Patient Registration

Patient Information

Name: ____ Today's Date: __/__/__

Sex: ________ Age: _________ Birthdate: ___/___/___ Social Security #: ________-______-________

Address: _______________________________________ City: ___________________________ State: __________ Zip Code: ___________

Home Phone #: _______________________ Work Phone #: ___________________ Mobile Phone #: ______________________

Seasonal Address:

Address: _______________________________________ City: ___________________________ State: __________ Zip Code: ___________

Email address: ____

Marital Status (Circle One): Married Single Divorced Widowed Separated Common Law Living Together

Domestic Partner Registered Domestic Partner Legally Separated Annulled Interlocutory

Lauguage (Circle One): English French German Vietnamese Italian Mandarin Spanish

Race (Circle One): Asian Black or African American Caucasian Hispanic Native American American Indian or Alaska Native

Ethnicity (Circle One): Hispanic or Latino Non Hispanic or Latino Other or Undetermined

Emergency Contact

Name: ______________________________ Phone: _______________________ Relationship to Patient: _________________________

For minors:

Guardian/Responsible Party: ___________________________ Relationship to Patient: ________________

Birthdate: ___/___/___ Social Sec #: _______________________ Tel#: ____________________

Address (if different from patient's): ____

Insurance: ____

- Are you the primary policy holder? YES NO

Primary policy holder:

Name: ____ Relationship ___________________________

DOB ____ Social Security Number ______________________________

ENT ASSOCIATES
(239) 939-2621

Otolaryngology Clinic Procedures

We are able to provide you with the latest technology available to assist with your diagnosis and treatment. These procedures are quick, painless and are invaluable for providing you the most comprehensive and advanced care possible. Please be aware that many of these procedures may be considered as a surgical procedure by your insurance company. Because of this, there may be a separate co-pay/deductible. The two most common procedures are Diagnostic Nasal Endoscopy, CPT 31231, Flexible Laryngoscopy , CPT 31575 and Video Stroboscopy, CPT 31579. Please check with your insurance company if there is any question. Thank you for helping us care for you.

I, ____ understand the above
Patient Signature

I, ____ understand the above
If Minor: Parent or Legal Guardian Signature

____
Signature of Witness

Patient name: ______________________________ Medical Record # ___________

Date: ____________________________________

CONFIDENTIAL PATIENT INFORMATION

I authorize any holder of medical information or other information about me to be leased to Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to the billing agent of this doctor, any information needed for this or a related Medicare claim and/or my Private Health Insurance claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party whom accepts assignment. I understand that this is a lifetime signature authorization. I understand that this authorization may be used to release medical information if necessary to process my insurance claims and pay the provider direct. I understand this also applies to my private and/or group health insurance as applicable.

______________________________ ____________________

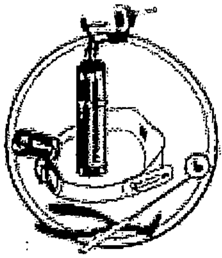
Signature of Patient or Guardian Date of Birth (Patient)

______________________________ ____________________

Print Name of Signer if NOT Patient Relationship to Patient

____

Date



EAR, NOSE & THROAT ASSOCIATES, MD PA
9711 COMMERC CENTER COURT, SUITE 101
FORT MYERS, FLORIDA 33908
(239) 939-2621

Consent to E-Prescribing

E-Prescribing is defined as a physician's ability to electronically send error free, accurate, and understandable prescriptions directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program.

These include:

- **Formulary and benefit transactions** - Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** – Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification** – Allow the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that Ear, Nose & Throat Associates, may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

Understanding all the above, I hereby provide informed consent to Ear, Nose & Throat Associates to enroll me in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

I give consent to Ear, Nose & Throat Associates, including their medical staff members and employees involved in my care, to access, use and disclose my protected heath information for my treatment, payment for my treatment and for health care operations consistent with the federal HIPAA privacy regulations. I consent to the disclosure of my prescription medical information by any provider, pharmacy, insurer, and prescription benefits manager, specifically including any state of federal health benefits program to Ear, Nose & Throat Associates, for the purpose of my treatment. I am aware that the privacy practices of Ear, Nose & Throat Associates are described in its Notice of Privacy Practices. This Consent is subject to my revocation at any time except to the extent it has already been acted on.

