

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: _____ Guarantor's 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)

PEDIATRIC HEALTH HISTORY

Patient's Name: _____

Age: _____ Birth Date: _____ Weight: _____

Referring Physician: _____

What symptoms led to this visit?: _____

Any **Drug Allergies**?: No: _____ Yes: _____

Does the child have, or has the child ever had one of the following (please check if yes):

<input type="checkbox"/> heart trouble	<input type="checkbox"/> pneumonia	<input type="checkbox"/> blood disorder	<input type="checkbox"/> born premature
<input type="checkbox"/> bronchitis	<input type="checkbox"/> rheumatic fever	<input type="checkbox"/> allergies	(before 37 wks.)
<input type="checkbox"/> asthma	<input type="checkbox"/> anemia	<input type="checkbox"/> seizure	<input type="checkbox"/> hepatitis/jaundice
<input type="checkbox"/> shortness of breath	<input type="checkbox"/> thyroid problems	<input type="checkbox"/> prolonged bleeding	<input type="checkbox"/> urinary problems

List any relevant family history _____

Any syndromes or major medical diagnoses? (please list) _____

Are the child's immunizations up to date? Yes No

Does anyone smoke @ home, in a car or where the child spends time? Yes No

If not school age, does the child attend daycare or pre-school? Yes No

Number of episodes your child has had **in the last 12 months**:

Strep throats/Tonsillitis Ear infection Sinusitis

Which Antibiotics has your child taken for the above (please check if applicable):

<input type="checkbox"/> Amoxicillin	<input type="checkbox"/> Augmentin	<input type="checkbox"/> Bactrim/Septa	<input type="checkbox"/> Biaxin
<input type="checkbox"/> Ceclor	<input type="checkbox"/> Ceftin	<input type="checkbox"/> Cefzil	<input type="checkbox"/> Emycin
<input type="checkbox"/> Gantrisin	<input type="checkbox"/> Lorabid	<input type="checkbox"/> Omnicef	<input type="checkbox"/> Pediazole
<input type="checkbox"/> Rocephin shot	<input type="checkbox"/> Septra	<input type="checkbox"/> Suprax	<input type="checkbox"/> Vantin
<input type="checkbox"/> Zithromax	<input type="checkbox"/> Primsol	<input type="checkbox"/> Cedax	<input type="checkbox"/> Augmentin ES

Does your child snore at night? Yes No

Is your child a mouth breather? Yes No

Today's Date: _____ Parent's Signature: _____

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

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

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

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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

