

TEXAS EAR, NOSE & THROAT SPECIALISTS, L.L.P.

NEW PATIENT INFORMATION

Date: _____

GENERAL PATIENT INFORMATION (Please Print)

Patient Name: _____ Date of Birth: _____
 Sex: Male Female Marital Status: Single Married Divorced Other
 Street Address: _____ Home Phone: _____
 City/State: _____ Zip: _____ Cell Phone #: _____
 Patient's Employer: _____ SS#: _____
 Employer's Address: _____
 Business Phone: _____ Occupation: _____
 Emergency Contact Name: _____ Phone #: _____
 Spouse's Name: _____ Business Phone: _____ Cell #: _____
 Full Time Student? Yes No If yes, Name of School: _____
 If patient is a minor: Father: _____ Home #: _____ Work #: _____ Cell #: _____
 Mother: _____ Home #: _____ Work #: _____ Cell #: _____
 Referred by: _____

RESPONSIBLE PARTY INFORMATION (Complete Only If Other Than Patient)

Responsible Party: _____ Home Phone: _____ Cell #: _____
 Relationship to Patient: _____ Driver's License #: _____ Date of Birth: _____
 Street Address: _____ City/State: _____ Zip: _____
 Employer: _____ Occupation: _____
 Employer's Address: _____ Business Phone: _____

INSURANCE INFORMATION (Please Allow Us To Make A Copy Of Your Insurance Card(s) and Driver's License)

Primary Insurance: Please check one: Medicare PPO HMO
 Insurance Company: _____ ID#: _____ Group#: _____
 Insurance Company Phone Number: _____
 Policyholder Name: _____ Relationship to Patient: _____ Date of Birth: _____
 Home Phone: _____ Cell Phone: _____ Business Phone: _____
 Employer & Address: _____ Occupation: _____

Is there another health insurance benefit plan? Yes No

If yes, please complete information below:

Secondary Insurance: Please check one: Medicare PPO HMO
 Insurance Company: _____ ID#: _____ Group #: _____
 Insurance Company Phone Number: _____
 Policyholder Name: _____ Relationship to Patient: _____ Date of Birth: _____
 Home Phone: _____ Cell Phone: _____ Business Phone: _____
 Employer & Address: _____ Occupation: _____

If no, please sign statement below:

I acknowledge that I do not have a secondary health insurance plan.

(Patient Signature)

(Guarantor Signature)

ASSIGNMENT AND RELEASE

I understand that I am financially responsible for payment of all copays, co-insurance amounts, deductibles, and/or noncovered services that are not paid by my insurance company.

(Guarantor Signature)

(Date)

Medical History

Date: _____

Name: _____ Ht: _____ Wt: _____

Please state specific reason for your visit: _____

Who is your primary care doctor? _____ Who referred you here: _____

Do you have a history of (circle correct answer):

Heart trouble	Yes	No	Allergies	Yes	No	Dizziness	Yes	No
High blood pressure	Yes	No	Thyroid Problems	Yes	No	Stroke	Yes	No
Asthma/COPD	Yes	No	Anemia	Yes	No	Migraines	Yes	No
Gastric reflux	Yes	No	Cancer	Yes	No	Seizure	Yes	No
Ulcers	Yes	No	Radiation Therapy	Yes	No	Glaucoma	Yes	No
Hepatitis	Yes	No	Urinary problems	Yes	No	Eye problems	Yes	No
Diabetes	Yes	No	Prostate problems	Yes	No	Hearing loss	Yes	No

Do you or **did you** smoke cigarettes/pipes/cigars? _____ How many per day? _____

For how long? _____ years

Do you dip or chew? (circle one). How many years? _____

If you quit either cigs, dip, chew, pipes, or cigars, when? _____

Do you drink alcohol? Yes No How many drinks per day, week or month (Circle one): _____

Have you ever had a reaction to anesthetics? _____

Do you have a history of increased bleeding tendency? _____

Do you have a history of bad scarring? _____ If yes, where? _____

Do you wear: Glasses Contacts (Circle if appropriate)

Do you wear hearing aids? Yes No, Left Right Both

Family History (includes brothers, sisters, parents and grandparents only)

Heart disease	Yes	No
Cancer	Yes	No
Diabetes	Yes	No
Seizure disorder	Yes	No
Bleeding disorder	Yes	No

Please Sign Here

TEXAS
EAR, NOSE & THROAT
SPECIALISTS, L.L.P.

Consent for Treatment

By signing this consent, I am authorizing my physician and/or other individuals he or she deems appropriate to perform and/or order exams, tests, procedures, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to Texas Ear, Nose and Throat Specialists, L.L.P. unless revoked by me in writing.

Please be informed Texas law allows a patient to be tested for possible exposure to the Human Immunodeficiency Virus (HIV), the virus associated with AIDS, in the following situations: 1) to screen blood, blood products, organs or tissues to determine suitability for donation; 2) if another individual is accidentally exposed to a patient's blood or body fluids, such as through a needle stick (any such test shall be conducted pursuant to Texas Ear, Nose and Throat Specialists, L.L.P. infectious disease protocol); or 3) if a medical or surgical procedure is to be performed which could expose health care workers to the patient's blood or body fluids. This disclosure is to inform you that you may be tested, at the expense of the Texas Ear, Nose and Throat Specialists, L.L.P. if any of these situations occur during your treatment period.

Patient's Printed Name

Date of Birth

Patient/Legal Representative Signature

Date

Relationship to Patient

Witness, if signature is marked with an X.

