David W. Van Kooten, MD **David A. Hartemink, MD**

PLEASE USE ONLY BLACK INK

TODAY'S DATE:____________

Patient Information:

Last Name__________________________First Name_______________________ Middle Initial_________

Mailing address________________________APT#______City________________State______Zip__________

Home Phone________________________________Cell Phone______________________________________

Work Phone__________________________Employer____

Date of Birth______________Age___________Sex________Social Security No.________________________

Email____________________________ Is it ok to communicate with you via email? Yes _______No_________

Race_______________Ethnicity____________Language______________Refuse to Answer_____________

Pharmacy Information

Pharmacy Name______________________Pharmacy City/Cross streets_______________________________

Referring Physician information

Primary Care Physician___________________________Phone Number ______________________________

Referring Physician______________________________Phone Number________________________________

Primary Insurance Information

Primary Insurance Name____________________ID #_________________Group No.______________________

SPECIALIST COPAY $_________________Policyholder's name____

(If patient is not the policyholder, please complete the section below)

Policyholder's Address____Phone _______________________

Policyholder's Social Security No.________________________Policyholder's Employer___________________

Policyholder's Marital Status__________________________Policyholder's Date of Birth__________________

Patient's relationship to Policyholder____

Secondary Insurance Information

Secondary Insurance Name_____________________ID #__________________Group No._________________

SPECIALIST COPAY $______________Policyholder's name____

(If patient is not the policyholder, please complete the section below)

Policyholder's Address____Phone number__________________

Policyholder's Social Security No.______________________Policyholder's Employer_____________________

Policyholder's Marital Status________________________Policyholder's Date of Birth____________________

Patient's relationship to Policyholder____

Auto Injury/ Work Comp

Auto injury or Work Comp?_______________Claim No.___________________Date of accident___________

Emergency Contact

Name________________________ Phone_________________ Relationship to patient___________________

Dr. David Van Kooten Dr. David Hartemink

Print Patient Name____**Date of Birth**_______________

AUTHORIZATION TO PROCESS CLAIMS

I authorize the release of any information required to process claims, utilization review and quality assurances for services rendered and hereby assign my insurance benefits to be paid directly to my physician.*

____ __________________________

Signature of Patient or Guardian Date

ACKNOWLEDGEMENT OF FINANCIAL POLICY

I have read and acknowledge the financial policies of the office. This policy includes a $50.00 fee for failing to cancel an appointment with 24-hour notice. I also understand it is my responsibility to update insurance information with the office and to have a current referral from my primary care office if required by my plan.

____ __________________________

Signature of Patient or Guardian Date

HIPAA ACKNOWLEDGEMENT

I acknowledge that I have read the Notice of Privacy Practices, including marketing contact. (A copy is available in the office upon request)

____ __________________________

Signature Patient or Guardian Date

***** Is there anyone we can talk to about medical issues? YES / NO**
Name___________________________**Phone Number** ________________**Relationship**______________
Name___________________________**Phone Number** ________________**Relationship**______________

Can we leave a voicemail regarding medical issues? YES / NO Phone Number____________________

ELECTRONIC PRESCRIPTION ACCESS

I acknowledge that the office may use an electronic system to look at/and prescribe medications

____ __________________________

Signature Patient or Guardian Date

*****The authorization to process claims, the financial policy, the HIPAA acknowledgement and E-prescribing access must be signed to be seen in our office.**

Dr. David Van Kooten Dr. David Hartemink

Welcome to our office. Please provide answers to the following questions so we may better care for you.

Patient Name______________________**DOB** ____________**Today's Date** _____________________

Reason for today's visit ____

Medications*** (Include all reasons for your medications)

Do you take any prescription medications or supplements? No_____Yes_____

1________________________________ 4 _______________________7 _____________________
2________________________________ 5_______________________ 8 ____________________
3________________________________ 6_______________________ 9 ____________________

Have you had a flu vaccine since last September? YES NO **If yes, Where**? _________________

Medical History (diabetes, heart disease, high cholesterol, asthma, allergies, cancer history etc)

1 ______________________________ 5 ________________________________
2 ______________________________ 6 ________________________________
3 ______________________________ 7 ________________________________
4 ______________________________ 8 ________________________________

Allergies

Do you have an allergy to latex? No ___Yes ___ Do You have a seafood or Iodine allergy? No___Yes____

Do you have an allergy to any medications? No_______ Yes ______ if so, please list.

1_____________________________ 4 ____________________________
2 ____________________________ 5 ____________________________
3_____________________________ 6 ____________________________

Surgical History (List any surgeries you have had)

1_________________________________ 3 ____________________________
2 ________________________________ 4 ____________________________

Have you ever had problems with general anesthesia? No ________Yes ________

Have you ever had a blood transfusion? No ________Yes _______

Hospitalizations (where, when, what were you seen for?)

