



*All information collected in this questionnaire is strictly confidential and will become part of your medical record.*

Have you had any previous surgeries? If so, what and when? (Operations and Cosmetic Surgery)

Type	Date	Complications or Difficulties
1. _____		
2. _____		
3. _____		
4. _____		

Any medical illness or medical conditions (previous and/or current)?

Explain \_\_\_\_\_

Any admissions to a hospital ?

Reason	Date	Complication or Difficulties
1. _____		
2. _____		
3. _____		
4. _____		

Are you currently on prescription medication? \_\_\_\_\_ YES \_\_\_\_\_ NO **If yes, please provide details below or attach a list.**

Type	Dosage/Amount	Take how often
1. _____		
2. _____		
3. _____		
4. _____		

Do you take over-the-counter drugs, vitamins, supplements, or use inhalers? \_\_\_\_\_ YES \_\_\_\_\_ NO **If yes, please provide details below.**

Type	Dosage/Amount	Take how often
1. _____		
2. _____		
3. _____		
4. _____		

Do you bruise or bleed easily? (With cuts/tooth extractions/pregnancy/surgery) \_\_\_\_\_ YES \_\_\_\_\_ NO

Explain: \_\_\_\_\_

Difficulties with local or general anesthesia? \_\_\_\_\_ YES \_\_\_\_\_ NO

Explain: \_\_\_\_\_

Have you ever had a blood transfusion? \_\_\_\_\_ YES \_\_\_\_\_ NO Are you Pregnant? \_\_\_\_\_ YES \_\_\_\_\_ NO

Are you allergic to any medication? \_\_\_\_\_ YES \_\_\_\_\_ NO **If yes, please provide details below or attach a list.**

STAFF USE ONLY:

**Past Medical History**

Heart Disease	_____ YES	_____ NO
Stroke	_____ YES	_____ NO
Asthma	_____ YES	_____ NO
Diabetes	_____ YES	_____ NO
Cancer	_____ YES	_____ NO
Thyroid Disease	_____ YES	_____ NO
Kidney Disease	_____ YES	_____ NO
Sleep Apnea	_____ YES	_____ NO
GERD	_____ YES	_____ NO
Blood Disorders	_____ YES	_____ NO
High Blood Pressure	_____ YES	_____ NO

**Family History**

Allergy	_____ YES	_____ NO
Cancer	_____ YES	_____ NO
Diabetes	_____ YES	_____ NO
Heart Disease	_____ YES	_____ NO
Stroke	_____ YES	_____ NO
Hearing Loss	_____ YES	_____ NO
Bleeding Disorders	_____ YES	_____ NO
Keloid Formation	_____ YES	_____ NO

**Social History**

Alcohol \_\_\_\_\_ YES \_\_\_\_\_ NO

If yes, how many per day? \_\_\_\_\_ Drinks/Glasses

Smoking \_\_\_\_\_ YES \_\_\_\_\_ NO

If yes, how many per day? \_\_\_\_\_ Packs/Cigarettes

Illicit Drug Use \_\_\_\_\_ YES \_\_\_\_\_ NO

If so, explain: \_\_\_\_\_

**Constitutional**

Fever	_____ YES	_____ NO
Chills	_____ YES	_____ NO
Weight Loss	_____ YES	_____ NO
Night Sweats	_____ YES	_____ NO

**Respiratory**

Shortness of Breath	_____ YES	_____ NO
Cough	_____ YES	_____ NO
Wheezing	_____ YES	_____ NO

**ENT**

Hearing Loss	_____ YES	_____ NO
Sinus Pain/Pressure	_____ YES	_____ NO
Voice Change	_____ YES	_____ NO
Swallowing difficulty	_____ YES	_____ NO

**Cardiovascular**

Chest Pain	_____ YES	_____ NO
Ankle Swelling	_____ YES	_____ NO
Irregular Heartbeats	_____ YES	_____ NO

