Associates of
EAR, NOSE & THROAT
Surgery

Dear Patient,

We look forward to your upcoming appointment with us**.** In order to give you the best care and service possible, please read carefully as we request the following:

Please complete the patient portal online. You should have received an email with instructions. Your PIN number is your year of birth (ei:1968). Please contact the office if you did not receive the email or if you have questions.

Please fill out the enclosed forms completely and return them to our office. You may fax them and bring them to your appointment.

Please bring the original forms with you, even if they have been faxed to us.

All copays are due at the time of your appointment.

You must bring your insurance card and driver's license, or picture ID

Please bring medical records pertaining to this visit for the doctor to review. This includes *all CT films (actual films/discs) with reports* and *hearing tests*. You may request that your referring doctor send these records to us or fax them to (972) 420-8812. Please note that CT films must be picked up from the facility at which they were conducted.

Please obtain a referral from your primary care physician, if needed. Review your insurance card and call your insurance company to determine if a referral is needed. Obtaining a referral and charges incurred without referrals are the patient's responsibility.

Please note that because we are a specialist office, at times there are procedures done that may be considered "special" procedures by your insurance company. These may be covered at a different rate, through a deductible or patient responsibility. We will not be able to determine ahead of time the specific procedure that may need to be conducted in order to diagnose our patients. Please be advised that your visit may incur some of these charges.

324 W. Main Suite 100 Lewisville, TX 75057 Phone (972) 420-7212 Fax (972) 420-8812
www.AssociatesofENT.com

Patient Consent for the Disclosure of Information

- I authorize Associates of Ear, Nose & Throat Surgery to release periodic status reports from the medical record.
- I understand that my records are confidential and cannot be disclosed without my written authorization, except otherwise provided for by law.
- I understand that records pertaining to the diagnosis and/or treatment of AIDS, HIV testing, psychiatric illnesses, and alcohol or chemical abuse and dependency cannot be disclosed without my written authorization, except otherwise provided by law.
- I understand that a photocopy or facsimile of this authorization is valid as the original.
- I authorize the release of any medical, billing or other information necessary to process claims on my behalf. I am aware that I am fully responsible for all lawful debts incurred by myself or dependant for services received from Associates of Ear, Nose & Throat Surgery whether covered by insurance or not.
- I authorize Associates of Ear, Nose & Throat Surgery to share any information necessary for ongoing operations of this office, including (but not limited to) the credentialing process, peer review, accreditation and compliance with all federal and state laws.

My consent is given and I understand that I may revoke this authorization at any time by doing so in writing. Any disclosures given prior to any revocation will be permissible.

Name of Patient _____

Signature of Patient, Parent or Legal Guardian _____ **Date** _____

If the office attempts to contact you and a message is taken by an answering machine, voicemail or another person, it is appropriate for us to leave **(PLEASE INITIAL ONE):**

☐ Detailed message regarding lab tests and conditions.

☐ Message to call our office.

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ASSOCIATES OF EAR, NOSE & THROAT SURGERY

Release to discuss information in patient's absence

PATIENT'S NAME_____ DATE OF BIRTH_____

If Patient is under 18:

Parent or Legal Guardian's Name _____ Phone (_____)_____

Parent or Legal Guardian's Name _____ Phone (_____)_____

Please complete the following information if you would like to give permission for someone else to discuss medical care and/or obtain medical treatment in your absence. A minor must be accompanied by the parent, legal guardian or one of the adults listed below in order to be seen by the physician. This information will be kept in the patient's chart. Please inform the receptionist when this information needs to be updated.

I give the following people permission to obtain medical treatment as needed for the patient named above:

Name_____ Relation _____ Phone (_____)_____

Name_____ Relation _____ Phone (_____)_____

Name_____ Relation _____ Phone (_____)_____

Name_____ Relation _____ Phone (_____)_____

Name_____ Relation _____ Phone (_____)_____

_____ _____

Signature of Patient/Guardian Date

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Specialist Procedure Release

Please note that because we are a specialist office, some procedures done in our office are defined by the American Medical Association as *surgical* procedures. These procedures are often considered "special" procedures by your insurance company and **may be covered at a different rate, through a deductible or patient responsibility. We will not be able to determine ahead of time the specific procedure that may need to be conducted in order to diagnose our patients.** Some of these procedures may be:

- Hearing testing
- Looking into the nasal passage through a lighted scope.
- Ear wax removal
- CT Scans

Please be advised that your visit may incur some of these charges and that you may owe more than your copay once all insurance has been paid.