Date

Texas Ear, Nose and Throat Specialists, L.L.P.

Authorization to Release Protected Health Information

I, _____, hereby authorize the health records of _____
Patient and/or Guardian **Patient's Name**

to be disclosed or released to the following person and or person by any of the following means: mail, fax and/or orally.

Name	Address	Relationship
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Name	Address	Relationship
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Name	Address	Relationship
------	---------	--------------

My authorization extends to any and all records, unless otherwise marked below.

- | | | |
|---|-----------------------------------|----------------------------------|
| Progress Notes | Statements of charges or payments | Discharge Summary |
| Records of all visits | Consultation Reports | History and Physical Examination |
| Photographs, digital, or images | | |
| Copies of records or reports provided to the above named (i.e. hospital, lab, clinic, etc.) | | |
| Other (must be specific): _____ | | |

I understand that records pertaining to the diagnosis and/or treatment of HIV/AIDS, psychiatric illness, alcohol or chemical abuse and dependency will not be released, unless I have given my specific consent to release this information below.

I consent to the release of any positive or negative test result for HIV/AIDS, antibodies for AIDS, or infection with any other causative agent of AIDS or psychiatric illness, alcohol or chemical abuse and dependency with the rest of my medical records.

Patient Signature: _____ **Date:** _____

- This authorization or release is given freely with the understanding that:
1. All records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
 2. A photocopy or fax of this authorization is as valid as this original.
 3. I may revoke this authorization at any time, except where information has already been released. To revoke my authorization, I must submit a Revocation of Authorization to Release Protected Health Information Form. The physician's office will act upon my revocation within two (2) working days of receipt.
 4. The physician's office, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
 5. Information used or disclosed pursuant to the authorization may be subject to disclosure by the recipient and may no longer be protected by this rule.
 6. The physician's office will not condition my treatment, payment, enrollment, or eligibility for benefits on whether I provide authorization for the requested use or disclosure.
 7. The patient may inspect or have a copy of the Protected Health Information (PHI) to be used or disclosed.
 8. The patient may refuse to sign this authorization; however, PHI will not be released to anyone other than the patient.
 9. If the physician's office uses or discloses your PHI, it may result in a charge to a Third Party entity.
 10. The patient will be provided with a copy of this authorization upon request.

_____	_____	_____
Patient's Printed Name	Date of Birth	Witness (only if marked with an X)

_____	_____	_____
Patient or Guardian's Signature	Signature Date	Relationship to Patient

_____	_____
This authorization is valid unless otherwise noted or revoked.	Expiration Date

TE★AS
EAR, NOSE & THROAT
SPECIALISTS, L.L.P.

Notice of Privacy Practices Acknowledgement

I have been provided with a Notice of Privacy Practices that provides me a description of the uses and disclosures of certain health information. I understand Texas Ear, Nose and Throat Specialists, L.L.P. reserves the right to change their Notice of Privacy Practices and will provide an updated copy posted in the waiting room. I may request a copy of the updated Notice of Privacy Practices in person or by phone.

 Patient's Printed Name

 Date of Birth

 Patient/Legal Representative Signature

 Date

 Relationship to Patient

 Witness, if signature is marked with an X.

 Date

The above named patient refused to sign the acknowledgement of review of Notice of Privacy Practices for Texas Ear, Nose and Throat L.L.P.

 Practice Representative

 Date

 Practice Representative

 Date

TEXAS EAR, NOSE & THROAT SPECIALISTS, L.L.P.

Dear Patient:

It is the responsibility of the patient to read their coverage documents for information regarding benefits, limitations, and exclusions. It is also your responsibility to be aware of your co-payments, deductibles, and co-insurance amounts. In an effort to help educate our patients regarding copays, deductibles and coinsurance please note that most managed care insurance companies consider your office visit applicable to your copay which is a separate charge from the procedures or tests listed below. We will be happy to provide you with our office visit fees per your request.

Your insurance could or may apply a test or procedure to your deductible or consider it as a non-covered service. If your physician needs to order a test or procedure and you would like verification of benefits for it (prior to it being performed), **upon your request**, we will be happy to verify that particular benefit.

Listed below are the most common tests and procedures that are performed in our office and the cost associated. Please note this is not an all-inclusive list, and prices are subject to change.

<u>Procedure</u>	<u>TENT Fee</u>
30200 Turbinate Injection	\$150.00
30300 Removal of foreign body nose	\$375.00
31231 Nasal endoscopy, unilateral or bilateral	\$190.00
31237 Nasal endoscopy debridement	\$431.00
31575 Laryngoscopy, flexible fiberoptic	\$242.00
69200 Removal of foreign body ear	\$200.00
69210 Removal impacted cerumen (Wax removal)	\$105.00
69220 Debridement of mastoid cavity	\$200.00
69433 Myringotomy with tube	\$233.00
92557 Audiometry (Hearing Test)	\$100.00
92567 Tympanometry	\$ 50.00
97140 Canalith Repositioning	\$ 39.00

Many managed care plans may cover these procedures or tests but apply them toward a deductible and/or co-insurance instead of your office visit co-pay. Some plans may consider any of these procedures as a non-covered service. If your plan applies a test or a procedure toward your deductible, co-insurance or considers it as a non-covered service, you will be responsible for payment.

I understand that the benefits quoted to the provider are not a guarantee of payment by my insurance company. I understand and agree that I am responsible for any charges related to the above procedures and/or tests that are performed and are not reimbursed by my insurance company.

If you have any questions, please request to speak with a member of our business office.

Patient or Legal Guardian Signature

Date

