Sino-Nasal Outcome Test (SNOT-22)* *(Initial Visit)*

Please print out and bring to your visit

The questionnaire is designed to help us understand your symptoms and compare your symptom severity scale over time and after treatment(s). Please rate problems you have experienced over the last two weeks.

Santos SINUS CENTER

Patient Name:

Last First

Date of Birth (m/d/yr): _____

Today's Date: (m/d/yr): _____

Previous Therapy for Sinusitis (other than Dr. Santos):	Medical:	Yes	No
	Surgical:	Yes	No

If you believe you have a sinus infection today please indicate by circling	Yes	No

Please circle the number in each row to rate the severity of the problem	No problem	Very mild problem	Mild or slight problem	Moderate problem	Severe problem	Problem as bad as it can be
1. Need to blow nose	0	1	2	3	4	5
2. Nasal Blockage (congestion)	0	1	2	3	4	5
3. Sneezing	0	1	2	3	4	5
4. Runny nose	0	1	2	3	4	5
5. Cough	0	1	2	3	4	5
6. Post-nasal discharge	0	1	2	3	4	5
7. Thick nasal discharge	0	1	2	3	4	5
8. Ear fullness	0	1	2	3	4	5
9. Dizziness	0	1	2	3	4	5
10. Ear pain	0	1	2	3	4	5
11. Facial pain/pressure	0	1	2	3	4	5
12. Decreased Sense of Smell/Taste	0	1	2	3	4	5
13. Difficulty falling asleep	0	1	2	3	4	5
14. Wake up at night	0	1	2	3	4	5
15. Lack of good night's sleep	0	1	2	3	4	5
16. Wake 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
TOTAL						
23. Forehead headaches	0	1	2	3	4	5
24. Eye region headaches	0	1	2	3	4	5
25. Cheek/teeth headaches/pain	0	1	2	3	4	5
26. Throat clearing	0	1	2	3	4	5
27. Nausea from drainage	0	1	2	3	4	5
28. Any additional sinus symptoms list here and rate:	0	1	2	3	4	5
TOTAL						

23-28 Santos Sinus Center questions added by our patients

Santos Sinus Center Vs. 20210729

SNOT-22 (1-22) Total	
23-27 Total	
Grand Total: (SNOT-22 + 23-27 Total)	

INITIAL

Santos SINUS CENTER

PERRY M. SANTOS, MD
3435 NW 56TH ST., STE. A-412
OKLAHOMA CITY, OK. 73112
WWW.SANTOSSINUSCENTER.COM
P: 405-945-4325
F: 405-945-4327

PATIENT INFORMATION

Last Name | **First Name** | **Middle Initial** | **Preferred Name**

Date of Birth | **Social Security Number** | **Gender** Male Female

If a Minor, Custodial Parent/Guardian | **Language** other than English

Race (Optional) Black – Non-Hispanic | American Indian/ Alaskan Native | Hispanic | Asian/Pacific Islander | White – Non Hispanic | Other | **Marital Status** M S W D

Home Address | **Apt #** | **City** | **State** | **Zip Code**

Home Phone | **Work Phone** | **Other Phone**

Email Address | **Employment Status** Active Military Employed Not Employed Student

Employer | **Occupation**

PHYSICIAN REFERRAL INFORMATION

Primary Care Physician | **Referring Physician**

Contact Number & Address | **Contact Number & Address**

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Relationship to Patient Self (If self, skip to Emergency Contact) Spouse Parent Other

Last Name | **First Name** | **Middle Initial**

Date of Birth | **Social Security Number**

Home Address | **Apt #** | **City** | **State** | **Zip Code**

Home Phone | **Work Phone** | **Other Phone**

Employer

EMERGENCY CONTACT INFORMATION / NOT LIVING IN THE HOME

Last Name | **First Name** | **Relationship to Patient**

Address | **Apt #** | **City** | **State** | **Zip Code**

Home Phone | **Work Phone** | **Other Phone**

PHARMACY

I assign my insurance benefits to Perry M. Santos, MD for any services provided. I understand that this form is valid for one year unless I cancel the authorization in writing to the health care provider. I have a copy of, understand and agree to the, “Financial Policy for Perry M. Santos, MD”.

