ENT Specialists, Inc.

Health History Form

NAME: **DOB:** **Primary Care: Dr.**
HT: **WT:**
Reason for Visit:

_____

_____

_____

Please Circle Any Pertinent Medical History
Heart disease Acid Reflux Seasonal Allergies Sinus Disease High Blood Pressure Asthma Glaucoma Thyroid Disease Diabetes Arthritis Sleep Apnea Cancer _____ Emphysema/Bronchitis Bleeding Issues Reaction to Anesthesia

Past Surgical History: List any operations/hospitalization.
1. _____ 2. _____
3. _____

Medication (over the counter and prescription medications) **Flu Shot: YES or NO**

_____

_____

_____

Allergies to Medications (circle reactions that apply)

No Known Drug Allergies (NKDA)
Latex allergy: YES or NO
Medication: _____ Rash Hives Anaphylaxis GI upset Other_____ Medication: _____ Rash Hives Anaphylaxis GI upset Other_____ Medication: _____ Rash Hives Anaphylaxis GI upset Other_____
Occupation: _____

_____
Smoker: Yes or No Current Smoker: Packs/day_____ Years smoked_____
Prior Smoker: Quit_____ Packs/day_____ Years smoked_____ **Chewing Tobacco: Yes or No**
Alcohol: Drinks per day_____ or per week_____
Coffee: Cups/day _____
Patient Signature: _____
Date: _____
Physician Reviewer: _____

Date: _____

ENT Specialists, Inc.

Consent Form

Name:

DOB:

Account #:

Financial Policy

I have reviewed the **Patient Financial Policy** provided to me by ENT Specialists and hereby agree to the terms outlined in the **Patient Financial Policy**.

_____

Signature of Patient or Legal Guardian Date

HIPPA Authorization Form

I authorize ENT to speak with the following people concerning my care.

_____

_____

We may get an updated list of your medications as needed: YES or NO.

I authorize ENT to communicate with me through the following methods.

Cell phone: YES or NO Number: _____ Leave Message: YES or NO

Email: YES or NO Email Address: _____

(Office appointment confirmation calls will still be made)

Race: Native American Asian Black/African American White Hispanic Native Hawaiian

Ethnicity: Hispanic/ Latino YES or NO Primary Language: _____

I request the following restrictions to the use and disclosure of Health Information:

_____

I have reviewed the **HIPPA Authorization Form** provided to me by ENT Specialists and hereby agree to the terms and conditions outlined in the **HIPPA Authorization Form**.

_____

Signature of Patient or Legal Guardian Date

ENT Specialists, Inc.

HIPPA Authorization Form

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal health care information is protected. The rule was also created to provide a standard for health care providers to obtain their patients' consent for use and disclosure of health information 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 need your health care information to provide care that is in your best interests.

We support your full access to your personal medical records. We may have to disclose personal health 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 the law, we have the right to refuse to treat you should you refuse to disclose your Personal Health Information (PHI). If you consent, then at some future time you may refuse part or all your PHI. You may not revoke actions that have already been taken which relied on a previously or currently signed consent.

If you have any objections, please ask to speak with our HIPPA compliance offices. You have the right to review our Privacy Notice and revoke consent in writing after you have reviewed our privacy notice.

Patient Financial Policy

I understand that it is my responsibility to be familiar with my insurance plan and what benefits it provides. This includes what referrals, copayments and deductibles are required.

I understand that is my responsibility to provide with ENT Specialists with accurate and up to date information about my insurance coverage at the time of my visit.

I understand that copayments and deductibles, required by my insurance company, are my responsibility. I understand that charges not covered by my insurance plan are my responsibility. This includes charges not covered by my insurance plan because I failed to provide the necessary information at the time of the visit that would have allowed for the proper adjudication of the insurance claim.

I understand that if I do not call at least 24 hours in advance of my appointment to cancel, I may be charged an administrative fee of $50.00. I understand that repeated missed appointments may result in the inability to make future appointments. Notification will be sent to my primary care physician in the event of dismissal from the practice.

I authorize my insurance pan to pay benefits directly to ENT Specialists Inc.

I authorize ENT Specialists to release pertinent medical information when requested by my insurance company to facilitate payment of a claim.

I request that payment of authorized Medicare and Medigap benefits be made on my behalf to ENT Specialists for any services provide to me by that provider. I authorize any holder on medical information about me to release to the CMS and its agents any information needed to determine these benefits or other benefits payable for related services. This authorization applies to all occasions of service and is in effect until I choose to revoke it.

If you have questions, please refer to the attached full Patient Financial Policy Form.