**Ophthalmologic**

Eye Pain	_____ YES	_____ NO
Double Vision	_____ YES	_____ NO
Dry Eyes	_____ YES	_____ NO

**Dermatologic**

Rash	_____ YES	_____ NO
Hair Loss	_____ YES	_____ NO
Growth/Spots	_____ YES	_____ NO

**Musculoskeletal**

Weakness	_____ YES	_____ NO
Joint Pain	_____ YES	_____ NO
Muscle Pain	_____ YES	_____ NO

**Gastrointestinal**

Abdominal Pain	_____ YES	_____ NO
Nausea	_____ YES	_____ NO
Heartburn	_____ YES	_____ NO

**Genitourinary**

Pain with Urination	_____ YES	_____ NO
Frequent Urination	_____ YES	_____ NO
Pelvic Pain	_____ YES	_____ NO

**Neuro/Psych**

Headache	_____ YES	_____ NO
Dizziness	_____ YES	_____ NO
Anxiety	_____ YES	_____ NO
Depression	_____ YES	_____ NO



PATIENT CONFIDENTIALITY  
AGREEMENT

T: 805.494.4797 • F: 805.494.4810 • www.BellaVistaENT.com  
555 Marin St., Suite 100 • Thousand Oaks, CA 91360



In order to comply with HIPAA standards and give our patients the best medical treatment possible, we require that a patient give us the authorization to discuss their medical records with any referring and/or referred medical providers.

Please list medical providers below:

Practice Name: \_\_\_\_\_

Physician Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Practice Name: \_\_\_\_\_

Physician Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

In the event you are unable to be contacted by our office, please indicate any family member or friend that we can release any or all information relating to your medical condition.

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

Relationship to Patient: \_\_\_\_\_ Phone Number: \_\_\_\_\_

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

Relationship to Patient: \_\_\_\_\_ Phone Number: \_\_\_\_\_

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

Relationship to Patient: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**By signing this agreement you allow Bella Vista ENT & Facial Plastic Surgery (Dr. Glenn Waldman & Dr. Jeffrey Feinfeld and their staff) access to your medical records; the release of your records to the above listed Physicians; and the release of medical information to the parties listed above.**

\_\_\_\_\_  
PATIENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINTED NAME



## PRACTICE POLICIES

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**SHOULD YOU HAVE ANY QUESTIONS REGARDING OUR PRACTICE POLICIES PLEASE CALL US AT**

**(805) 494-4797 SO THAT WE MAY ASSIST YOU.**

### **OFFICE HOURS AND MAKING AN APPOINTMENT:**

The physicians at Bella Vista ENT & Facial Plastic Surgery offer several ways to request an appointment. You can make an appointment by calling our office directly, or filling out an online appointment form. Please note appointment schedules may vary depending on the doctor's surgery schedule. Follow-up appointments should be made when you check out.

**Thousand Oaks**  
555 Marin St Suite 100  
Thousand Oaks, CA  
Hours: M-F:  
Phone: (805) 494-4797

### **MISSED APPOINTMENTS/UNTIMELY CANCELLATION:**

Missed appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. If you are unable to keep your appointment, please give 24-hours notice to avoid a \$50 charge. This is not a billable charge to any insurance company and is the responsibility of the patient and payable at your next office visit. We reserve the right to charge for missed or untimely canceled appointments. Excessive abuse of scheduled appointments may result in discharge from the practice. Patients who are more than 15 minutes late may have to wait until an opening becomes available or asked to reschedule.

### **WAITING TIME:**

The physicians and staff of Bella Vista ENT & Facial Plastic Surgery make every effort to schedule patient visits according to average times needed to provide quality care for new patients and follow up visits. There can be unexpected urgent or emergent situations that may cause the allotted practice visit times to be altered or delayed. We understand that your time is important, and will make every effort to keep our schedule on time or inform you if our physicians are behind.

