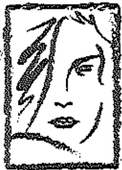
Commonwealth
ear nose and throat specialists pc



COMMONWEALTH
FACIAL PLASTIC SURGERY

Commonwealth ENT & Facial Plastic Surgery
1 Park West Circle, Suite 200, Midlothian, VA 23114
(804) 378-7443

Patrick J. Gibbons M.D. / Matthew A. Bridges M.D.
Sheri Stoots M.Ed / Marcie Luton LE

DIRECTIONS:

From our current location:
Turn right onto CenterPointe Parkway, proceed through the stoplight at the intersection of Charter Colony and Lucks Lane, then make the first left onto Park West Circle.

From Powhite pkwy South:
Continue past Rt. 288 exit. At the end of the expressway make a right at the stoplight onto Charter Colony Pkwy. At the next stoplight turn right onto Lucks Lane, then make your first left onto Park West Circle.

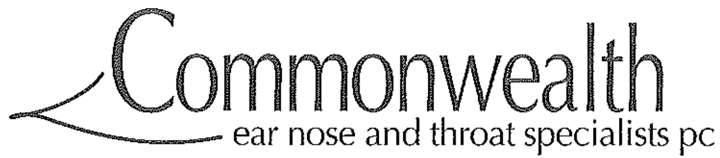
From Midlothian Tnpk West/East:
Turn onto Charter Colony Pkwy. At the 2nd stoplight, turn left onto Lucks Lane. First left onto Park West Circle.

From Hull Street West/East:
Turn onto Old Hundred Road. Follow for approx. 3.5 miles (road becomes Charter Colony) at 4th stoplight turn right onto Lucks Lane. Make your first left onto Park West Circle.

From Route 288:
Take the Lucks Lane exit. Proceed west on Lucks Lane/Center Pointe (Rt. 720) once you cross the bridge make your first right onto Park West Circle.

From Center Pointe Parkway:
Continue through stoplight at the intersection of Charter Colony and Center Pointe/Lucks Lane. Make your first left onto Park West Circle.

From Watkins Centre:
Head northeast on Watkins Centre Pkwy. Take Route 288 to Lucks Lane exit. Bear right onto Lucks Lane. Make your first right onto Park West Circle.



Dr. Patrick Gibbons
Dr. Matthew Bridges

Commonwealth Ear, Nose, and Throat Specialists
1 Park West Circle
Suite 200
Midlothian, VA 23114

We are now located across the street from the "front" of St. Francis Hospital. We are in the Center Pointe Office Building which is right off of Lucks Lane.

Please fill out the patient forms before you come to your appointment. You can fax the forms to our office but we ask that you also bring them with you just in case we do not receive them. Our fax number is (804) 378-0744. Make sure you bring your picture ID and Insurance card with you to the appointment. Co-pays are collected at the time of your appointment. If no co-pay is listed on your card we will collect $45.00.

We look forward to seeing you!

Patient Information

Referring Physician ______________________ Primary Care Physician ______________________

Patient's Full Name ____

Date of Birth________________Age _____ Sex: ❑ Male ❑ Female Social Security# ______________________

Address ____ Apt# __________

City ______________________ State ______________ Zip code__________

Home Phone (___) ______________ Work Phone (___) ______________ Cell Phone (___)______________

Email Address ______________________ Patient's Employer ______________________

Preferred Method of Contact ❑ Home Phone ❑ Work Phone ❑ Cell Phone ❑ Email

Pharmacy Name ______________________ Number or Location ______________________

Race ______________ Ethnicity ______________ Language ______________

Spouse's Name ____ Date of Birth__________

Spouse's Social Security# ______________________ Spouse's Phone ______________________

Spouse's Employer ____

Responsible Party

If you are providing the information above for a patient under the age of 18 years old, please complete this section below:

Father/Guardian's Name ____ SSN __________

DOB ______________ Phone ______________ Relationship to Patient __________

Address (If different from above) ____

Employer Work ______________________ Phone (___) ______________________

Mother/Guardian's Name____ SSN __________

DOB ______________ Phone ______________ Relationship to Patient __________

Address (If different from above) ____

Employer Work Phone(___) ____

Insurance Information

Insurance Company ____

Policy ID# ______________________ Group#______________________

Policy Holder's Name ____ DOB __________

Address______________ Phone______________ Relationship to Patient __________

Secondary Insurance Company____

Policy ID# ______________________ Group#______________________

Policy Holder's Name ____ DOB __________

Address______________ Phone______________ Relationship to Patient __________

Is today's visit pertaining to a motor vehicle accident or a workman's comp injury? ❑ Yes ❑ No

If you answer yes please complete the following Information:

Insurance Company Name____

Agent Name/Contact Name ______________________ Phone (___) ______________________

Claims/Billing Address____

Claim#______________________ Date of Accident or Injury ______________________

Please read, initial each policy, and sign acknowledging that you have read and understand each policy below.