________________________	__________________
Patient Name (Print)	Patient Date of Birth
________________________	__________________
Signature of Patient or Legal Representative	Date and Time Signed
________________________	__________________
Print Patient Representative Name	Relationship to Patient

EAR, NOSE, AND THROAT ASSOCIATES
FINANCIAL POLICY

Ear, Nose & Throat Associates, is dedicated to providing our patients with the best possible care. We ask your help by understanding and cooperating with our financial policy. We must emphasize that as physicians, our relationship is with you, NOT with your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are strictly your responsibility. We realize that temporary financial problems may effect timely payments on your account. If such problems arise, we encourage you to contact us promptly for assistance in the management of your account. A copy of this policy will be provided to you upon request.

INSURANCES:
We participate with many insurance companies. Please check with our staff, we will be happy to assist you. Many times this requires seeing the actual card. If we DO participate with your insurance company, all services performed in our office will be submitted, unless we have received prior notification of non-covered services. If we DO NOT participate with your insurance plan, this means that we will bill your insurance company as a courtesy. We do not accept the insurance company's payment for these services as payment in full. All insurance carriers have a schedule of fees from which they will pay: however, the doctor's fee maybe more than what the insurance company will allow. Any balance not covered by the insurance company will become your responsibility.

For secondary insurances, we will submit your secondary insurance claim a maximum of two times. After two submissions, the balance will be billed to you.

CO-PAYS / DEDUCTIBLES AND OUTSTANDING BALANCES:
All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with you insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

REFERRAL/ AUTHORIZATION:
If your insurance has referral or authorization requirements, you are required to have prior authorization or referral from your Primary Care Physician (PCP) prior to your visit. If this authorization or referral is not provided the day of service, you may be asked to either reschedule your appointment or pay for the visit, at the time of services.

PROOF OF INSURANCE:
All patients must complete our patient information forms before seeing the doctor. We must have a current copy of your insurance card or cards and a photo ID. If your insurance has changed, it is your responsibility to update your information with our office and present a new insurance card. All cards **cannot** be altered in any way. We will not file a claim to an insurance company that we do not have a valid insurance card for verification. Updating insurance information must be done timely. We are not able to file a claim 90 days past the date of service. Failure to provide us with insurance changes in a timely manner, will make you responsible for any balances due.

FAMILY LEAVE OR DISABILITY INSURANCE FORM:
Our office will complete your FMLA or Disability claim forms. The fee for each form is $25.00. and must be paid in advance, prior to completion of the forms. **PLEASE ALLOW 7-10 business days for all form to be completed.**

MINORS: Must be accompanied by a parent /guardian. The parent / guardian who signs the financial policy and provides the financial information, will be financially responsible and the guarantor of the account.

COLLECTION ACCOUNTS:
Our office will make every effort to communicate with you about your account and will present reasonable options for payment. In the event a bill goes unpaid without contacting the billing department to discuss payment options, the account will be turned over to collections. If your account is sent to our collection agency, a collection charge of 25% will be added to the balance of your account. In the event your account is turned over to an attorney you will be responsible for any and all attorney fees plus court cost. You agree, in order for the collection agency to contact you regarding your account, they may call any number associated with your account, including wireless telephone numbers, text messages and emails, which could result in charges to you. Methods of contact may include using pre-recorded/ artificial voice messages and/or automated dialing devices.

SELF-PAY POLICY:
Payment is expected at the time of services.

COPIES OF RECORD: A release must be signed by the patient or if under the age of 18, parent or guardian. As a courtesy we will forward your patient information to your physician at no charge. If you wish to have a copy there is a minimal charge of $5.00 to cover employee time, paper expense and copier cost. Records release to other parties, please speak to our billing department regarding cost.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH BY EAR, NOSE & THROAT ASSOCIATES, MD, PA. AND AGREE TO THE TERMS OF THE FINANCIAL POLICY. I ALSO UNDERSTAND AND AGREE THAT THE TERMS OF THE FINANCIAL POLICY MAYBE AMENDED BY THE PRACTICE AT ANY TME WITHOUT PRIOR NOTIFICATION TO THE PATIENT.

______________________________ ______________________
SIGNATURE OF PATIENT/ GUARDIAN DATE

Acknowledgment of Receipt of Notice of Privacy Policy

I hereby acknowledge that I was offered to read or take with me a copy of the Privacy Policy issued by ***Ear, Nose & Throat Associates***, on the date indicated below.

______________________________ Signature

______________________________ Date

If you are not the patient, please state relationship:

- ☐ Parent (s)
- ☐ Legal Guardian
- ☐ Son or Daughter
- ☐ Facility Caretaker
- ☐ Other______________________________

To respect your privacy please tell us how we may contact you:

Home Phone

- ☐ You may leave a message with the following person(s) if I am not available:
- ☐ You may leave DETAILED Information on my answering machine.
- ☐ You may leave your NAME and PHONE NUMBER ONLY and I will return your call.