### **TELEPHONE CALLS:**

In order for us to see patients at their scheduled appointment time, the doctor's do not answer calls while they are seeing patients except in emergencies. Our front desk will advise you to leave a message and a staff member will return your call by the end of the following business day at the latest.

### **PHYSICIAN EMERGENCY ON CALL:**

For Life Threatening Emergencies, Please Dial 911. For all non-emergent issues, phone calls will be returned in the order they are received. Our paging system is available 24 hours per day 7 days a week. After hour calls are reserved for Non-Life Threatening Medical Emergencies related to the care you are receiving from the Physicians of Bella Vista ENT and Facial Plastic Surgery.

### **BILLING AND INSURANCE INFORMATION:**

All patient-billing questions should be directed to our Billing Coordinator:

**Alicia Brosius**  
555 Marin St. Suite 100  
Thousand Oaks, CA 91361  
P: 805.210-5491  
F: 805.494.4810  
E-Mail: [Billing@BellaVistaENT.com](mailto:Billing@BellaVistaENT.com)



#### **FINANCIAL POLICY:**

We are committed to providing you with the best care possible. In order to achieve this goal we are in need of your assistance and understanding of our financial policy. The physicians at Bella Vista ENT & Facial Plastic Surgery participate with most major insurance companies. When scheduling any type of appointment with our physicians, we will need to verify your insurance coverage. Please have your insurance card(s) available when scheduling appointments, as you may be asked to re-verify information to guarantee coverage. Our office individual coverage varies within our contracts and your coverage is an agreement between you and your health insurance company. It remains your responsibility to verify that the care you receive is covered by your health plan.

- We have made prior arrangements with insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment and/or deductible at the time of service. This office has the policy to collect this co-payment and/or deductible when you arrive for your appointment.
- If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of service.
- Our billing department will not become involved in disputes between you and your insurance company regarding uncovered charges, coordination of benefit issues, eligibility issues, or pre-existing conditions which cause the claim to be denied. Should your claim be denied for any of these reasons, the claim will become the responsibility of the patient and payment will be expected within 30 days.
- (Medicare patients) - since our office accepts Medicare assignment; we will bill Medicare for you. Patients who have only Medicare are responsible for the co-insurance portion approved by Medicare. If you have a secondary insurance, we will also bill them for you.

#### **PAYMENT OPTIONS:**

For your convenience, we offer a variety of payment options. We accept Visa, MasterCard, and Discover credit cards, checks, and cash. All returned checks will be assessed a \$25.00 returned check fee in addition to the original charge.

#### **ADDITIONAL OFFICE CHARGES:**

In addition to office consultations, procedures may be performed, if needed, at the time of service. Examples of these procedures are nasal endoscopy, video stroboscopy, flexible laryngoscopy, nasal cautery and the use of an operating microscope. Please be assured that our office is following accepted billing and coding guidelines and that all procedures performed are in the best interest of patient care. These services are an additional fee, and the patient's cost may vary depending on their insurance company. Many insurance companies will label these procedures as a "surgical code", and apply it towards a patient's deductible or yearly out-of-pocket maximum amount. Patients will be responsible for this amount at the time of service.

#### **IN-OFFICE COSMETIC APPOINTMENTS:**

Our Physicians provide one cosmetic consult per patient free of charge. A credit card is required to be placed on file for this and any other cosmetic appointment (photo-morphing, injectables, chemical peels, etc.) as a gracious amount of time is set aside for these appointments. Payment for these in-office cosmetic procedures is required in full on the date of service. No-shows and cancellations made less than 24 hours in advance will be charged a \$250.00 fee.

#### **SURGICAL APPOINTMENTS:**

Our surgery coordinator will discuss your insurance benefits prior to scheduling your procedure. When scheduling a cosmetic surgery, a \$500 non-refundable deposit is required to reserve your desired date. Any co-payment, deductible, co-insurance, or cosmetic fees need to be paid in full two weeks prior to your surgery date. If financing is needed, we are partnered with CareCredit Inc., who provides multiple payment options. If state or work disability-related paperwork needs completion, the patient will be charged a \$30.00 document fee.