1 ______________________________4 ________________________________
2 ______________________________5 ________________________________
3 ______________________________6 ________________________________

Family History (circle what applies and list who in your family had the issue)

Hearing loss__________Heart disease_________Anesthesia problems___________

Diabetes_____________Cancer (if yes what type?) _________________________

Social History

Do you use or have you used tobacco? Never ________Former Smoker (date quit)_________________

Current Smoker No_____Yes_______ Packs Per Day (now or past) ________Number of years Smoked:____

Do you use alcohol?* Never Rare Socially Moderate Heavy

Have you used recreational drugs of ANY type in the past 12 Months? What kind?_________ When?________

Dr. David Van Kooten **Dr. David Hartemink**

Review of System

Patient Name_________________ Date of Birth____________Today's Date_______________

Do you have any of the following? (Please circle ALL that apply to you)

ENT: ear infection, ear drainage, hearing problem, dizziness, change in smell/taste, nasal drainage, nasal obstruction, facial pain, nasal trauma, snoring, voice change, pain with swallowing, chronic cough, neck mass, head and neck cancer, mouth lesions/sores, tonsillitis, shortness of breath, difficulty swallowing, ear pain, nosebleed, ringing in the ears, sinus infections

Ophthalmologic: glaucoma, Blurred vision

General/ Constitutional: chills, fatigue, fever, recent weight gain, recent weight loss

Cardiovascular: high blood pressure, chest pain at rest, chest pain with exertion, palpitations

Respiratory: asthma, wheezing

Gastrointestinal : heartburn, nausea

Skin: eczema, rash

Hematology: easy bleeding, family history of bleeding, swollen glands

Musculoskeletal: joint pain, neck pain

Psychiatric: anxiety, depressed mood

Infectious Diseases: HIV, hepatitis A, hepatitis B, hepatitis C, tuberculosis

Neurologic: stroke, headache, seizures/epilepsy

Endocrine: diabetes, thyroid problems

Patient Signature____Date_____________

7850 Vance Dr Suite #225 Arvada, CO 80003
500 W 144th Ave Suite #100 Westminster, CO 80023
3555 Lutheran Pkwy Suite #160 Wheat Ridge, CO 80033
12253 E 104th Pl Suite #101 Commerce City, CO 80022

Dr. David Van Kooten Dr. David Hartemink

To comply with Federal HIPAA (Health Insurance Portability and Accountability Act) guidelines Dr. Van Kooten and Dr. Hartemink have implemented the following policy regarding Patient Privacy and Confidentiality. There are posters in the office with ALL the HIPAA guidelines. This sheet serves as notification of our policy. (A copy of the entire HIPAA law is available at any time)

PRIVACY NOTICE

Our office holds patient record information confidential. However, we will use this information for the following reasons: TREATMENT, PAYMENT & HEALTHCARE OPERATIONS. The following is a list of who your information might be disclosed to:

- Primary care physician or other physicians involved in your care
- Diagnostic Facilities
- Hospitals
- Labs
- Insurance Companies
- Billing and Collection Services
- Workers' Compensation

DISCLOSING RECORD INFORMATION

Release of information to any other entity (not listed above) will require a signed request from the patient or guardian. This request must be dated, show who the information is to be released to, their address and specify what information will be released. These authorizations are good for one time only. Additional requests will require a separate authorization. We will keep a record of any disclosure of your medical records. This information will be available for your review.

YOU HAVE A RIGHT TO ACCESS YOUR RECORDS

Patients can review and obtain copies of their records. Our office requires a written request:

- In compliance with Federal and State Laws our office will have records available within 10 days of receipt of the request.

MARKETING

This office, on occasion, will mail information to our patients regarding upcoming sales, promotions or information that may be of value to our patients. I acknowledge that I understand that I may receive some of this information and this office may receive reimbursement for the cost of these mailings from a third party. I also understand that I have the right to opt-out, in writing, at any time and no longer receive these mailings. Appointment and reminder calls/cards are not bound by these policies.

OTHER INFORMATION

If we need to contact you by telephone and leave a message we will only leave the practice name, the person calling and our phone number. We WILL NOT leave any medical information on an answering machine or with anyone other than the patient or guardian. It will then be your responsibility to return the call.

Advantage
ENT & Audiology

Dr. David Van Kooten Dr. David Hartemink

Patient Financial Policy

Billing & Payment: Payment is expected at the time of service unless prior arrangements have been made. Co-pays are required at the time of service prior to being seen. We accept cash, Master Card, Visa, Discover, American Express and checks with valid driver's license. If you pay in cash you will receive a receipt. It is your responsibility to know your co-payment.

Insurance: If your insurance coverage requires a referral from your primary care doctor it is your responsibility to have that sent to our office prior to making an appointment. As a courtesy we will submit your bill to your insurance company. Your insurance company will send an Explanation of Benefits (EOB) to you as well as to us. If there is any amount owed by you due to co-insurance or deductible we will send you a statement reflecting that. If the bill is not paid within 90 days of the date of service, the balance will be due and payable by you. Payment for our services is your responsibility. Please call your insurance company if you have any questions or complaints about your coverage.

Non-Insured Patients: Patients with no insurance are asked to pay for their visit at the time of service. The staff will collect the office visit charge before seeing the doctor. If any other services are preformed (Audio testing, use of Microscope, etc) those charges will be expected at the time they are done.

Forms: Disability forms, FMLA forms, restrictions forms/question forms sent by your employer, and letters to attorneys will be provided after requested pre-payments are received. If you require documentation for your HRA spending account, please request a copy of your bill at the time of service, otherwise there will be a $25.00 fee assessed if we have to provide it to you later.

Missed Appointments: Missed appointments or failure to call the office 24 hours before scheduled appointment will result in a $50.00 charge.

We appreciate your assistance and look forward to serving you.