CHERRY HILL CENTER
FOR ENT & FACIAL PLASTIC SURGERY

Scott L. Busch D.O., F.A.C.S.
ENT-HEAD & NECK SURGERY • HEARING & BALANCE
SINUS & ALLERGY • COSMETIC SURGERY • MEDISPA

DIPLOMATE AMERICAN BOARD OF OTOLARYNGOLOGY
FELLOW AMERICAN ACADEMY OF FACIAL PLASTIC
& RECONSTRUCTIVE SURGERY

Snoring/Sleepiness Questionnaire

PLEASE CIRCLE ANYTHING THAT APPLIES WHETHER YOU ARE BEING SEEN FOR SNORING PROBLEMS OR NOT.....THANK YOU

Name: _____ Date _____

Snoring Questionnaire

If you snore, you are very familiar with the effect lack of sleep has on your quality of life. Snoring not only disrupts sleep, it may also be a sign of a serious condition called obstructive sleep apnea (OSA).

To find out if you should be concerned about your snoring, choose a number from the scale below that best describes your snoring in each situation. Add up each question's score for your total score.

0 = Never
1 = Infrequently (1 night per week or less)
2 = Frequently (2–3 nights per week)
3 = Most of the time (4 or more nights per week)

Situation	*Your Score*
My snoring affects my relationship with my bed partner.	0 1 2 3
My snoring causes my partner to be irritable or tired.	0 1 2 3
My snoring requires us to sleep in separate rooms.	0 1 2 3
My snoring is loud.	0 1 2 3
My snoring affects other people when I am sleeping away from home (hotel, camping, etc).	0 1 2 3
Total Score	_____

If you scored 5 or greater, your snoring is affecting your quality of life and relationships. It's important to discuss your snoring problem with your doctor.

Epworth Sleepiness Questionnaire

In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situation? Use the scale below to choose the most appropriate number for each situation. Add the scores together for your total score.

0 = Would never doze off or fall asleep
1 = Slight chance of dozing off or falling asleep
2 = Moderate chance of dozing off or falling asleep
3 = High chance of dozing off or falling asleep

Situation	*Your Score*
Sitting and reading	0 1 2 3
Watching television	0 1 2 3
Sitting inactive in a public place (movie theater)	0 1 2 3
As a passenger in a car for an hour without a break	0 1 2 3
Lying down to rest in the afternoon	0 1 2 3
Sitting and talking to someone	0 1 2 3
In a car while stopped for a few minutes in traffic	0 1 2 3
Total Score	_____

If you scored 6 or greater, you may have a sleep disorder. A sleep disorder can have significant health consequences, so be sure to talk to your doctor about the results of this questionnaire.

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Hearing and Balance Survey

PLEASE CIRCLE ANYTHING THAT APPLIES WHETHER YOU ARE BEING SEEN FOR HEARING PROBLEMS OR NOT.....THANK YOU

Name: _____ Date _____

1.	Do you have trouble hearing?	NO	YES
2.	Do you have difficulty understanding speech in background noise?	NO	YES
3.	Do you have ringing or noise in your ear(s)?	NO	YES
4.	Do you have noise in your head?	NO	YES
5.	Do you have fullness in your ear(s)?	NO	YES
6.	Do you get ear infections?	NO	YES
7.	Do you have dizzy spells and/or lose your balance?	NO	YES
8.	Are you now or have you ever worked in a noisy place?	NO	YES
9.	Do you have difficulty understanding on the telephone?	NO	YES
10.	Do significant others ever say that the television or radio is too loud?	NO	YES
11.	Do you have to turn the radio or television up louder than normal?	NO	YES

Signature _____

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FINANCIAL POLICY

Thank you for choosing Dr. Busch as your health care provider. We are committed to making your visit with our office a pleasant experience. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment.

INSURANCE BILLING:
Dr. Busch is a participating provider in most HMO, PPO and Managed Care programs. Our charges are the usually and customary for our area. As a courtesy to our patients, we will bill your insurance carrier for all services provided in our office (excluding cosmetic procedures) or in the hospital. However, it is important that you provide us with the proper and most current insurance information so your claim will not be delayed. **Any unpaid balance after your insurance payments have been received will be your responsibility.** This would include any co-payments, coinsurances, deductibles, or if your insurance company declines the claim for any reason. **All claims which are not resolved within ninety (90) days after submission will become the patient's responsibility, which may include legal and collection fees.** Please remember, the insurance contract is between YOU AND THE INSURANCE COMPANY, NOT THE INSURANCE COMPANY AND THE DOCTOR. It is your responsibility to contact the insurance company if they are not responsive to claims for payment.