#### **TERMINATION POLICY:**

Termination notes will be placed in each patient's file and these notes will reflect both the reason for termination, as well as whether it was a mutual or unilateral decision on the part of the patient. If you request further treatment, a recommendation will be made to direct you to three other local practitioners for follow-up care. Any unpaid balance at the termination of treatment will be the responsibility of the patient.



## PATIENT INFORMATION CONSENT/DISCLOSURE FORM

The following are the conditions for services provided by the physicians of Bella Vista ENT & Facial Plastic Surgery for the patient whose name appears below. **Please read carefully and initial each section, if a section does not apply to you mark N/A.** Should you have any questions, please call us at (805) 494-4797 so that we may assist you

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

Date \_\_\_\_\_

X \_\_\_\_\_

Signature

### CONSENT FOR MEDICAL TREATMENT

I hereby voluntarily consent for care encompassing diagnostic procedures and treatment by my physician, and his staff, including but not limited to, physician assistant, nurse practitioner, designees or consultants, as may be necessary in the judgment of my physician.

I am aware that follow up office visits are required to review the results of diagnostic or therapeutic tests. I understand that I cannot assume that my test results are normal until they are thoroughly reviewed with the doctor. I further acknowledge that it is my responsibility to make appropriate follow up visits with my Physician to maximize improvement in my condition.

X \_\_\_\_\_

### RELEASE FROM RESPONSIBILITY

If I should leave the practice against medical advice or prior to treatment being completed, I hereby relieve said physician and the Clinic of all liability for my action.

X \_\_\_\_\_

### PHYSICIAN AS INDEPENDENT CONTRACTOR

I understand that each practitioner is an independent contractor at Bella Vista ENT and Facial Plastic Surgery.

I recognize that medical and surgical services provided by my physician are independent of, and will be billed separately from, other physicians or facilities. At times my physician may refer me to a physician or facility to assist in the best care of my condition. I understand that these providers may or may not be in network or participate with my insurance policy. It is my responsibility to verify that the care that I receive is covered by my health plan for each physician, and facility.

Imaging tests, lab tests, Audiology, or similar studies may be ordered during the course and treatment of my condition. Those facilities are independent and financially separate from this practice.

X \_\_\_\_\_

### AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the Clinic or the Clinic's designee to disclose to payors including, but not limited to, insurers, the Centers for Medicare Services, or any other parties that may be liable for all or part of the Clinic charges ("Third Party Payors"), all or part of my medical records as may be necessary to process payments for health care services provided. I authorize these payors to pay directly to the Clinic. I also authorize the Clinic to utilize my medical information, or to release all or part of my medical information to other health care providers consulted by my physician or the Clinic, as may be necessary. I understand that the Clinic will take actions in reliance on this authorization to release medical information and that this information will be released only as necessary to carry out treatment, payment or Clinic operations.

X \_\_\_\_\_

### ACKNOWLEDGEMENT OF GENERAL OFFICE POLICIES

I have read and understand the general office policies, and agree to the arrangements outlined.

