Our goal is to provide quality medical care in a timely manner. In order to do so we have had to implement an appointment/cancellation policy. The policy enables us to better utilize available appointments for our patients in need of medical care.

Cancellation of an Appointment

In order to be respectful of the needs of the community please be courteous and call the office promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in need of treatment. This is how we can best serve the needs of all.

If it is necessary to cancel your scheduled appointment we require that you give 24 Hour Notice. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to care.

How to Cancel Your Appointment

To cancel appointments please call 540-667-7200. If you do not reach the receptionist you may leave a detailed message on the voice mail.

Late Cancellations

Late cancellations will be considered as a “broken appointment/no show”.

Broken Appointment/No Show Policy

A “broken appointment/no show” is someone who misses an appointment without canceling within 24 Hours. Broken Appointments/No-shows inconvenience those individuals who need access to care in a timely manner.

A failure to present at the time of a scheduled appointment will be recorded in the patients’ chart as a “broken appointment/no show”. A fee of $25.00 up to $125.00 will be billed to the patient that failed the scheduled appointment. The fee must be paid prior to the rescheduling of the appointment.

Winchester Ear, Nose and Throat Center
2055 Valley Avenue
Winchester, VA 22601
(540)667-7200 Office (540)667-6377 Fax

Please complete all enclosed paperwork and bring with you on the day of your appointment. A guardian/parent must be present at all office visits. Our office will need a photo I.D. and a copy of your medical insurance cards. If for any reason you do not have a copy of either your medical insurance card, then you must provide your ID number, Group number, Claim address, and Provider contact phone number. We will also need the Subscriber's date of birth and social security number. **If we do not receive your medical insurance information at the time of your first initial consultation visit; then it may result in your appointment being rescheduled or you being held financially responsible for the initial consultation fee.**

In order to keep your scheduled appointment, it is imperative that you bring with you the completed paperwork, and all insurance information. PLEASE GIVE 24 HOUR NOTICE IF UNABLE TO MAKE THE APPOINTMENT. A broken appointment fee of $25.00 up to $125.00 less 24 hour notice will apply if adequate notice not given. If you have any questions, please contact our office. Thank you for your patronage.

Sincerely,

Winchester Ear, Nose and Throat Center,

	CHECKLIST OF ITEMS REQUIRED AT CONSULTATION VISIT
	Guardian/Parent present at all office visits
	Completed new patient paperwork
	List of Medicine or Herbal Substances of any kind and Medication(s) dosages
	Medical Insurance Card(s)
	Photo I.D. (ex. Drivers License)
	Referral from referring physician
	Any CT's x-rays that may assist in your care

Winchester Ear, Nose and Throat Center

Medical History & Physical

Patient's Name: _____ Date of Birth:_____

Reason for today's visit?: _____

Have you received past treatment for today's visit?: _____

Referring Doctor: _____Family Doctor: _____

Medical History (Previous Surgery and procedures: (What, When, and Where):

_____

_____

Have you ever been hospitalized for non-surgical conditions? (What, When, and Where):

_____

_____

Have you ever tested positive for MRSA in the past? (What area(s), When): _____

Substance Abuse/Social History

	YES	NO	How Many/How Often	Amount of Years
Alcohol	☐	☐	/	
Cigarette	☐	☐	/	
Cigar	☐	☐	/	
Pipe	☐	☐	/	
Oral/Snuff	☐	☐	/	
Drug Use	☐	☐	/	

Personal & Family History/Medical History

	YOU	FAMILY		YOU	FAMILY
AIDS/HIV	☐	☐	Anesthesia Problems	☐	☐
Atrial Fibrillation	☐	☐	Breast Cancer	☐	☐
Alcoholism	☐	☐	Lung Cancer	☐	☐
Angina	☐	☐	Colon Cancer	☐	☐
Heart Attack	☐	☐	Prostate Cancer	☐	☐
Stroke	☐	☐	Other Cancer	☐	☐
Heart Disease	☐	☐	Bleeding Problems	☐	☐
High Lipids	☐	☐	Arthritis	☐	☐
High Blood Pressure	☐	☐	Mental Illness	☐	☐
High Cholesterol	☐	☐	Radiation Therapy	☐	☐
Coumadin Therapy	☐	☐	Emphysema	☐	☐
Mitral Valve Prolapse	☐	☐	Hepatitis	☐	☐
Colitis	☐	☐	Pacemaker Implant	☐	☐
Diabetes	☐	☐	Asthma	☐	☐
Kidney Disease	☐	☐	Seizure Disorder	☐	☐
Thyroid Disease	☐	☐	Chemotherapy	☐	☐
Liver Disease	☐	☐	Stomach Ulcers	☐	☐
TB	☐	☐	Bleeding Tendencies	☐	☐

REMARKS (Please explain any boxes you checked above) _____

_____

Winchester Ear, Nose and Throat Center

Medical History & Physical (cont.)

