



**Jeffrey H. Aroesty, M.D., F.A.C.S., P.C.**

Diplomat American Board of Otolaryngology

Michele Corrice, A.P.N.-C

Nurse Practitioner

Anne Anderson, M. A., CCC/A, F.A.A.A.,

Audiologist & Hearing Aid Dispension

To Our New Patient:

Our office staff would like to take this opportunity to welcome you to our practice and to assist in making your visit a pleasant and comfortable experience.

We have combined a ***Patient Registration Package*** of our most-commonly used forms. Download the entire package, complete the information on each form and return them to our office, at your earliest convenience.

Thank you,

*The Office Staff*

Dr. Jeffrey H. Aroesty

400 Valley Road Suite 105

Mount Arlington, NJ 07856

973.770.7101 (Phone)

973.770.7108 (Fax)

Hours By Appointment

**Registration :**

**Jeffrey Aroesty, MD, P.C.**

Date	Account ID	Chart ID	Other ID	Internal Use
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**Patient Information**

Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Age	Social Security #
Address			Home:		How did you hear of us?		
Address 2			Work:				
			Cell:				
			Email:				
City	State	Zip Code	Employer Name & Address			Occupation	
Emergency Contact			Phone		Pharmacy		Pharmacy Phone

<b>Physician</b>	<b>Family Physician</b>	<b>Referring Physician</b>
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Medical Insurance	Name & Address	Policyholder	Relationship	Policy ID	Group ID
1					
2					
3					

**Guarantor (Person to be billed, if different than patient)**

1 Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #
Address			Home:		Work:	Email:
City	State	Zip Code	Employer Name & Address			Occupation
2 Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #
Address			Home:		Work:	Email:
City	State	Zip Code	Employer Name & Address			Occupation

**HIPAA Approved Contacts**

1 Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship
Address		City	State	Zip Code	Home:	Cell:
						Work:
2 Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship
Address		City	State	Zip Code	Home:	Cell:
						Work:

**Patient's or Authorized Person's Signature**

I the undersigned give my authorization to treat and assign directly Jeffrey Aroesty, MD, P.C., all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I her authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.

I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

<b>Signature</b>	<b>Signature Date</b>	<b>Jeffrey Aroesty, MD, P.C.</b>	Phone: 973-770-7101
X		400 Valley Road, Suite 105	Email:
		Mount Arlington, NJ 07856	

**Please attach all pertinent insurance ID cards for photocopying.**

**PATIENT HEALTH HISTORY**

Patient's Name (last) \_\_\_\_\_ (first) \_\_\_\_\_

Sex  Male  Female      Date of Birth: \_\_\_\_\_

Name of Primary Care Physician: \_\_\_\_\_

Pharmacy Preference(location and phone number) \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

**PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:**

Name of Medication	Dosage	How often taken

**MEDICATION ALLERGIES?  YES  NO If Yes, please list below:**

Name of Medication	Type of Reaction

**SURGERIES AND HOSPITALIZATIONS:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PROBLEMS WITH ANESTHESIA?  YES  NO**

If yes, what type? \_\_\_\_\_

Have you ever been hospitalized for non-surgical reasons?  YES  NO If yes, list reasons \_\_\_\_\_

**CURRENT OR MOST RECENT OCCUPATION:** \_\_\_\_\_

**JEFFREY H. AROESTY M.D. F.A.C.S., P.C.**  
**Diplomate American Board of Otolaryngology**  
**Otolaryngology Head & Neck Surgery**  
**Michele M. Corrice, APN-C**

**Financial Policies**

Thank you for choosing us as your healthcare provider. The following is an explanation of our financial policies which we require you to read and sign. All patients must complete all information requested including our financial policy forms prior to being seen by the Doctor.

**For Medicare Beneficiaries: Medicare Lifetime Signature on file**

I request that payment of authorized Medicare benefits be made on my behalf to *Jeffrey H. Aroesty, M.D., P.C.* for services rendered to me by the physician or his licensed staff. I authorize any holder of medical information about me to release to the Centers for Medicare and its agents any information needed to determine these benefits or benefits payable for related services.

**Date:** \_\_\_\_\_ **Signed:** \_\_\_\_\_

**Co-Payment & Referral Compliance (if applicable)**

We ask all of our patients to be mindful of their health insurance plan requirements. If your insurance plan requires co-payments and/or referrals, it is your responsibility to have these available at each office visit. It is considered fraud for us to collect co-payments from some and not others. Please be advised that should you choose not to pay your co-pay or supply us with a current referral we will have to notify your insurance carrier, and in turn, they may drop you as a subscriber for non-compliance.

Our intention is to support you by providing the highest quality of care and assist you in processing your medical claims. We would never want to jeopardize your insurance or our contract with your carrier by not collecting your co-payment or obtaining a current referral. Our staff makes every effort to remind the patients when a new referral is required; however, the ultimate responsibility lies with the patient.

**Thank you for your cooperation.**

\_\_\_\_\_  
**Patient signature** **Date**

**Patients without Insurance**

Full payment is due at time of service. We accept cash, checks, Visa, Mastercard and American Express.