Signature _____ **Date** _____

Name | **Address** | **Phone**

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PATIENT MEDICAL HISTORY

Patient Name: **Date of Birth:** **Height:** **Weight:**

Chief Complaint	
Current treating doctors	Healthcare Provider Name Specialty

Drug Allergies	
Environmental/ Seasonal	Allergy Testing **YES NO** Allergy Desensitization shots **YES NO** Successful **YES NO**

Medications	**ALL** prescription, over the counter, vitamins /supplements & nasal sprays

Medical	Circle **ALL** that apply				
Heart Disease	Heart Attack	High Blood Pressure	Blood Thinners	Abnormal Bleeding Tendencies	HIV/AIDS
Cancer	Stroke	Neurological	Seizure	Thyroid Disease	Liver
Asthma	Bronchitis	Pneumonia	COPD	Sleep Apnea	Diabetes
GERD	C-Diff	Heartburn/Reflux	Chronic Constipation	Chronic Diarrhea	Hepatitis
Kidney Disease	Arthritis	Face Fracture/Trauma	Weakness	Musculoskeletal	Psychiatric
Sinus Infection	Mononucleosis	Strep throat/Tonsillitis	Ear Infection	Glaucoma/Cataract	Dentures/Implant

Please list ANY additional illnesses, medical problems or pertinent history:

Surgery/Year	List **ALL** surgeries	Anesthesia Complication YES NO	Malignant Hyperthermia YES NO

Social History	Smoke	Chew/Snuff	Vape/E-Cigarette	Alcohol	Street Drugs (cocaine/heroin, etc)	Chronic Afrin use
How Long						
When Quit						

Family History	Please list all **RELEVANT** family medical history including cancer

Patient/Guardian Signature **Date**

COMMUNICATION PRACTICES AND ACKNOWLEDGEMENT OF NOTICES OF PRIVACY PRACTICES AND PATIENT BILL OF RIGHTS IN WAITING ROOM FOR THE OFFICE OF PERRY M. SANTOS, MD

I have reviewed the Notice of Privacy Practices and Patient Bill of Rights for the office of Perry M. Santos, MD., available in waiting room and personal copy available upon request.

Name:_____ Date of Birth: _____

Signature: _____ Date: _____

I understand that it is my right to be contacted in a specific manner. I wish to be contacted in the following manner (check all that apply):

☐May call and leave detailed message at:
Home: _____
Mobile: _____
Work: _____

☐Home Telephone: _____
☐may leave message with detailed information
☐may leave message with call back number only

☐Work Telephone: _____
☐may leave message with detailed information
☐may leave message with call back number only

☐Mobile Telephone: _____
☐may leave message with detailed information
☐may leave message with call back number only

☐Written Communication
☐may send my protected health information to home address
☐may send my protected health information to listed post office box
☐may send my protected health information to: _____

☐Electronic Communication, Email: _____
☐may send my protected health information to email
☐may receive my health information via email
☐may receive office updates via email

Other ways to communicate with patient and/or legal representative:

_____

_____ _____
Signature of patient and/or legal representative DATE

Financial Policy for Perry M. Santos, MD

Welcome to the practice of Perry M. Santos M.D. We're glad you have chosen us for your medical and surgical needs. This document is a copy of our office's financial policy to help you understand your financial responsibilities as our patient, and our responsibilities as your provider. It is very important that you understand the provisions of your own health insurance plan, i.e., what it will allow (pay) when it comes to medical care.

We participate with many managed care plans in this area. For those plans with which we do not participate, we ask that your office visits be paid prior to the time of service. Managed care "co-pays" are also expected at time of service.

Our clinical office staff will be happy to answer any of your clinical questions. Please call 405-945-4325.

Outlined below are brief statements regarding our patient financial policies:

1. Patients [or their guardians] need to complete our "Patient Information Sheet" under the following conditions:
    - New patient/first time in the office
    - When a significant change has occurred, ie, remarriage, divorce, change of guarantor, insurance carrier, etc.
2. Worker's compensation Evaluation/Disability patients will be asked to provide separate information related to the Worker's Compensation disability or injury prior to scheduling an appointment.

GUARANTOR INFORMATION [PERSONS RESPONSIBLE FOR ACCOUNT]

The patient's or the patient's guardian's signature on our Patient Information Sheet is an acknowledgment of responsibility for that particular patient's account.

Please remind custodial individuals, i.e., step-parents, grandparents, etc., that they assume responsibility for any charges required to be paid at the time of that patient's visit.

In cases of divorce, separation and parental [or other] custody, please remember: The custodial individual will be responsible for the patient's account. Dr. Santos does not bill non-custodial [absent] individuals.

GENERAL STATEMENT REGARDING PAYMENT AT TIME OF VISIT

Self Pay

Patients who are "self pay" [no insurance coverage or insurance plans for which Dr. Santos is not enrolled] are required to pay for all services at the time of the visit. Surgical procedures must be paid prior to the surgery being scheduled.