Initial Patient Acknowledgement of Financial Responsibility ______**Initial**

I hereby authorize Commonwealth ENT Specialists, P.C. to release medical information to any of my physicians or insurance companies that may be pertinent to my case. I hereby authorize payment directly to Commonwealth ENT Specialist, P.C. of benefits otherwise payable to me. I hereby authorize the release of medical records to third party insurers or other authorized persons to whom disclosure is necessary to establish or collect a fee for the service. I understand that I am financially responsible for charges not covered by this authorization. A photocopy of this authorization shall be valid as the original.

I certify that I have read and fully understand the above statement and consent fully and voluntarily to its contents.

Referral Policy ______**Initial**

If a referral is required by the Insurance carrier, it ls the sole responsibility of the patient to provide Commonwealth ENT Specialists, P.C. with such referral or to be held responsible for payment of services rendered.

Acknowledgement of Receipt of Notice of Privacy Practices ______**Initial**

I acknowledge that I have received from the Group a copy of a separate document, entitled, "Notice of Privacy Practices" which sets forth this Group's privacy practices and my rights regarding the privacy of my protected health information.

Consent for Use or Disclosure of Patient Information for the Purposes of Treatment, Payment, and Healthcare ______**Initial**

I hereby consent to Commonwealth ENT using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me or to carry out the Practice's health care operations. I also consent to Commonwealth ENT using or disclosing my protected health information for treatment activities provided by another health care provider, as well as the payment activities conducted by another health care provider or entity. I further consent to the disclosure of my protected health Information ln order for another provider or health care entity to conduct health care operations including quality assessment and reviewing the competence of health care professionals.

Patient's Signature (or responsible party) ______________________________ Date ____________

Printed Name of Patient or
Personal Representative ____

Relationship to Patient____

Patient's Consent for Provider to Disclose PHI to Authorized Persons

I hereby authorize you, my healthcare provider (" Provider"), to disclose any and all of my medical and protected health information ("PHI") to the person indicated below.

Persons to Whom Disclosure May be Made. Provider may disclose my PHI to the following persons:

Name	Relationship	Contact#
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________

Purpose of Disclosure – The purpose of the disclosure is to allow these persons to participate In my care, participate In the payment of my medical bills, and/or to know the status of my health.

Expiration of Authorization – This authorization shall continue until I revoke this authorization in writing, which I may do at any time by sending a letter addressed to the Privacy Officer to any office where I am treated by Provider.

Conditioning of Treatment – Provider may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this consent.

Redisclosure by Recipient – I understand that once Provider discloses my PHI to the persons listed herein, my Provider has no control as to whether those persons may redisclose my PHI, which may no longer be protected by federal or state law.

Acknowledgment of Reading and Agreement – I have read and understand this authorization.

____ ______________

Patient Name or Representative Date

____

If a Representative Signs, state the Representative's Authority

CANCELLATION/NO SHOW POLICY FOR DOCTOR APPOINTMENTS, AUDIOGRAMS, VNG APPOINTMENTS, SURGERY

1. CANCELLATION/NO SHOW POLICY FOR DOCTOR APPOINTMENTS & AUDIOGRAMS

   When you do not call to cancel an appointment, you may be preventing another patient from getting much-needed treatment.

   If an appointment is not canceled at least 24 hours In advance, you will be charged a forty dollar ($40.00) fee PER appointment; this will not be covered by your insurance company. If the appointment Is scheduled on a Monday please contact our office on FRIDAY to cancel/reschedule. Cancellations over the weekend (Saturday and Sunday) for Monday appointments will result in a no show fee.

2. CANCELLATION/NO SHOW POLICY FOR VNG APPOINTMENTS

   Due to the large block of time need for a VNG test, no shows or cancellations with less than 24-hour notice will be subject to an $85.00 fee.

   If a VNG appointment Is not canceled at least 24 hours In advance, you will be charged an eighty-five dollar ($85.00) fee; this will not be covered by your insurance company. If the appointment is scheduled on a Monday, please contact our office on FRIDAY to cancel/reschedule. Cancellations over the weekend (Saturday and Sunday) for Monday appointments will result in a no show fee.

3. CANCELLATION/NO SHOW POLICY FOR SURGERY

   In order to give full consideration to the hospital staff and anesthesia staff, it is necessary for us to implement a cancellation/no show policy.

