MIDWEST Ear Institute

Vincent B. Ostrowski, M.D.
Jamie P. Weber, N.P.-C.
Main office: 7440 North Shadeland Avenue, Suite 150
Indianapolis, Indiana 46250

Phone:
(317) 842-4901
Toll Free:
(800) 818-3277
Fax:
(317) 842-4393

Welcome! We ask that you carefully complete the accompanying forms and bring them with you to your appointment, along with any previous test results and/or medical records you may have. **Please arrive with your *completed* forms at least 15 minutes before your appointment time** to allow for registration and preparation of your record. Alternatively, you can also complete the equivalent of the Patient Registration and blue medical history forms online using our secure Patient Portal, which would allow the doctor to have your medical history already in your record when he sees you. Call our office to obtain your PIN number to register for the Portal. When you have your PIN number go to our website, www.midwestear.com, and click on the Portal button to get started. Click on *Register* up in the top left of the screen to set up your Portal account. Once registered, go to *Online Patient Forms* and use the *New Patient Enrollment* and *Pre-Visit Medical History Questionnaire* forms.

Please check with your health insurance and/or your primary care doctor to make sure the doctor you are seeing is an enrolled provider with your insurance and if you will need a referral for this visit. **If you do need a referral authorization for your insurance to cover this visit, it is your responsibility to obtain this referral.** You may either bring it with you to the visit or have your doctor's office fax it to us at (317) 842-4393 at least 2 days before your appointment.

Our insurance contracts require that we collect any co-pays at the time of your visit. For your convenience, our practice accepts cash, personal checks, Mastercard, Visa, Discover Card, and American Express.

If you have any questions about fees, insurance, or referral information, please call our Patient Accounts Representative at (317) 570-7353 extension 126. If you need to cancel or reschedule this appointment, please call (317) 842-4901 during normal business hours. **Please notify us at least 24 hours in advance if you are unable to keep your appointment.**

IN SUMMARY, BRING WITH YOU:

- ❒ Enclosed forms, completed and signed
- ❒ Any pertinent test results and/or medical records, including hearing tests in last 6 months or CT/MRI of head (please bring the CD of your CT/MRI).
- ❒ **Your current insurance card(s)**. Please bring your insurance cards to every visit. If we do not have your cards, we will not be able to bill your insurance and you will be responsible for the visit fees.
- ❒ **A Driver's License or other Photo I.D.** as for your protection we verify identity
- ❒ Any necessary referral forms or referral numbers if required by your insurance. Remember, unauthorized visits will not be covered by your insurance. Unauthorized, non-urgent visits will be rescheduled unless you are willing to pay in full at the time of service.

We look forward to your visit!

Office addresses:

NORTHEAST: 7440 N. Shadeland Avenue, Suite 150, Indianapolis
NORTHWEST: 8240 Naab Road, Suite 155, Indianapolis
MOORESVILLE: 904 N. Samuel Moore Pkwy, Mooresville

rev 05-20

PATIENT REGISTRATION

PLEASE PRINT

PATIENT INFORMATION: **Date completed**_____

Patient's Last Name:	Social Security No.:
First Name and Middle Initial:	Occupation:
Address:	Employer:
City: State: Zip:	Employer Address:
Home Phone: ( )	Work Phone: ( ) Ext.
Cell Phone: ( )	Date of Birth: Age: Sex: M F O
Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced ☐ Domestic Partnership	E-mail address that we may use to let you know you have a secure message:
How did you hear about us? Check all that apply: ☐ Family Doctor ☐ Specialist ☐ Insur Co ☐ Family/Friend ☐ Yellow Pages ☐ Website ☐ Other	
Referring Dr: ☐ same as Family Dr	Family Dr:
Ref Dr Address:	Fam Dr Address:
Ref Dr City/State/Zip:	Fam Dr City/State/Zip
Ref Dr. Phone: ( ) Ref Dr. Fax: ( )	Fam Dr. Phone: ( ) Fam Dr. Fax: ( )