X \_\_\_\_\_





## PATIENT INFORMATION CONSENT/DISCLOSURE FORM

### ACKNOWLEDGEMENT OF FINANCIAL POLICY

Bella Vista ENT & Facial Plastic Surgery is dedicated to providing our patients with the best possible care and customer service. We ask for your help by understanding and cooperating with our financial policy. We must emphasize that as physicians, *our relationship is with you*, NOT your insurance company. While the filing of insurance claim is a courtesy that we extend to our patients, all charges are strictly your responsibility. The Physicians at Bella Vista ENT & Facial Plastic Surgery have provider contracts with some insurance carriers, however our office individual coverage varies within our contracts and your coverage is an agreement between you and your health plan/health insurance company. It remains your responsibility to verify that the care you receive is covered by your health plan/health insurance. This office is not responsible for the expense of treatment not paid by your health plan/health insurance. With continuous changes in coverage, you should verify your benefits and understand all requirements of your health plan/health insurance by calling the customer service number located on your health plan/health insurance card. When Bella Vista ENT & Facial Plastic Surgery does not have a contract with your health plan/health insurance carrier you will be responsible for the entire amount at the time services are rendered. Your initials on this Financial Policy will be your acknowledgement that you are aware of your benefits and our financial policy.

× \_\_\_\_\_

### NO INSURANCE COVERAGE (SELF PAY)

The patient or guardian will be responsible for payment, which may include diagnostic or therapeutic tests at the time of service, as well as the office visit charge.

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### ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign to the Physicians and Bella Vista ENT & Facial Plastic Surgery all rights, title, and interests in the benefits payable to me by an insurance policy(ies) or benefits plan under which I am covered for services rendered by the physician. I understand that I am responsible for all charges not covered by the assignment along with any deductibles and/or co-insurance and hereby promise to pay any remaining balance. For Medicare beneficiaries: I have provided all necessary information for proper assignment of Medicare benefits.

× \_\_\_\_\_

### ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices. The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. I understand that Bella Vista ENT & Facial Plastic Surgery has reserved a right to change its privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me upon request.

× \_\_\_\_\_

### CANCELING AN APPOINTMENT/NO SHOW/LATE POLICY:

Patients who do not keep their medical appointments or provide 24-hour notice of cancellation will be subject to a charge of \$50.00. This fee will be applied after the first missed appointment or first failure to provide 24-hour notice. This is not a billable charge to any insurance company and is the responsibility of the patient. If a patient misses or cancels 4 times, we reserve the right to dismiss that patient from the care of Bella Vista ENT & Facial Plastic Surgery.

#### IN-OFFICE COSMETIC APPOINTMENTS:

A credit card is required to be placed on file for this and any other cosmetic appointment as a gracious amount of time is set aside for these appointments. Payment for these in-office cosmetic procedures is required in full on the date of service. No-shows and cancellations made less than 24 hours in advance will be charged a \$250.00 fee.

× \_\_\_\_\_

### PHOTO / VIDEO RELEASE:

I understand that all preoperative and postoperative photos and/or videos will be the property of Bella Vista ENT & Facial Plastic Surgery. I consent to the use of these photos and/or videos for the purpose of patient education, physician conferences, and marketing purposes.

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**BELLA VISTA**  
ENT & FACIAL PLASTIC SURGERY

GLENN E. WALDMAN, M.D. & JEFFREY K. FEINFELD, M.D.

## Sino-Nasal Outcome Test (SNOT-22) Questionnaire

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

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

Below you will find a list of symptoms and social/emotional consequences of your nasal disorder. We would like to know more about these problems and would appreciate your answering the following questions to the best of your ability. There are no right or wrong answers, and only you can provide us with this information. Please rate your problems as they have been over the past two weeks. Thank you for your participation.

**A. Considering how severe the problem is when you experience it and how frequently it happens, please rate each item below on how "bad" it is by circling the number that corresponds with how you feel using this scale:**