   If you need to cancel your surgery, we ask that you do so in a timely manner.

   Cancellations less than seventy-two hours before surgery will be charged a two hundred dollar ($200.00) fee; this will not be covered by your insurance company.

   Cancellations less than twenty-four hours before surgery will be charged a four hundred dollar ($400.00) fee; this will not be covered by your Insurance company.

Fees are subject to change

____
PRINT:

______________________________________ ______________
Signature Date

COLLECTIONS POLICY

Collection Agency/Attorney Fees

In the event that your account is turned over to a collection agency or attorney, you agree that you will be responsible for a collection fee equal to 33.3% of the outstanding balance due on the date the account is turned over for collection.

Collection Costs

In the event that the account becomes delinquent and is necessary to expend costs for the collection of the account, you understand that you will be responsible for the costs. These costs could include court costs for filing suit against you.

____ _______________

Patient/Responsible Party Signature Date

COVID-19 SCREENING QUESTIONS

(PLEASE CIRCLE YES OR NO)

1. Have you had any **NEW** flu-like symptoms: fever, body ache, cough, trouble breathing, loss of taste and/or smell?

YES or NO

2. Have you been in contact with anyone who has tested positive for COVID-19?

YES or NO

____ ________________

Patient Signature Date

Date:________________

Name ____ Date of Birth ___________________________ Age_________

Referring Physician ___________________________ Primary Care Physician_________________________________

Occupation____________________________________ Employer ______________________________________

Please specifically give the reason for your visit ____

If your reason Involves an injury or Injuries, please describe the nature and give dates: ______________________

Do you currently have, or have you ever been treated for any of the following conditions:

- ❑ Allergies
- ❑ Anemia
- ❑ Asthma
- ❑ Cancer
  Type__________________
- ❑ COPD or emphysema
- ❑ Depression
- ❑ Diabetes
- ❑ Gastroesophageal Reflux
- ❑ Glaucoma
- ❑ Heart Attack
- ❑ Heart Problems
- ❑ Hepatitis
- ❑ Hiatal Hernia
- ❑ High Blood Pressure
- ❑ HIV
- ❑ Irregular Heartbeat
- ❑ Kidney Disease
- ❑ Latex Allergy
- ❑ Liver disease
- ❑ Low Blood Sugar
- ❑ Lupus
- ❑ Migraines
- ❑ Mitral Valve Prolapse
- ❑ MRSA
- ❑ Nasal Obstruction
- ❑ Pneumonia
- ❑ Psychiatric Problems
- ❑ Rheumatoid Arthritis
- ❑ Sickle Cell Disease
- ❑ Sleep Apnea
- ❑ CPAP
- ❑ Stroke
- ❑ Thyroid problems
- ❑ Tuberculosis
- ❑ Other: ________________
  ____
  ____

In the past 6 months, have you experienced:

❑ Weight loss	❑ Chest Pain	❑ Joint Pain
❑ Nausea/Vomiting	❑ Shortness of Breath	❑ Headaches
❑ Fever/Chills	❑ Nasal Obstruction	❑ Depression
❑ Night Sweats	❑ Muscle weakness	❑ Sore throat
❑ Fatigue	❑ Difficulty Swallowing	❑ Heartburn

Social History

Do you currently use tobacco? ❑ Yes ❑ No

Packs per day_________ How long? _________ years

If you smoked previously, when did you quit?______________

Does anyone in the house smoke? ❑ Yes ❑ No

Do you drink alcohol? ❑ Yes ❑ No

Indicate if drugs or alcohol ever posed a dependency problem for you: _________Drugs _________Alcohol

SURGERIES ❑ Check if none

List all surgeries you have had, including childhood surgeries such as tonsillectomy or ear tubes:

Surgery	Date	Surgeon/hospital

MEDICATIONS ❑ Check if none

List all medications you are currently taking (including over the counter medicines, aspirin or aspirin-containing medicines, birth control pills, diet pills, Vitamin E, or herbal preparations), along with the dosage and frequency:

Medication	Dosage	Duration (How long?)

ALLERGIES TO MEDICATIONS ❑ Check if none

List any medications to which you are allergic:

Medication	Type of Reaction

Do you or anyone In your Immediate family have a history of bleeding problems? ❑ No ❑ Yes: explain_______________

Do you or anyone In your immediate family have a history of anesthesia reactions? ❑ No ❑ Yes: explain_______________

Do you have a history of bad scarring? ❑ No ❑ Yes: explain_______________

For Office Use

❑ Dr. Bridges
❑ Dr. Gibbons
❑ Entered in EMA