Managed Care Plans

Patients insured by one of our managed care plans, ie, PPO are required at the time of service to:

1. Pay any co-payment amount
2. Pay for any verified co-insurance, deductible, or non-covered services indicated under the plan.
3. When the co-payment or deductible amount is not known, we ask that you pay $25.00.
4. We require the unmet deductible and copayment on all surgical procedures. Postoperatively, any subsequent balance owed by the patient can either be paid in full or we can initiate a monthly payment plan in order to pay the debt under the following conditions:
    A. Payments must be structured in order to fulfill the debt within 6 months.
    B. Any future visits must be paid in full. Amounts cannot be added to the payment plan.
    C. Payments not made on specified dates are placed with our collection agency.

Services Not Covered by Insurance
An insurance company may determine that a procedure or service is "not medically necessary" or considered to be "routine" or even "experimental". This may even include care that you and/or Dr. Santos have good reason to believe you need. In the event this occurs then patients are expected to be financially responsible for these charges.

Worker's Compensation Injury
Patients who are being seen for a Worker's Compensation injury must:

1. Have their employer's or insurance employer's representative provide all information regarding where claims are to be filed for payment, claim reference numbers, case workers name and contact phone number prior to the appointment being scheduled.
2. If this information is not provided, the patient will be responsible for payment in full at the time of service.

Refunds
Occasionally, a patient will incur a "credit" or positive balance due to a secondary insurance payment, reaching a deductible satisfaction limit, etc. In that event, we will be glad to:

1. Refund the patient
2. Allow the patient to use the credit upon return visits

Please note that refund requests from patients must first be verified before processing.

Collection Placement
Should your account be placed with our collection agency for any reason, you will be required to deal directly with that agency. Patients whose accounts are placed with a collection agency will not be able to return to the practice for further care until the bill is paid in full.

Therefore, we encourage you to stay in contact with our billing office. We will gladly work with you to clear up any past due balances. However, if there is no response or communication from you whatsoever, we assume you would rather deal with our collection agency and no longer desire services from our facility.

Fees for Copying Records and Completing Benefit Forms
We will copy patient records <u>for the patient</u> as a courtesy free of charge for the first time only. Subsequent record requests will incur a fee of: $1.00 for the first page, then $0.50 for each additional page. Other patient-authorized entities requesting patient records will incur a fee of: $1.00 for the first page, then $0.50 for each additional page.

UNDER NO CIRCUMSTANCE CAN RECORDS BE RELEASED WITHOUT A SIGNED AUTHORIZATION.

Please remember, the original medical record is the property of Perry Santos, M.D. You are always entitled to a properly authorized/released copy of your medical record.

FMLA and related documents, i.e., Worker's Compensation Evaluations, etc. will incur a completion fee of $25. For preparation of both medical records, please allow a minimum completion time of two weeks.

Disability evaluation [including narrative evaluations] requested by attorneys, insurance carriers, agencies or patients will be charged according to the Physician's time to document and complete these requests. Prepayment is required.

If you have any questions about our financial policies, please contact our Patient Account Specialist.

Thank you!

CONSENT TO THE USE AND DISLCOSURE OF PROTECTED HEALTH INFORMATION FOR THE TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I understand that as part of my health and medical care, the office of Perry M. Santos, M.D., originates and maintains medical and health information describing my health history, symptoms, examinations, test results, diagnoses, treatments, and any plans for future care and treatment. I further understand that this information serves as a basis for planning my care and treatment, a means of communication among healthcare professionals who contribute to my care, a source of information for applying my diagnoses and treatments to bill for services rendered or to be rendered by other healthcare professionals and third party payers.

I further understand and agree that this agreement to release information shall apply to all information accumulated up to the date this agreement is signed and to any information acquired in the future. This agreement to release future information shall remain in effect until such time as I shall revoke it in writing.

I understand and have reviewed a Notice of Privacy Practices that provides me with a more detailed description of information and uses and disclosures. I understand that I have the right to request restrictions as to how my protected health information may be used and disclosed in order to carry out treatment, to receive payment, and/or healthcare operations and that the office of Perry M. Santos, MD, is not required to agree to the restrictions requested. I understand that I must revoke this consent in writing.

By Oklahoma law we are required to notify you that the information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

I consent for my protected health information to be released to an entity for treatment, payment, or healthcare operations at the discretion of the office of Perry M. Santos, MD, as detailed in their Notice of Privacy Practices.

Please list what persons <u>you want to have access</u> to your protected health information:

_____

_____

_____ _____

Signature of patient or legal representative DATE

The office of Perry M. Santos, MD _____ accepts _____ declines _____accepts conditionally the restrictions imposed on your release of information as state above.

_____ _____

Signature/Title DATE