Work Phone

- ☐ You may call my work place
- ☐ You may leave DETAILED Information on my answering machine.
- ☐ You may leave your NAME and PHONE NUMBER ONLY on my answering machine and I will return your call.
- ☐ You may not call my work place.

Cell Phone

- ☐ You may leave DETAILED Information on my voice mail.
- ☐ You may leave your NAME and PHONE NUMBER ONLY and I will return your call.
- ☐ You may not call my cell phone.

Please list spouses, family, friends, caretakers, etc…that WE may communicate with in regards to your personal medical and financial information. This will include but not limited to: test results, prescriptions, billing information. Only the names that are listed below will be able to receive your information. Do not include your physicians on this list.

(1)______________________________ (2)______________________________
(3)______________________________ (4)______________________________
(5)______________________________ (6)______________________________

Unless you notify us in writing stating otherwise the above person(s) will always be able to receive information about you.

______________________________ Patient/Guardian Signature

______________________________ Date

Name: ______________________________ **DOB**________________________

Medical History

Please check off any of the following medical conditions that you currently have:

- ☐ Cancer: __ Skin __ Other______________________________
- ☐ Cardiac: ______________________________
- ☐ Endocrine: __Diabetes __ Type 1 __Type 2 __ Other______________________________
- ☐ Gastro: __Reflux __ Other______________________________
- ☐ Urology: __Kidney __Other______________________________
- ☐ OB/GYN: ______________________________
- ☐ Immuno: __Deficiency __ HIV __Other______________________________
- ☐ Lymph: __ Anemia __Bleeding __ Other______________________________
- ☐ Ortho: __Arthritis __Degenerative Joint __Other______________________________
- ☐ Neuro: __Autism __Migraine __Other______________________________
- ☐ Ophth: __Glaucoma __Macular Degeneration __ Other______________________________
- ☐ Psych: __Depression __ Other______________________________
- ☐ Pulm: __Asthma __COPD __Obst Sleep Apnea __Other______________________________
- ☐ Rheum: __Gout __Lupus __Sjorgren's syndrome __Other______________________________
- ☐ Vasc: __Carotid stenosis __ Other______________________________

SURGICAL HISTORY

Please list any surgeries you have had and approximate year:

- ☐ ______________________________ Year__________
- ☐ ______________________________ Year__________
- ☐ ______________________________ Year__________
- ☐ ______________________________ Year__________
- ☐ ______________________________ Year__________
- ☐ ______________________________ Year__________
- ☐ ______________________________ Year__________

MEDICATIONS:

Drug______________________________ Dosage ________________Frequency __________
Drug______________________________ Dosage ________________Frequency __________
Drug______________________________ Dosage ________________Frequency __________
Drug______________________________ Dosage ________________Frequency __________
Drug______________________________ Dosage ________________Frequency __________
Drug______________________________ Dosage ________________Frequency __________

Allergies

Please list all known allergies (environment, drug, food), as well as the type of reaction and level of severity:

Allergy: ________________________ Reaction: ________________________ Severity: __________
Allergy: ________________________ Reaction: ________________________ Severity: __________
Allergy: ________________________ Reaction: ________________________ Severity: __________

ENT History

Please check off any of the following procedure you have had and *__provide date of procedure__:*

ENT Disease History

- ☐ None
- ☐ Cancer: Head and neck Cancer - specify location
- ☐ Cancer: Lymphoma, neck nodes
- ☐ Cancer: Sinus or nasal cavity
- ☐ Cancer: Skin - basal cell carcinoma
- ☐ Cancer: Skin - Melanoma
- ☐ Cancer: Skin - other type - specify
- ☐ Cancer: Skin - squamous cell carcinoma
- ☐ Ear: Acoustic neuroma
- ☐ Ear: Cholesteatoma
- ☐ Ear: Hearing loss
- ☐ Ear: Mastoiditis
- ☐ Ear: Other
- ☐ Ear: Otitis externa (swimmer's ear)
- ☐ Ear: Otitis media (middle ear infection)
- ☐ Ear: Otosclerosis
- ☐ Ear: Tinnitus (ringing or other noise of the ear)
- ☐ Ear: Vertigo
- ☐ General: Facial fractures
- ☐ General: Other
- ☐ General: reflux
- ☐ Larynx/trachea: Papillomas
- ☐ Larynx/trachea: Subglottic stenosis
- ☐ Larynx/trachea: Tracheal stenosis
- ☐ Larynx/trachea: Vocal cord nodules
- ☐ Larynx/trachea: Vocal cord paralysis
- ☐ Larynx/trachea: Vocal cord polyps
- ☐
- ☐ Larynx: Other
- ☐ Nasal: Deviated septum
- ☐ Nasal: Epistaxis (nose bleeds)
- ☐ Nasal: Loss of smell
- ☐ Nasal: Nasal fracture
- ☐ Nasal: Nasal obstruction
- ☐ Nasal: Other
- ☐ Nasal: Polyps
- ☐ Nasal: Rhinitis (allergies)
- ☐ Nasal: Septal perforation
- ☐ Nasal: Sinusitis
- ☐ Nasal: Turbinate hypertrophy
- ☐ Neck: Branchial cleft cyst
- ☐ Neck: Hyperparathyroidism
- ☐ Neck: Neck mass
- ☐ Neck: Other
- ☐ Neck: Parotid tumor
- ☐ Neck: Sialoadenitis (infected or inflamed salivary gland)
- ☐ Neck: Sialolithiasis (stone of the salivary gland)
- ☐ Neck: Thyroglossal duct cyst
- ☐ Neck: Thyroid nodules
- ☐ Oral: other
- ☐ Oral: Sleep apnea
- ☐ Oral: Tonsillitis
- ☐ Oral: Ulcers
- ☐ Other ____________________