MEDICARE PATIENTS:
If you do not have supplemental insurance to Medicare, your 20% coinsurance will be collected at the time of service.

HMO PATIENTS:
We are a specialist's office and visits to our office require a referral, either written or electronic, from your primary care physician. As per HMO regulations, we cannot see you without this referral (except in the event of a medical emergency), and it is your responsibility to arrive for your appointment with the proper referral. Otherwise, you will be responsible for the charge of the office visit and any additional testing performed at that visit.

SELF-PAY PATIENTS:
If you do not have health insurance, you will be responsible for payment at the time the services are provided.

MISSED APPOINTMENTS:
Missed appointments without a 24-hour notice will be charged a rate of $40. Please help us to serve you better by keeping scheduled appointments.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY OF DR. SCOTT BUSCH. ANY QUESTIONS OR CONCERNS WERE DISCUSSED WITH A BILLING REPRESENTATIVE.

Print Name_____ Signature_____ Date_____

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HIPAA PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal heal information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have received our privacy notice.

PAYMENT AUTHORIZATION

I hereby authorize Scott L. Busch, D.O., P.A. to furnish information to the appropriate insurance carriers concerning my illness and treatments, and I hereby assign to Dr. Busch all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by insurance.

RECORDS RELEASE

I hereby authorize Scott L. Busch, D.O., P.A. to receive or disclose my protected health information concerning my illness and treatment. A photocopy of this authorization shall be considered as effective and valid as the original. Please be advised there is a $1.00/page and a retrieval fee of $10 for copying records.

Print Name_____ Signature_____ Date_____
(Insured or Authorized Person)

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I, _____, acknowledge that Scott L. Busch, DO may order certain tests and/or prescribe medications.

The purpose and need for these tests and/or medicines will be explained to you. It is **your responsibility** to follow through with the tests and take the medicine prescribed. If you feel that you will not take the tests or medicine ordered, you need to let Dr. Busch know at the end of your exam.

Also, if a follow-up appointment is suggested, it is **your responsibility** to schedule and keep the appointment.

Thank you for your cooperation in this regard.

Sincerely,

Scott L. Busch, D.O., F.A.C.S.

_____ _____ _____
Patient/Guardian Signature Date Witness Signature

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Dear Patient,

Dr. Busch and his staff are dedicated to providing you with the healthcare services you need to enhance your quality of life. As part of this mission, our office is transitioning to an electronic health record (EHR) system. EHRs have been shown to improve patient safety and office efficiency. As a result, you will continue to receive safe and appropriate healthcare in an environment that has the added benefit of modern technology.

At this time, you are being asked to update your patient information, including medical history and coverage information, for our files in order to ensure a successful transition to our new system. It is imperative that this paperwork be filled out in its entirety to ensure that accurate and up to date information be transmitted to our new system. Failure to adequately fill out all paperwork given to you, will add greater delays in providing you the healthcare you desire. Please bear with if it may take a few extra minutes to schedule an appointment, getting checked in at the front desk before seeing Dr. Busch, or get answers to your billing questions. We apologize for the temporary delays that you may experience.

One of the benefits of our new EHR system is a self-service feature that we are excited to introduce to our patients. Our online Patient Portal will help us improve our patient relations with a variety of convenient features, facilitated by a private and secure portal. Through the portal, our patients have the ability to request appointments, request prescription refills, access their medical records, as well as view account balances and make payments with a credit card.

How the Online Patient Portal Works
On our website, we have an active link to the login of our patient portal. As a self-service feature, a patient can click the practice's patient portal link, log in securely and begin using its features. Our office can also send message alerts to patients. To set up access, we are requesting an e-mail address to send an invitation to so that a secure login account can be established for each patient that wishes to use the portal.

If you would you like to set up an account on our patient portal, please provide your **e-mail address**. If you do not have an e-mail or do not wish to have access to the patient portal please indicate this on the line below.

_____

Print Name_____ Signature_____ Date_____
(Insured or Authorized Person)

After the initial set up, you can get to the portal directly by visiting this link to type in your Login E-Mail and password

https://patientportal.advancedmd.com/Account/LogOn?lk=123809

By providing your e-mail you agree to receive alerts and information from our office at this address.
We are confident that this technology will be a key factor for our practice to enhance its effectiveness and ultimately its quality of healthcare and services we provide, therefore we encourage our patients to use this portal. If you have any questions or concerns about our EHR system, please do not hesitate to ask a staff member. Thank you for your patience while we implement our new EHR system.

Sincerely,

Cherry Hill Center For ENT & Facial Plastic Surgery