointment with your provider, results will not be mailed.

Returning Patients or Follow-Up Appointments

At each follow-up appointment you will be asked to update your Medical and Billing information, even if you were seen the prior day. This is in an effort to help determine any issues or problems since your previous visit. Please have a current list of medications to compare, update, and verify the list we have in our office. Please let us know if you need any prescriptions refilled at this time.

Office Calls/Prescription Refill Requests

Your questions or concerns are important to our providers and will be submitted through the Registered Nurse or Certified Medical Assistant that works directly with your provider. When calling the clinic with a question, please listen carefully for the option for the Clinical team. If we can't answer your call immediately, our goal is to return calls the same day or within one business day. Multiple calls in one day will cause a delay in the Nurses or Medical Assistants ability to return your call. Any message left after 4:00 p.m. will be returned the following business day. Secure messages may also be sent via our Patient Portal on our website.

Routine prescription refill requests must be received at least two business days in advance so that your chart may be reviewed by your provider. It is best to have your pharmacy fax us directly a refill request several days before you are out of medication. Most prescription refills will be sent electronically to your pharmacy and may take up to an hour to process. Please expect a delay if requests are called in over a weekend or after business hours. Some prescriptions can take up to two business days to fill, so please be patient before contacting us a second time. It is our policy that we do not provide refills on some medications without provider approval, which may require an office visit. All prescriptions picked up in our office will require photo identification verification by our staff.

Appointments/Late Arrivals/Cancellation Policy

Our goal is for you to be seen at your scheduled appointment time, but sometimes delays are unavoidable. Regularly scheduled office visits allow us to better assist you in identifying and managing your medical care. We utilize an automatic phone reminder system that will call you 24 hours in advance of your appointment. It is your responsibility to update us of any changes in phone numbers, emails, etc. We kindly ask that you provide notice if you need to reschedule or cancel an appointment so that we may offer your appointment to another patient. You may cancel by calling 907-279-8800 or during the time of your confirmation reminder call. It is our policy that three no show or missed appointments within one year, may result in a discharge of your care from our practice. In addition, a late arrival or arriving without the required information or documentation may require a rescheduling of your appointment. As a courtesy to all of the patients in the clinic, a patient who arrives 10 minutes later than their scheduled appointment may require rescheduling.

Medical Insurance Billing

We offer medical insurance billing in our clinic as a courtesy to our patients however, please keep in mind that your healthcare coverage is a contract between you and your insurance company. It is your responsibility to know your benefits, including any preferred facility and preferred lab. In order to properly bill your insurance, we require that you provide your insurance cards and disclose all insurance information at the time of service. It is your responsibility to inform us of any change in insurance information including any new policy providing its effective date and termination date. The estimated portion not covered by your insurance including deductible, copays, and coinsurance amount will be collected at the time of service unless previous arrangements have been made with the financial services department. Although, we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefit coverage.

We are contracted providers with Blue Cross, AETNA, CIGNA, VA, VA Choice, Medicare, and Medicaid. We will bill for Tricare and accept assignments but we are NOT contracted with Tricare. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the insurance allowed amount or any amount not paid because we are out of network.

When signing this agreement, you consent and authorize the payment of insurance benefits to ACENT and acknowledge understanding that you are financially responsible for any and all charges for services given regardless of insurance coverage. In addition, you authorize the release of any information acquired in the course of your examination or treatment, to and from any medical providers, facilities, and or your insurance company.

Financial Obligation/Payment Terms/Options

It is the patients or guardians responsibility to notify ACENT of any changes to your contact phone numbers, address, employment, or insurance coverage.

All patients or guardians are required to pay any co-payments, co-insurance, or deductibles at the time of your visit per the requirement of your healthcare insurance plan policy. If proof of insurance is not provided, you will be expected to make a payment in full at the time of service.

Self-pay patients (uninsured) – **a 10% discount will be offered if payment is made in full at the time of service.**

Payment is due upon receipt of a statement from our Financial Services billing office. Account balances must be paid in full or an individual payment plan must be set up with the billing department. All accounts for which payment arrangements have not been made are subject to collections procedures. There will be a $35.00 charge for any checks returned to us for non-payment. If your account is not current or paid as outlined in this policy we reserve the right to refuse future appointments to be scheduled.

FMLA Forms/Disability Forms/Medical Records

A patient's first request for the copying, faxing, or mailing of medical records will be free of charge. Subsequent requests will be subject to $1.00 per page charge. These are not billable charges to your insurance company. Please allow 5-7 working days for the completion of any forms, prior authorizations, or letters.