✘_____ _____

Patient Signature Date

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THIS NOTICE DESCRIBES HOW YOUR PERSONAL HEALTH INFORMATION (PHI) MAY BE USED AND DISCLOSED AND HOW THIS INFORMATION MAY BE ACCESSED.

Personal health information (PHI) is any information, whether oral or recorded in any form that is created or received by us as it relates to your past, present, or future physical or mental health or condition, to the provision of health care to you, or the payment for your health care. We are required by law to maintain the privacy of your PHI and give you notice regarding our privacy practices, our legal duties, and your rights concerning your PHI. As our patient, you are bound by the terms of the notice currently in effect. We reserve the right to refuse treatment. We reserve the right to change our privacy practices and the terms of this notice at any time for all health information that we maintain, including health information we created or received before these changes were made. Following significant revisions of our privacy practices, a new notice will be available upon request. You may request a copy of our policies at any time.

PHI is used and disclosed about you for the following purposes:
Treatment from your physician or other healthcare providers or to other physicians or healthcare providers.
To obtain **Payment** for services that were provided to you.
Service provided in connection with our **Healthcare Operations**. These include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professional, evaluating practitioner and provider performance, conducting training, accreditation, certification, or licensing activities.

Authorizations must be given in a signed Release Form giving us permission to use specified PHI for specific purposes or to disclose PHI to a third party specified by you. You may revoke these authorizations at any time. We may disclose your PHI to a family member, friend or other person to the extent necessary to aid in your healthcare or payment for your healthcare only with your permission. We intend to contact you to provide appointment reminders or information about your treatment alternatives by phone or letter.

PHI may be used and disclosed *without consent or authorization*s for public purposes as required by law and involve:
Public health activities
Victims of abuse
Judicial and administrative proceedings and law enforcement
Descendents, coroners, and medical examiners
Imminent threat to the health or safety of you or the public
Military and intelligence functions
Workers compensation

Your rights as a patient include the right to:
Receive notice of our privacy policy and practices.
Request restrictions on certain uses and disclosure to other of your PHI, however we are not required to agree to the requested restriction.
Receive confidential communication of PHI by an alternative method than our typical form of communication. This request must be in writing.
Inspect and obtain a copy your PHI.
Receive an accounting of disclosures of PHI
Receive a paper copy of this notice if the notice was received electronically (by email) upon request.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, please contact us immediately. You may also submit a written complaint to the U.S. Department of Health and Human Services. We support your right to the privacy of your health information.

Associates of Ear, Nose & Throat Surgery
324 West Main, Suite 100
Lewisville, TX 75057
Phone (972) 420-7212 Fax (972) 420-8812
Contact Officer: Michelle Millward, M.A., F-AAA

Patient Health History

SECTION 1

FIRST NAME: _____ **MIDDLE:** _____ **LAST:**_____

DATE OF BIRTH:_____ **SEX :** ☐ **Male** ☐ **Female**

RACE: ☐ **White** ☐ **Black/Af Am** ☐ **Asian** ☐ **Indian** **ETHNICITY:** ☐ **Hispanic/Latino** ☐ **NOT Hispanic/Latino**

PRIMARY ON INSURANCE_____ **PRIMARY ON INS DATE OF BIRTH:**_____

PHARMACY NAME:_____ **LOCATION:**_____

REFERRING DR:_____**PRIMARY DR:**_____

MEDICAL REASON FOR TODAY'S VISIT:_____

SECTION 2 ***PLEASE COMPLETE THIS SECTION ONLY IF YOU WERE UNABLE TO COMPLETE PATIENT PORTAL ONLINE. Please call the office for portal instructions.***

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

NAME OF MEDICATION	DOSAGE	HOW OFTEN TAKEN

Please use a separate sheet of paper if needed

ARE YOU ALLERGIC TO ANY MEDICATION? ☐ **YES** ☐ **NO** ***If Yes, please list below:***

NAME OF MEDICATION	TYPE OF REACTION

Please use a separate sheet of paper if needed

SURGERIES/HOSPITALIZATIONS	PHYSICIAN/HOSPITAL	YEAR

DO YOU OR ANY OF YOUR FAMILY MEMBERS BRUISE OR BLEED EASILY? ☐ **YES** ☐ **NO**

HAVE YOU OR ANY OF YOUR FAMILY MEMBERS EVER HAD PROBLEMS WITH ANESTHESIA? ☐ **YES** ☐ **NO**

Patient Signature_____ **Date**_____

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