Review of Systems

Are you currently experiencing any of the following symptoms/conditions?

	YES	NO		YES	NO
Fevers?	☐	☐	Watery, itchy eyes?	☐	☐
Chills?	☐	☐	Eye pain?	☐	☐
Blurry Vision?	☐	☐	Ringing in ears?	☐	☐
Double Vision?	☐	☐	Ear pain?	☐	☐
Hearing Loss?	☐	☐	Stuffy Nose?	☐	☐
Dizziness?	☐	☐	Sinus Pain?	☐	☐
Runny Nose?	☐	☐	Dry Mouth?	☐	☐
Bloody Nose?	☐	☐	Hoarse Voice?	☐	☐
Snoring?	☐	☐	Shortness of breath?	☐	☐
Sore Throat?	☐	☐	Irregular heart beat?	☐	☐
Cough?	☐	☐	Heart burn?	☐	☐
Sneezing?	☐	☐	Upset stomach?	☐	☐
Chest Pain?	☐	☐	Bone/Joint pain?	☐	☐
Muscle Aches?	☐	☐	Gland Swelling?	☐	☐
Skin Rash?	☐	☐	Numbness?	☐	☐
Depression?	☐	☐	Decreased Energy?	☐	☐
Nervousness or Anxiety?	☐	☐	Daytime Sleepiness?	☐	☐
Difficulty urinating?	☐	☐	Unexplained weight loss or gain?	☐	☐

Patient's current height? _____ Patient's Weight? _____

Allergies to Medications:

_____

_____

_____

_____

Medications List:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Name of Pharmacy you use and location: _____

Phone Number to Pharmacy: _____

Any additional information you would like for us to know?

_____

_____

_____

Patient's Signature _____ Date _____

Staff's Initials _____

Winchester Ear, Nose and Throat Center
2055 Valley Avenue
Winchester, VA 22601
540-667-7200 (Office) 540-667-6377 (Fax)

Patient Registration Information

Legal Patient First Name M.I. Last

Patient's Name _____ Date of Birth____/____/_____Age___Sex___

SSN#___/___/____ Marital Status _____ Is this visit a result of injury ☐Yes ☐ No Date of Injury_____

Have you ever been a patient here before? ☐ Yes ☐ No If yes specify reason and year _____

Physical Address _____City_____ State ___Zip_____

Full Mailing Address_____City_____ State ___Zip_____

Home Phone _____ Cell Phone _____

Best Number to Call_____ Best Time to Call _____

Email Address _____ Emergency Contact Person and Phone Number _____

Race: • White • Hispanic or Latino • Indian or Alaskan Native • Asian • Black or African American • Hawaiian Pacific Islander • Other

Ethnicity: • Non-Hispanic • Hispanic or Latino • Other _____

Primary Language: • English • Spanish • Other _____

Insurance Information **Please provide all Insurance Card(s) and picture I.D. to receptionist**

Primary Insurance _____ Identification Number _____ Group Number _____

Name of Insured _____ Insured Date of Birth _____/_____/_____

Employer _____ Relationship to Patient _____

Secondary Insurance ☐ Yes ☐ No

PLEASE COMPLETE ONLY IF FILING WORKMANS COMPENSATION OR AUTOMOBILE INSURANCE

File ☐Workman's Compensation ☐ Automobile Insurance

Employer Name: _____ Contact Business Name: _____

Contact Business Phone Number: _____ Claim Number:_____

Other Important Information Related to case: _____

Complete this section only if a spouse, parent or other guardian is the insured or responsible party for account:

Responsible Party's Name _____Date of Birth _/_____/_____Age___Sex___

SSN#_____ Relationship to patient _____

Full Mailing Address _____City _____State____Zip _____

Home Phone _____ Cell Phone _____

WINCHESTER EAR, NOSE and THROAT CENTER, PLLC
AGREEMENT AND CONSENT TO TREATMENT, RELEASE OF INFORMATION, INSURANCE ASSIGNMENT, AND PAYMENT OF CHARGES

Financial Agreement:
I authorize payment of all medical benefits otherwise payable to me directly to WENT. I understand that I am responsible for all health insurance deductibles and coinsurance. I understand that if my insurance company has a precertification requirement that it is my responsibility to obtain this pre-certification. The benefits of Homestead Exemption are waived as to any debt created incident to this account for the services covered by this Consent Form. I understand that I remain financially responsible for any and all charges not met by the proceeds of this assignment, and for all charges if payment is not received within a reasonable time after charges are filed or if payment is deemed retroactively. I accept responsibility for payment in full, or agreed upon payment arrangements, for services provided within thirty (30) days of receiving a statement. A 1.5% interest fee will be applied to all accounts not paid in full within (30) days of receiving a statement. In the event I do not meet my financial responsibility, I agree to pay costs for collection including the collection agencies fees 35% interest, court costs, and attorney fees up to the maximum of the Commonwealth of Virginia Statute.

Office Fees:
Missed//No Show Appointment fee $25.00, Same Day (less 24 hour notice) Cancellation fee $25.00, Missed/No Show Audiologist Appointment fee $50.00, Same Day (less 24 hour notice) Audiologist Cancellation fee $50.00, Surgery Cancellation Fee $155.00.

Medical and Clinical Consent:
I request treatment and consent to all: diagnostic evaluations, surgical procedures, therapy services, diagnostic tests, medications and/or treatments that are ordered or performed by my physician or any other independent medical service providers as are advisable or necessary in my physician's judgment. I understand that all services are available and will be provided to all individuals regardless of age, sex, race, color, creed, national origin, religion or handicap.

Release of Information:
I authorize to release to my physician and any other health care providers treating me, insurance company, reimbursing agency, affiliated entities, attorneys and other as allowed by law; whatever information, including a copy of, or access to, my medical record for determination of benefits payable or for additional medical care. Further, I authorize the social Security Administration to release any information regarding my benefits or Medicare eligibility to any health care provider or other independent medical care provider.

Medicare Beneficiary:
I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the holder of medical or other information about to release to the Social Security Administration or its agents any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

Right to Decide:
I understand that I have the right to make decisions about my care. I have the right to refuse or accept treatment. I have the right to have a "Living Will", Advance Directive or to designate someone to make decisions for me by using a "Durable Power of Attorney for Health Care".

Notice of Deemed Consent to HIV Blood Testing:
A law was enacted in Virginia in 1989 and amended in 1993 which authorizes healthcare providers to test their patients for HIV, Hepatitis B and C antibodies when the healthcare provider is exposed to the body fluids of a patient in a manner which may transmit these antibodies. Pursuant to this law, in the event of such an exposure, you will be deemed to have consented to such testing and to the release of the test results to the healthcare provider who may have been exposed. You will be informed prior to your blood being tested for HIV, Hepatitis B or C antibodies. The testing will be explained, and you will be given the opportunity to ask any questions.

I have been given or offered a copy of the Notice of Privacy Practices.
I have read this form or have had it read to me, and it has been explained to my satisfaction. I understand that this form is valid for one (1) year from the date that I sign it.

_____ _____ _____
Patient Name (Print) Patient or Responsible Party Signature Date

_____
Responsible Party's Relationship to Patient

I witnessed the signature: _____ _____ _____
Employee Signature Title Date

Appointment Reminder Consent

As a courtesy to you, we will attempt to remind you of your appointment by contacting you the day before your scheduled appointment. We are pleased to notify you by preference of telephone, e-mail, or text message reminder. Please indicate your preference below.

☐ -I prefer to be contacted by telephone:
The best phone number to reach me by telephone is _____

OR

☐ -I prefer to be contacted by e-mail:
My email is _____

OR

☐ -I prefer to be contacted via text message on my cell phone:
To receive text my cell phone number is _____
My service provider is _____ (Example: AT&T, Verizon, Sprint, etc.)

_____ _____
Authorized Patient Signature Date