Your medical records are strictly confidential. The Health Information Portability and Accountability Act (HIPAA) restrict us from releasing any information without your written consent. You may choose to fill out an Authorization to Release Medical Records at one of your visits to keep on file in case an urgent need arises for such records.

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PATIENT MEDICAL RECORDS ACCESS AUTHORIZATION

Please write below who will have permission to access your chart other than yourself.

Full name: _ Relationship to patient: _

Full name: _ Relationship to patient: _

Medical records access only? Yes or No

Billing information access only? Yes or No

Both? Yes or No

****

AGREEMENT

This is an agreement between ACENT and the patient named below. By signing this agreement you are acknowledging your understanding and that you are agreeing to all of our policies discussed above.

I have read, understand, and agree to comply with these policies. A photocopy of this agreement shall be as valid as the original. I acknowledge that I have been offered a copy of the Notice of Privacy Practices for ACENT, and have been given a copy if requested.

Photo Consent

•Do you authorize use of my photographs for teaching purposes or to illustrate scientific papers, books, or lectures? ***(Please Circle One)*** **Yes** or **No**

•Do you authorize the use of your photos for advertisement or release to media, i.e. website, newspaper, television or trade shows? ***(Please Circle One)*** **Yes** or **No**

I further consent to examination and the performance of treatments that may be medically necessary or advisable.

Signature and Date:

Printed Name: _

Patient/Guarantor Signature:_ **Date**: _

PATIENT REGISTRATION

Dwight Ellerbe, MD, FACS, FAAS | James Kallman MD, FACS | Stephen Schaffer, MD, FACS | Mark Lorenz, MD
Nicole Tiefel, FNP | Kaylyn Hum, AuD | Caitlin Milligan, AuD | Stefan Harris, BC-HIS | Elise Blomfield, RN | Audra McKellar, Esthetician

In order to serve you properly we require the following information. Please COMPLETE ALL Sections. ***(PLEASE PRINT)***

Patient Information:

First Name: ____________ M.I. ____________ Last Name: ____________
Mailing Address: ____________
City: ____________ State: ____________ Zip Code: ____________
Home#: ____________ Cell#: ____________ Work#: ____________
Birth Date: ____________ Gender: ☐ Male ☐ Female Preferred Language: ____________
Marital Status: ____________ Email: ____________
SSN#: ____________ Would you like us to email you our latest newsletter? Y ☐ N ☐
Employer: ____________ Preferred Contact *(circle one)*: Home Phone | Cell Phone | Work Phone
Occupation: ____________ Referring Physician: 1. ____________ 2. ____________

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Declined

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ African American
☐ Hawaiian/Pacific Islander ☐ Caucasian ☐ Other Race ☐ Declined

Please check below all boxes that apply to you:

Employed ☐ Minor ☐ Retired ☐ Disabled ☐ Full-Time Student ☐ Unemployed ☐ Other ☐

Parent/Legal Guardian Information: (If patient is a minor or disabled)

Full Name: ____________ Relationship to Patient: ____________
Address: ____________ City: ____________ State: ____________
Birth Date: ____________ Phone: ____________
SSN#: Employer: Work Phone:

Primary Insurance Information: (Please provide your insurance card to our front office staff)

Insurance Co name: ____________
Subscriber's name: ____________ Birth Date: ____________
SSN#: ____________ Subscriber's Relationship: ____________
Employer name: Type of Plan *(circle one)* : Actively Employed | Retiree Plan | COBRA | WorkComp

Secondary Insurance Information: (Please provide your insurance card to our front office staff)

Insurance Co name: ____________
Subscriber's name: ____________ Birth Date: ____________
SSN#: ____________ Subscriber's Relationship: ____________
Employer name: Type of Plan *(circle one)* : Actively Employed | Retiree Plan | COBRA | WorkComp

Emergency Contacts:

Name: ____________ Name: ____________
Contact#: ____________ Contact#: ____________
Relationship to Patient: Relationship to Patient:

Would you like your emergency contact person to be able to discuss your medical information and/or billing account? Yes ( ) No ( )

Authorization and Assignment

I assign all medical and/or surgical benefits to which I am entitled, including private insurance and any other health plan t o ACENT. This assignment will remain in effect until revoked in writing by me. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure payment. **I understand that I am financially responsible for all charges incurred from medical treatment at ACENT, whether or not the services are paid by my insurance.** If, for any reason, it becomes necessary for ACENT to engage an attorney or collections agency to secure payment from me, I agree to pay all reasonable interest charges, attorney fees, and collection costs.

