

**Ear, Nose & Throat Consultants
Patient Medical Hx Form**

Name: _____

Date: ___/___/_____ DOB: ___/___/_____ Age: _____

Reason for today's visit: _____

Medications (include Aspirin, vitamins and herbal remedies, birth control and over-the-counter allergy and cold meds): _____

Allergies to Medications: ___ **None known**

Med _____ rash/hives/swelling/anaphylaxis/breathing problem

Med _____ rash/hives/swelling/anaphylaxis/breathing problem

Med _____ rash/hives/swelling/anaphylaxis/breathing problem

Your Past Medical History:

	<u>Yes</u>	<u>No</u>	(please explain if yes)
Diabetes	O	O	_____
High Blood Pressure	O	O	_____
Thyroid disease	O	O	_____
Heart Disease	O	O	_____
Heart Murmur	O	O	_____
Elevated Cholesterol	O	O	_____
Respiratory/lung disease	O	O	_____
Digestive/stomach/intestinal disease	O	O	_____
Urologic/kidney disease	O	O	_____
Neurologic/seizure/depression	O	O	_____
Glaucoma/eye disorder	O	O	_____
Environmental Allergy	O	O	_____
Cancer	O	O	_____
Other Medical Disease	O	O	_____
Autoimmune Disease	O	O	_____

No prior surgery

Previous Surgery (include operations and dates): _____

Social Hx

What is your occupation? _____

How much do you smoke? _____ packs/day (Check if none O)

If none, did you ever smoke? _____ If yes, when did you quit? _____

How often do you drink alcohol? _____

Caffeine Use _____ If Yes, please list source and frequency _____

Exposed to high level of Environmental noise _____

Family Hx

Please note which **relatives** have had the following:

	Yes	No	(please explain if yes)
Cancer	O	O	_____
Hearing Loss	O	O	_____
Allergy	O	O	_____
Bleeding disorders	O	O	_____
Diabetes	O	O	_____
Headaches	O	O	_____
Heart Disease	O	O	_____
Adverse reaction to anesthesia	O	O	(Malignant Hyperthermia?) _____

Reviewed by: _____ M.D. Date _____

**Ear, Nose and Throat Consultants
Patient Registration Form**

Date: _____

Email: _____

Name / Address

Last Name: _____ First Name: _____ MI: _____

If minor: Parent's name: _____

Street Address: _____

City: _____ State: _____ Zip: _____ - _____

Home Phone: () _____ - _____ Cell phone: () _____ - _____

Work Phone: () _____ - _____ Employer: _____

Statistics

Soc. Sec. #: _____ - _____ - _____ Date of Birth: ____/____/____ Sex: Male/Female

Marital Status (Circle one) Married, Single, Divorced, Widow, Other _____

Spouse / Next of Kin: _____ Contact Tel #: () _____ - _____

Referring Physician

Primary Care Doctor: _____ Referring MD: _____

Address: _____ Tel: () _____ - _____

Insurance Information

Primary Insurance Company	Identification or Certificate #	Group #
_____	_____	_____

Name of insured if not self: _____ **Relation to Insured (circle one)**

Insured Adr1: _____ Self, Spouse, Child

Insured City: _____ State: _____ Zip: _____

Insured Date of Birth: ____/____/____ Insured Soc. Sec : #: _____ - _____ - _____

Insured Employer: _____

Secondary Insurance Company	Identification or Certificate #	Group #
_____	_____	_____

Name of insured, if not self: _____ **Relation to Insured (circle one)**

Insured Adr1: _____ Self, Spouse, Child

Insured City: _____ State: _____ Zip: _____

Insured Date of Birth: ____/____/____ Insured Soc. Sec : #: _____ - _____ - _____

Other Insurance

Is this Workers Comp.? Y/N Is this Motor Vehicle? Y/N Is this Personal Injury? Y/N

Authorization and financial Policy

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS FOR MEDICAL BENEFITS.
I AUTHORIZE PAYMENT OF ALL MEDICAL BENEFITS TO ENT CONSULTANTS FOR SERVICES PROVIDED.
I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AND ALL BALANCES NOT PAID BY MY INSURANCE COMPANY.