RESPONSIBLE PARTY, IF OTHER THAN PATIENT (For minors, complete for parent or legal guardian):

Name:	Relationship to Patient:
Address:	Social Security No.: Date of Birth:
City: State: Zip::	Employer:
Home Phone: ( )	Address:
Work Phone: ( ) Ext:	City: State: Zip:

NEAREST RELATIVE NOT LIVING WITH PATIENT:

Name:	Home phone: ( ) Relationship:
Address:	City/State/Zip:

PRIMARY INSURANCE:	***SECONDARY INSURANCE:***
Insur Name:	Insur Name:
Claims Address:	Claims Address:
City: State: Zip:	City: State: Zip:
Policy Holder's Name:	Policy Holder's Name:
Policy Holder's Birthdate: Sex:	Policy Holder's Birthdate: Sex:
Policy Holder Certificate/ID No:	Policy Holder Certificate/ID No:
Group or Policy No.:	Group or Policy No.:
Patient's Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other	Patient's Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other

AUTHORIZATION & ASSIGNMENT:

I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid or any other insurance company with which my/my dependent's care is covered any information needed to determine these benefits or benefits for related services. I further request that payment of authorized Medicare, Medigap, or any other insurance company benefits be made on my behalf directly to Midwest Ear Institute, P.C., for any services furnished to me by my physician. I acknowledge responsibility for payment of any deductibles, co-insurance, non-covered services, and services obtained without prior authorization from my insurance when required. By providing a wireless telephone number, I consent to receive calls and/or text messages, including those made by pre-recorded, artificial voice or automatic telephone devices from the office and its' affiliates including collection agencies. This authorization is valid until revoked by me or my legal representative. A photocopy of this authorization shall be considered as valid as the original. If for any reason the account should become delinquent, I agree to pay for all collection and legal fees.

Patient/Legal Representative Signature:_____ Date:_____

rev 04-13

Pharmacy and Prescription Benefits Information

Should the doctor decide you need to be taking a prescription medication, we are able to transmit prescriptions directly to your pharmacy, so your medication can be ready for you upon arrival. Please provide the name and address of the pharmacy that you would wish to have your prescriptions sent to. You may also provide information on an alternate pharmacy, in case you have one close to home and another close to your work. At the time a prescription is issued, we will verify with you the pharmacy to which you want the prescription sent but having the information in our system will speed up the process of getting your prescription on its way. Even if we have your pharmacy entered in our system, you may elect to take a printed copy to your pharmacy.

PLEASE PRINT

PATIENT INFORMATION: **Date completed**_____

Patient's Last Name:	Date of Birth:
First Name and Middle Initial:	

PREFERRED PHARMACY:	***ALTERNATE PHARMACY:***
Name:	Name:
Address:	Address:
City: State: Zip::	City: State: Zip::
Phone: ( )	Phone: ( )

Please provide the name and group number of any prescription drug benefits that you may have so that the doctor can check any medications he may wish to prescribe for you against the formulary of your insurance plan with the goal of minimizing your out-of-pocket costs whenever possible. You may have a separate identification card for your prescription drug benefits. **If this information is on the insurance identification cards you are presenting at registration, you may skip this section.**

PRESCRIPTION DRUG BENEFITS – 30 day supply	***MAIL ORDER – 90 day supply***
Rx Insur Plan:	Mail Order Rx Insur Plan:
Claims Address:	Claims Address:
City: State: Zip:	City: State: Zip:
Rx Group No.	Rx Group No.
Patient's Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other	Patient's Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other

Patient/Legal Representative Signature:_____ Date:_____

Please print clearly in ink. **Midwest Ear Institute, P.C.** Acct.#_____

First Name:	Last Name:	Age:	Weight:	Height:	❒ M ❒ F ❒ O
Medical problem for today's visit:		Birth Date: _____/_____/_____ Mo Day Year			

Allergy Questions (Please answer all.)