**Non-Participating Provider and/or Non-Covered Benefits**

If Dr. Aroesty is not a participating provider with your insurance carrier, or the services to be rendered are not covered benefits, then we will require full remittance at the time of service or prior to the service depending on the nature of the care. Upon request, we will provide you with an itemized statement for your records and appropriate forms that you may submit for reimbursement.

**IF YOUR INSURANCE HAS CHANGED YOU MUST NOTIFY THE FRONT DESK.** Your insurance card must be provided at each visit.

**Non-Sufficient Funds**

Any check returned for non-sufficient funds will be assessed a \$35 processing fee. Failure to pay in full within 10 days of the date of billing will result in your account entering into Collection proceedings. You are responsible for all costs incurred by our office in our effort to obtain reimbursement for services provided.

**Outstanding balances**

Outstanding balances are due within 30 days. Payment in full of any past due balance is expected prior to being seen in our office. All balances that reach 90 days past due will be sent to collection. Should your account be sent to our collection agency, you will be responsible for a 30% collection fee, and any legal fees that our office incurs through the process utilized to collect a delinquent balance.

**Broken Appointment Policy**

Our office maintains a strict policy regarding broken appointments. A broken appointment is defined as any reserved block of time scheduled for a patient which the patient either verbally cancelled less than 24 hours prior to the scheduled appointment or just “no shows” without any advanced notification.

As a courtesy to our patients, we have a service that calls the patients two days prior to their appointments. This automated system will make several attempts to reach the patient and will leave a message on the patient’s answering machine. Patient’s scheduled for an appointment with our Audiologist will receive an additional reminder call from a member of our staff. Before rescheduling a patient who had a broken appointment due to a “no show”, they will be subject to a broken appointment fee of \$50.00.

If a patient breaks an appointment three times, then he/she may not be scheduled without the approval of the physician or Practice Administrator.

When appointments are not cancelled in a timely manner, our practice is unable to fill valuable appointment slots with other patients who are eager to be cared for by our practice. It is necessary for us to enforce this policy in order to be fair to all of our current and future patients. This policy will decrease waiting time for all patients and help ensure availability and prompt medical care. We understand that a situation may arise that may not permit you to give us a 24 hour cancellation notice. Exceptions to this policy will be determined on an individual basis according to circumstances.

**Medical Records**

Medical records created by our Practice will be released only with your expressed written consent and completion of the appropriate authorizations to release health information in compliance with federal and state laws. Medical records sent to our office may not be forwarded even with consent. According to New Jersey State regulations (NJAc 8:43G-15-3), a copying fee shall not exceed \$1.00 per page or \$100. per record for the first 100 pages. For records that contain more than 100 pages, a maximum of \$200.00 may be charged.

Our goal is to provide our patients with optimum care. By disclosing our office policies to our patients in advance, we hope to avoid any misunderstandings in the future and make your association with us a pleasant experience.

Thank you for your cooperation.

\_\_\_\_\_  
**PATIENT OR RESPONSIBLE PARTY SIGNATURE**

\_\_\_\_\_  
**PRINT NAME**

\_\_\_\_\_  
**DATE**

**Contact Authorization**

In order to abide by the HIPPA Compliance Law to protect the patient’s privacy, it is necessary to complete the information below. Please check the appropriate boxes below in order for us to protect your HIPPA rights.

**Patient Name:** \_\_\_\_\_

**Minor:**  Yes  No

**May message be left on answering machine?**  Yes  No

**Person(s) we may speak with regarding the patient’s condition, appointments, tests and test results:**

**Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_

**Insurance Information**

Patient name: \_\_\_\_\_

DOB: \_\_\_\_\_

Insurance carrier: \_\_\_\_\_

Policy # \_\_\_\_\_

Referral required? Yes  No

Policy Holder: \_\_\_\_\_

DOB: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**\*\*Please bring your insurance card with you to office visits\*\***

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

## SNORING QUESTIONNAIRE

Snoring can be a harmless annoyance or an indication of a more serious sleep disorder. This short quiz can help you to determine if your snoring is affecting your life and relationships.

Choose the number from the scale below that best describes the snoring in your situation.

0 = Never

1 = Infrequently (1 night per week)

2 = Frequently (2 - 3 nights per week)

3 = Most of the time (4 or more nights per week)

Situation:	Your Score
Snoring affects my relationship with my partner.	
Snoring causes my partner to be irritable or tired.	
Snoring requires us to sleep in separate rooms.	
The snoring is loud.	
Snoring affects other people when I am sleeping away from home (hotel, camping, etc.).	
<b>Total:</b>	

If your total score is **5** or greater, your snoring is affecting your quality of life and relationships. You should consider discussing treatment options available for your snoring with your doctor.

## SLEEPINESS QUESTIONNAIRE

In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations? Use the scale below to choose the most appropriate number for each situation:

0 = Would never doze

1 = Slight chance of dozing

2 = Moderate chance of dozing

3 = High chance of dozing

Situation:	Your Score
Sitting and reading	
Watching television	
Sitting inactive in a public place (movie theater)	
As a car passenger for an hour without a break	
Lying down to rest in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car while stopped for a few minutes in traffic	
<b>Total:</b>	

If your total score is **6** or greater, you may have a sleep disorder. Your doctor will discuss results with you.