Your Signature: _____

HIPAA Notice of Privacy Practices

Ear, Nose and Throat Consultants

This notice explains how your medical information about you can be used and disclosed and how you can access it.

This Notice of Privacy Practices describes how we may use and disclose your health record or protected health information (PHI) for treatment, payment, and health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. Protected Health Information is information about you including demographics that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. The doctors and staff of Ear, Nose and Throat Consultants are committed to maintaining the privacy of your health information.

Uses and Disclosures of PHI

Your PHI may be used and disclosed by your physician, our office staff, and others outside of our office who are involved in your health care and treatment to provide health care services, pay your medical bills, support our office practice operation, and any other use required by law. We are required to abide by the terms of the notice currently in effect.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This can include communication with a third party, for example, to a referring physician, an emergency room doctor, or a home health agency that will be providing home services.

Payment: We will use your PHI as needed to obtain payment for health care services we have delivered. For example, we must provide a diagnosis to your health insurance company for proper billing for an office or hospital visit.

Health Care Operations: We may use or disclose, as needed, your PHI to support our business activities. These may include but are not limited to quality assessments, employee reviews, training of staff and medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical students who see you when you are in the hospital. In addition, we may have you sign in when you register at our front desk. We may call your name when we are ready to bring you to an exam room. We may disclose your PHI when reminding you of an appointment.

Disclosures without Authorization: Your PHI may be used or disclosed without your authorization in the following situations: Required by law; Public Health issues as required by law; Communicable Diseases; Health Oversight, Abuse or Neglect; Food and Drug Administration requirements; Legal proceedings; Law Enforcement; Coroners; Funeral Directors; Organ Donation; Research; Criminal Activity; Military Activity and National Security; Worker's Compensation; Correctional Institutions; Required Uses and Disclosures. Under law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization at any time in writing, except to the extent that your provider or the practice has taken an action in reliance on the use or disclosure indicated in the authorization. Your health record is the physical property of Ear, Nose and Throat Consultants, Inc. The information in the record is accessible to you.

Your Rights

Following is a statement of your rights with regard to your protected health information (PHI)

You have the right to inspect and copy your PHI. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of or use in a civil, criminal or administrative action or proceeding; and PHI that is subject to law that prohibits access to PHI.

You have the right to request a restriction of your PHI. This means that you may ask us to not use or disclose any part of your PHI for the purpose of treatment, payment, or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you request. If the provider believes that it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use a different Healthcare Professional.

You have the right to request receipt of confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us upon request, even if you have agreed to accept this notice alternatively.

You may request to have your physician amend your PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or to withdraw from the practice as provided in this notice.

Complaints. If you have any questions or would like additional information, you may contact our office manager, Miran, at 781-937-3001. You may complain to us or to the Secretary of Health and Human Services if you believe we have violated your privacy rights. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice becomes effective on or before April 14, 2003.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, hereby acknowledge that I have received Ear, Nose and Throat Consultants' Notice of Privacy Practices. I understand that I can contact the office manager, at 781-937-3001 if I have any further questions or concerns about the office's privacy policy.

I understand that I am entitled to receive updates upon request if Ear, Nose and Throat Consultants Notice of Privacy Practices is amended or changed in a material way.

Please note the following special request(s) for the privacy of my records, health care, and communications:

Patient's Signature

OR

Date

Patient's Personal Representative

Authorization to Pay Benefits to Physician: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for services, but not to exceed the reasonable and customary charges for those services.

Authorization to Release Information: I hereby authorize the Physician to release any information acquired during the course of my examination or treatment for purposes of treatment, payment, or health operations.

Patient's Signature (Parent or Guardian)

This Section to be filled out by Office Staff only.

To be filled out if unable to obtain written acknowledgement from the patient or guardian.

On _____, I attempted to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

Patient declined to sign this written acknowledgement.

Patient did not understand the request to sign the written acknowledgement.

Other (please specify details) _____