Do you have a history of:

- Asthma or wheezing? □ No □ Yes: How often do you use your rescue inhaler? _____
  Ever been hospitalized for severe attack? _____
- Beta-Blockers? □ No □ Yes: Which medications do you take? _____
- MAO- inhibitors? □ No □ Yes: Which medications do you take? _____
- Repeated sinus infections? □ No □ Yes
- Repeated ear infections? □ No □ Yes
- Severe allergic reaction or anaphylaxis (shock)? □ No □ Yes

Ever been hospitalized for allergic reaction? □ No □ Yes | Ever been allergy tested? □ No □ Yes

General symptoms: *(check all that apply)*

Pollen allergy symptoms
___ Worse outdoors
___ Worse in low damp place
___ Worse outdoors from 7 to 11 am
___ Worse in cold weather
___ Worse mowing or playing in grass
___ Worse in change of temp
___ Worse while dusting or sweeping
___ Worse in barns

Dust allergy symptoms
___ Worse 30 min. after lying down
___ Worse on cool evenings
___ Worse in low damp places
___ Worse in warm or cool air
___ Worse when dusting
___ Better indoors
___ Worse on humid evenings
___ Worse in certain homes

Mold allergy symptoms
___ Worse indoors
___ Worse outdoors from 4 to 9 pm
___ Worse on windy days
___ Better outdoors
___ Worse on clear days
___ Worse when sleeping
___ Worse in basements
___ Worse around pets or animals

Are your symptoms: ALL THE TIME OR SOMETIMES *(circle one)*
What medicines have helped your allergy symptoms? _____
During what months do you usually have allergy symptoms? _____
During what months are your allergy symptoms most severe? _____

Does your nose feel: *(check all that apply)*

	Never	Sometimes	Seasonally	Constantly
Stuffy or Congested?				
Runny?				
Itchy?				
Post-Nasal Drip?				

Do your eyes feel: *(check all that apply)*

	Never	Sometimes	Seasonally	Constantly
Full or Plugged?				
Itchy or Irritated?				
Wet or Discharge?				
Sore or Painful?				

Do you sneeze frequently? *(check all that apply)*

	Never	Sometimes	Seasonally	Constantly
Year-round				
Seasonally				
Daytime				
Nighttime				

Do you cough frequently? *(check all that apply)*

	Never	Sometimes	Seasonally	Constantly
Year-round				
Seasonally				
Daytime				
Nighttime				

How many colds do you usually have per year? _____ | Do you have house plants? □ No □ Yes

Do you have any dogs (inside or outside)? □ No □ Yes | Do you have any cats (inside or outside)? □ No □ Yes

Do you smoke? □ No □ Yes: *(see below)*
How much? _____ How long? _____
Around people that smoke? □ No □ Yes: How often?_____

What type of housing do you have?
___ Single Housing ___ Duplex ___ Apartment
___ Condo ___Other: _____ *(specifiy)*
When was it built?_____ Where is it located? *(below)*
___ City ___ Suburban ___ Rural ___ Farm

Do you have any food allergies? □ No □ Yes: Specify: _____
Is there a family history of allergies? □ No □ Yes: If yes, who? _____

Page 2: Patient Name: Birth Date:

Review of Body Systems

	Circle any of the following symptoms you may be experiencing.
General	Weight loss Weight gain Fever Other
Eyes	Dryness Blurry vision Double vision Pain Other
Nose/Throat/Sinus	Congestion Pressure Drainage Pain Hoarseness Difficulty swallowing Other
Heart/Blood Vessels	Chest pain Chest pressure Palpitations Leg swelling Other
Lungs/Breathing	Shortness of breath Cough Wheezing Other
Stomach/Bowels/Ulcers	Acid reflux Cramping Diarrhea Constipation Pain Other
Kidney/Bladder/Prostate	Incontinence Difficulty starting stream of urine Bleeding Pain Other
Muscles/Bones/Joints	Pain Stiffness Swelling Other
Skin/Breasts	Skin dryness Skin sores Skin rash Breast swelling/tenderness/lump Other
Neurologic	Headaches Tremor--Weakness--Numbness (arm, leg, both) Sleep apnea Other
Psychiatric	Depressed Anxious Other
Endocrine/Hormones	Diabetes/High blood sugar Low blood sugar Menopause High thyroid Low thyroid Other
Blood/Lymph	Easy bruising Easy bleeding Low blood count Hemophilia Sickle cell history Other
Allergy/Immune System	Allergies: (Food Insects Latex) Steroid Use History of organ transplant Other

Current Medications

(Include prescription, over-the-counter, and herbal.) ☐ None

1. _____
Dose: _____
2. _____
Dose: _____
3. _____
Dose: _____
4. _____
Dose: _____
5. _____
Dose: _____
6. _____
Dose: _____

Past Medical History

Have you had any present or past medical problems that doctors have treated?
☐ No ☐ Yes (If yes, please list below.)

1.
2.
3.
4.
5.

Past Surgical History

Have you had any past surgeries or surgical procedures?
☐ No ☐ Yes (If yes, please list below.)

1.
2.
3.
4.

Do you have any drug allergies? ☐ No ☐ Yes (list):
If yes, what are your reactions? ☐ Itching ☐ Rash ☐ Swelling ☐ Trouble breathing ☐ Other:

Family History

Does anyone in your family have hearing loss? ☐ No ☐ Yes
If yes, who? _____
_____

Any other medical problems in your family? ☐ No ☐ Yes
If yes, list:
_____
_____
_____
_____
_____

Social History

1. What is, or was, your occupation?_____
2. Have you ever worked in a noisy place? ☐ No ☐ Yes
   If yes, what place? _____ How many years?_____
3. Have you ever been subjected to loud noises in the military? ☐ No ☐ Yes
   If yes, how many years? _____
4. Do you have any noisy hobbies? ☐ No ☐ Yes
   If yes, what?_____ How many years?_____
5. Are you at risk for HIV/AIDS? ☐ No ☐ Yes
6. Do you smoke or use tobacco? ☐ Yes **If yes**, ☐ Daily or ☐ Occasional?
   ☐ No **If no**, have you ever smoked? _____
7. Do you put salt on your food? ☐ No ☐ Yes
8. # cups of coffee/tea/cola (containing caffeine) you have/day _____
9. Do you drink any alcohol? ☐ No ☐ Yes, ____ drinks/week

Please Sign here (Patient or Guardian):
X_____Date_____

Vincent Ostrowski, MD_____ Jamie Weber, NP-C_____ Rev. w/patient_____/_____/_____

NOTE:
SIGNATURE REQUIRED ON REVERSE

FINANCIAL POLICY

Whether you are new to our practice or we have had the pleasure of serving you over the years, we would like you to be aware of our financial policies. **Please read this information carefully—front and back sides—sign on the reverse, and turn in to the receptionist.** We will be happy to give you another copy to keep for your reference.

Registration. At each visit our receptionist will verify and update your demographic information and insurance coverage and may periodically ask you to complete a new registration form to insure our information is accurate. **Please be sure to have your insurance cards with you at every visit so we may properly bill your insurance company. If you do not have your card with you, you may be required to make full payment that day.** Because of new federal laws designed to protect you from identity theft, we must also ask for **photo I.D.** such as Driver's License or other government-issued identification.