	No Problem	Very Mild Problem	Mild or Slight Problem	Moderate Problem	Severe Problem	Problem as bad as it can be	Most important items
1. Need to blow nose	0	1	2	3	4	5	[ ]
2. Sneezing	0	1	2	3	4	5	[ ]
3. Runny nose	0	1	2	3	4	5	[ ]
4. Nasal obstruction	0	1	2	3	4	5	[ ]
5. Loss of smell or taste	0	1	2	3	4	5	[ ]
6. Cough	0	1	2	3	4	5	[ ]
7. Post-nasal discharge	0	1	2	3	4	5	[ ]
8. Thick nasal discharge	0	1	2	3	4	5	[ ]
9. Ear fullness	0	1	2	3	4	5	[ ]
10. Dizziness	0	1	2	3	4	5	[ ]
11. Ear pain	0	1	2	3	4	5	[ ]
12. Facial pain/pressure	0	1	2	3	4	5	[ ]
13. Difficulty falling asleep	0	1	2	3	4	5	[ ]
14. Waking up at night	0	1	2	3	4	5	[ ]
15. Lack of a good night's sleep	0	1	2	3	4	5	[ ]
16. Waking up tired	0	1	2	3	4	5	[ ]
17. Fatigue	0	1	2	3	4	5	[ ]
18. Reduced productivity	0	1	2	3	4	5	[ ]
19. Reduced concentration	0	1	2	3	4	5	[ ]
20. Frustrated/restless/irritable	0	1	2	3	4	5	[ ]
21. Sad	0	1	2	3	4	5	[ ]
22. Embarrassed	0	1	2	3	4	5	[ ]
<b>TOTALS (each column):</b>							

**GRAND TOTAL SCORE (all columns together):** \_\_\_\_\_

**B. Please check off the most important items affecting your health in the last column (max of five items)**



### Credit Card Payment Authorization Form

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Dear Patient,

This letter is to inform you of our billing guideline that our office has implemented in order to reduce the need for phone calls and billing statements from our office staff regarding a balance on your account. It is our policy to have a valid credit card on file. It is kept on site and stored in a HIPAA compliant program. Your credit card will be charged on the last day of the month if you have an open balance (Co-Pay, Co-Insurance, Deductible, Non-Covered Service, No-Show Fee, Surgery/Procedure Cancellation Fee, etc). A receipt of payment will be kept on file, and is available to you upon request.

I, \_\_\_\_\_, authorize Bella Vista ENT & Facial Plastic Surgery, BVOS, Glenn Waldman, M.D. & Jeffrey Feinfeld, M.D. to charge my credit card for any outstanding balance on my account in full (unless other arrangements have been made) on the last day of every month, as long as an open balance remains, on the following credit card:

Please Circle One:      VISA                      MasterCard                      Discover

Credit Card#: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

CVV-Security Code: \_\_\_\_\_ Name on Card: \_\_\_\_\_

Billing Zip Code: \_\_\_\_\_

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

Patient(s) Name(s): \_\_\_\_\_

*I authorize the above named business to charge the credit card indicated in this authorization form according to the outlined above. I certify that I am the authorized user of this credit card and that I will not dispute the payment with the credit card company; so long as the transaction corresponds to the terms indicated in this form.*

Bella Vista ENT & Facial Plastic Surgery  
Glenn Waldman, M.D. & Jeffrey Feinfeld, M.D.  
555 Marin Street Suite 100 Thousand Oaks, CA 91360  
805-494-4797

**Bella Vista ENT Plastic Surgeons**  
**555 Marin St Suite 100**  
**Thousand Oaks, CA 91360**

I have been informed of my right to formulate an Advanced Directive, and I have been provided with information regarding the execution of an Advanced Directive.

Please Select One:

- ☐ I have previously completed an Advanced Directive and have provided a copy of inclusion in my medical record
- ☐ I will provide a copy of my previously executed Advanced Directive to Bella Vista ENT for Inclusion in my medical record
- ☐ A copy of my Advanced Directive is on file with: \_\_\_\_\_  
Name of Provider or Health Care Facility
- ☐ I have not executed an Advanced Directive and I am not interested in any further information
- ☐ I am interested in formulating an Advanced Directive and will discuss my options with my primary care physician

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient Name (Print):** \_\_\_\_\_

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Comments: Include steps taken to obtain a copy of Advanced Directive

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- ☐ A copy of the Advanced Directive has been requested

Signature of Group Representative: \_\_\_\_\_ Date: \_\_\_\_\_