ENT Surgical History

- ☐ None
- ☐ Ear: Acoustic neuroma resection
- ☐ Ear: Mastoidectomy
- ☐ Ear: Myringotomy and tubes (specify ear)
- ☐ Ear: Myringotomy (specify ear)
- ☐ Ear: Other - specify
- ☐ Ear: Otoplasty
- ☐ Ear: Stapedectomy
- ☐ Ear: Tympanoplasty (repair ear drum)
- ☐ Head and neck: Lymph node biopsy
- ☐ Head and neck: Neck dissection
- ☐ Head and neck: Other - specify
- ☐ Head and neck: Parathyroidectomy
- ☐ Head and neck: Parotidectomy
- ☐ Head and neck: Resection in mouth or throat - specify
- ☐ Head and neck: Skin graft
- ☐ Head and neck: Skin resection
- ☐ Head and neck: Submandibular gland excision
- ☐ Head and neck: Thyroglossal duct cyst excision
- ☐ Head and neck: Thyroidectomy
- ☐ Head and neck: Tracheotomy
- ☐ Nose: Balloon sinuplasty
- ☐ Nose: Endoscopic sinus surgery
- ☐ Nose: Nasal fracture repair
- ☐ Nose: Other - specify
- ☐ Nose: Rhinoplasty
- ☐ Nose: Septoplasty
- ☐ Nose: Turbinate reduction
- ☐ Throat: Adenoidectomy
- ☐ Throat: Other - specify
- ☐ Throat: Sleep apnea surgery - uvulopalatopharyngoplasty (UPPP)
- ☐ Throat: Tonsillectomy
- ☐ Other ____________________

ENT Family History

- ☐ None
- ☐ Otitis Media
- ☐ Sinusitis
- ☐ Smoking
- ☐ Thyroid Cancer
- ☐ Thyroid Disease
- ☐ Other ____________________

ENT Pediatric History

- ☐ None
- ☐ Cleft Lip
- ☐ Cleft Palate
- ☐ Otitis Media
- ☐ Other ______________________

Social History

Smoking Status:

- ☐ NEVER
- ☐ Former Smoker
- ☐ Light Tobacco Smoker
- ☐ Heavy Tobacco Smoker
- ☐ Current Some Day smoker
- ☐ Current Everyday Smoker
- ☐ Cigar Smoker
- ☐ Chewing Tobacco User

If applicable:

When did you start smoking? ________________

When did you quit smoking? ________________

Number of packs per day: ________________

Total number of years smoking: ________________

Alcohol Consumption:

- ☐ None
- ☐ Less than 1 Drink per Day
- ☐ 1-2 Drinks per Day
- ☐ 3+ Drinks per Day

Other:

Driving Status:

- ☐ Drives in the Daytime
- ☐ Drives at Night

Employer & Occupation: ____

Place of Residence: ____

FAMILY HISTORY

Please list any family history of illness or disease:

Disease/Illness:______________________________ Relationship: ______________Deceased? Yes No

Disease/Illness:______________________________ Relationship:______________ Deceased? Yes No

Disease/Illness:______________________________ Relationship: ______________Deceased? Yes No

Disease/Illness:______________________________ Relationship: ______________Deceased? Yes No

Pharmacy and Referrals

Name, Location & Telephone #:____

Primary Care Physician's Name, Location & Telephone #: ______________________________

Referring Physician's Name, Location & Telephone #: ______________________________

If you are under the care of any specialists, please provide their Names, Locations, & Telephone #s:

____