Insurance. We participate in Medicare, traditional Medicaid (but not Medicaid Managed Care Plans) when secondary to other insurance, and most commercial insurance plans in the central Indiana area but cannot know the details of the coverage and benefits for your particular policy. Therefore, you will need to be familiar with your policy and know what is required to access medical care. Your insurance may have one or more of the following requirements:

- Referral from your primary care physician authorizing your visit with our doctor, done either by a specific form or by a tracking number assigned to your visit. (If your insurance card has a physician's name on it, it usually means that physician must authorize your care by a specialist.)
- Co-pay that must be paid each visit
- Annual deductibles that apply
- Specific hospitals, x-ray facilities, and clinical laboratories that must be utilized for these services.

If you are unsure of what you need, contact your insurance representative or primary care physician before your visit.

A further note about Referral Authorizations: If your insurance policy requires this referral, **it is your responsibility to make sure we have authorization prior to being seen by the doctor**. **Unless you have a medical emergency, if we do not have a referral authorization for your visit and you are unable to obtain one, the visit will be rescheduled.** While this may seem harsh, it is for your protection as much as ours, as some insurance plans will not pay for any tests or treatment that result from an unauthorized initial visit. If you have a second insurance company, please consider whether that insurance company may require prior referral authorization for the services; if so, and none has been obtained, they will deny payment and you will be responsible for the amounts they might have otherwise paid on your behalf.

Patient responsibility balances. You will be responsible for

- Services not covered by your insurance.
- Co-pays (will be collected at check-in) and balances remaining after your insurance company has paid, including deductibles and co-insurance (percentage of the allowed amount that is your obligation).
- Balances that remain unpaid 60 days after they have been filed with your insurance company but we have received no payment or response

(Continued on reverse)

Payment in full is expected within 30 days from your first statement advising you of the patient balance due. A $5.00 rebilling fee will be added to your account balance for each subsequent statement and delinquent accounts may be turned over for pursuit by an external collection agency, so *please inform us immediately if financial difficulties arise*.

Self-Pay, Services not covered by insurance, and Large deductibles. If you do not have medical insurance or we are not contracted with your insurance plan, you will be expected to pay at the time of service, or, in some instances, prior to service. Similarly, if you have a large deductible on your insurance policy, we may require a prepayment towards the cost of certain diagnostic tests or surgical procedures. Our billing office will be happy to help you plan to meet the costs of your care.

Disability and FMLA forms. We will complete the first form for your disability insurance at no charge but for all subsequent forms there will be a $15.00 charge. There is also a $15.00 charge for completing FMLA paperwork. Payment should be presented with the form.

Payment methods. For your convenience, in addition to cash or personal check, we also accept VISA, MasterCard, Discover, and American Express cards. Please be aware that checks returned for insufficient funds will result in a $25.00 fee being added to your account.

Medical Care to Minors. If both parents have insurance, the insurance of the parent whose birthday falls first in the calendar year will be considered primary for the child, and the other parent's insurance will be secondary. When the parents are divorced, we will consider the parent/legal guardian who presents a child for care to be the responsible party for payment of services, regardless of financial responsibility established in a divorce decree. Further, care for a patient under 18 years of age must be authorized by a parent, legal guardian, or someone to whom you give written authorization to present the child for care.

Motor Vehicle Accidents. If your medical condition results from a motor vehicle accident, we will treat your account as any other, i.e., we will consider you—not your auto insurance—to be the responsible party for all fees. If you have health insurance, we will bill the health insurance and look to you for any unpaid balances. It will be up to your health insurance company to obtain reimbursement from either your automobile insurance or that of another party who is held responsible for the accident. If you have no health insurance, you will be considered a Self-Pay patient.

Acknowledgement and Authorization. I have read, understand, and agree to the above policies. I Regardless of any insurance I may have, I am ultimately responsible for payment for any professional services rendered. I authorize the release of medical information necessary to process a claim for benefits under my policy and assign payment of my insurance benefits to the Midwest Ear Institute, P.C. If my account should become delinquent, I agree to pay the costs of collection, including legal fees and court costs.

Signature _____ Date_____

Patient or Responsible Party

rev 5-11