Signature: ____________ Date: ____________

Todays Date: ____________________

NAME____**DATE OF BIRTH** _______________

WHAT BRINGS YOU TO OUR OFFICE TODAY?

____

ARE YOU OR HAVE YOU EVER BEEN TREATED FOR ANY OF THE FOLLOWING? (check all that apply)

- [ ] High Blood Pressure
- [ ] Heart Attack
- [ ] Stroke
- [ ] Other Heart Problems
  Specify: ________________
- [ ] Asthma
- [ ] Other Lung Problems
  Specify: ________________
- [ ] Diabetes
- [ ] Thyroid Problems
  Specify: ____________
- [ ] Skin Cancer
- [ ] Skin Problems-Specify: __________________
- [ ] Hearing Loss
- [ ] Hearing Aid
- [ ] Other Cancer-Specify: ___________________
- [ ] Bleeding Disorder
- [ ] Blood Clots
- [ ] Kidney Problems
- [ ] HIV
- [ ] Hepatitis
- [ ] Depression
- [ ] Anxiety
- [ ] Allergies/Hayfever
- [ ] Sinus Problems-Specify: _______________
- [ ] Stomach Problems-Specify: _____________
- [ ] Obstructive Sleep Apnea
- [ ] Other (list)____________________________

PAST SURGERIES (list surgery, approximate date)

____

____

____

HAVE YOU RECEIVED ANY OF THE FOLLOWING?

- [ ] Flu Vaccine (over 50 years of age) Year:_____________
- [ ] Pneumonia Vaccine (over 50 years of age) Year:_____________
- [ ] Asthma Evaluation Year:_____________

- [ ] (Over the age of 60) Have you recently fallen? [ ] yes [ ] no

CURRENT MEDICATIONS & STRENGTH (prescription & over the counter)

____

____

____

____

ALLERGIES TO MEDICATIONS (list medication, reaction)

____

____

____

____

PRIMARY PHYSICIAN ____________________________________

PHARMACY ____

FAMILY HISTORY (check all that apply)

- [ ] Hearing Loss
- [ ] Allergies
- [ ] Asthma
- [ ] Cancer
- [ ] Thyroid Disease
- [ ] Diabetes
- [ ] Other Health Problems (list)
- [ ] High Blood Pressure
- [ ] Heart Disease
- [ ] None

____

____

____

SOCIAL HISTORY

Have you ever used tobacco? yes [ ] no [ ] quit date_____
Amount: _____packs/day for_____years
Type (circle one): cigarettes pipe chewing tobacco

Do you drink alcohol? yes [ ] no [ ]
Amount: _____drinks per day/week/month

Do you drink caffeinated beverages? yes [ ] no [ ]
Amount: _____cups or cans per day
Type: [ ] coffee [ ] tea [ ] soda [ ] energy drink

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING? (check all conditions that apply)

Constitutional
- [ ] fever
- [ ] pain
- [ ] weight loss/gain
- [ ] dizziness issues
- [ ] balance issues

Neurological
- [ ] headaches
- [ ] weakness
- [ ] numbness

Ears, Nose, Mouth, Throat
- [ ] hearing loss
- [ ] tinnitus/ringing in the ears
- [ ] nasal obstruction
- [ ] runny nose
- [ ] nosebleeds
- [ ] snoring
- [ ] sore throat
- [ ] lump in neck
- [ ] ear pain
- [ ] ear drainage

Cardiovascular
- [ ] chest pain
- [ ] shortness of breath
- [ ] palpitations

Respiratory
- [ ] cough
- [ ] hoarseness
- [ ] wheezing
- [ ] noisy breathing

Gastrointestinal
- [ ] heartburn
- [ ] throat clearing

Musculoskeletal
- [ ] muscle pain
- [ ] joint pain

Skin
- [ ] rash
- [ ] acne
- [ ] change in moles

Endocrine
- [ ] cold/heat intolerance
- [ ] night sweats

Allergic/Immunologic
- [ ] sneezing
- [ ] frequent infections

Eyes
- [ ] itching
- [ ] dryness
- [ ] excessive tearing

Dwight Ellerbe, MD * Christopher Kowalski, MD * Steve Schaffer, MD * Mark Lorenz, MD * Nicole Tiefel, FNP * Audra McKellar, Esthetician * Elise Blomfield, RN * Kaylyn Hum, AUD * Caitlin Milligan, AUD * Stefan Harris, BC-HIS
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