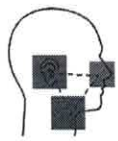
Patient Information



Elite ENT
General Ear, Nose, & Throat
Allergy – Sinus – Audiology – Hearing Aids

2340 E. Beardsley Road, Suite 260
Phoenix, AZ 85024
P: 602-802-8240
F: 602-802-8245

Please print.
All information will be confidential.

Patient Name:_____ **Date:** _____ - _____ - _____

☐ Male ☐ Female Date of Birth: Home Phone:

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Address: *(if different from above)* _____

City: _____ State: _____ Zip: _____

Check Appropriate Box:

☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Patient's Employer: _____ Work Phone: _____

Spouse of Patient's Name: _____ Employer: _____

Referring MD: _____ Primary Care Physician: _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

☐ Newsletter Sign-Up Email Address: _____

Insured Party: *(if different from patient)*

Name: _____

Relationship to Patient: _____ Date of Birth: _____ SSN# ____ - ____ - ____

Home Address: *(if different from patient)* _____

City: _____ State: _____ Zip: _____

Employer: _____ Is this person financially responsible for this account? ☐ Yes ☐ No

Secondary Insurance: *(if different from patient)*

Name: _____ Holder: _____

Relationship to Patient: _____ Date of Birth: _____ SSN# ____ - ____ - ____

Pharmacy: *(All prescriptions are sent electronically. List the pharmacy you would like us to keep on file)*

Pharmacy Name: _____ Location: _____ Phone: _____

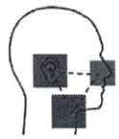
Assignment of Benefits:

I authorize payment of medical benefits to the provider for services rendered or to be rendered in the future, without obtaining my signature on each claim submitted, my signature below will bind me as though I personally signed the claim. I understand that I am responsible for all charges not covered by my insurance. I authorize the release of any medical or other information necessary to process my medical claims. I have read and understand the office policy and procedures.

_____ _____

Patient / Guardian **Date**

Health History



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Name:_____ DOB: _____

Reason for Today's Visit (in detail):_____

_____

Current Medications: _____

Drug Allergies: ☐ Yes ☐ No If YES, list: _____

What Pharmacy Do You Use? _____

Past Medical History:

- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding Disorders
- ☐ Blood Disease
- ☐ Blurred Vision
- ☐ Cancer Type_____
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Coronary Artery Disease
- ☐ Cortisone Treatments
- ☐ Cough (persistent or bloody)
- ☐ Diabetes
- ☐ Difficulty Swallowing
- ☐ Dizziness
- ☐ Ear Discharge
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Headaches
- ☐ Hearing Loss
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis Type _____
- ☐ Herpes
- ☐ Hiatal Hernia
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hoarseness
- ☐ Jaundice
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Nosebleeds
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Therapy
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Ringing in the Ears
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Sinus Problems
- ☐ Special Diet
- ☐ Stroke
- ☐ Swollen Feet or Ankles
- ☐ Swollen Neck Glands
- ☐ Thyroid Disorders
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumor or Growth in Head/Neck
- ☐ Venereal Disease

List any other disease or conditions: _____

_____

Any family history of Cancer, Heart Problems, etc ☐ Yes ☐ No. If YES, list: _____

_____

Previous Surgeries: (Please list all surgeries & dates)

- ☐ Appendectomy
- ☐ Cancer Surgery
- ☐ Carotid Surgery
- ☐ Cervical Spine Surgery
- ☐ C-Section
- ☐ Eardrum Repair
- ☐ Extremity Surgery
- ☐ Gallbladder
- ☐ Heart Bypass
- ☐ Heart Stent
- ☐ Hernia Repair
- ☐ Hysterectomy
- ☐ Joint Replacement
- ☐ Knee L/R _____
- ☐ Mastoidectomy
- ☐ Pacemaker
- ☐ Removal of Neck Mass
- ☐ Septoplasty
- ☐ Shoulder R/L _____
- ☐ Sinus Surgery
- ☐ Thyrodectomy
- ☐ Tonsilectomy & Adenoidectomy
- ☐ Tubes in Ears
- ☐ Tympanoplasty
- ☐ Wisdom Teeth
- ☐ Other_____

Do you drink alcohol? ☐ Yes ☐ No How often? _____ Beer _____ Wine _____ Liquor

Do you smoke? ☐ Yes ☐ No How much per day? _____ Cigarettes _____ Pipe _____ Cigar _____ other

Have you ever smoked? ☐ Yes ☐ No How long ago did you quit? _____ years ago after that

Do you use smokeless tobacco? ☐ Yes ☐ No How much?_____ How long ago?_____

Do you use or have you ever used recreational drugs? ☐ Yes ☐ No If YES, how often and what type? _____

_____

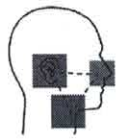
Are you pregnant? ☐ Yes ☐ No Due date:_____ Are you nursing:_____

_____ _____

Patient Signature Today's Date

Review of Systems

Have you had any of the following during the past three months? *(Check Yes or No)*



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Yes	No	Constitutional
☐	☐	Good general health lately
☐	☐	Recent weight change
☐	☐	Fever
☐	☐	Fatigue
☐	☐	Headaches

		Eyes
☐	☐	Eye Disease or injury
☐	☐	Wear Glasses/contacts lens
☐	☐	Blurred or double vision
☐	☐	Glaucoma

		ENT
☐	☐	Hearing loss
☐	☐	Ringing in the ears
☐	☐	Earaches or drainage
☐	☐	Sinus problems
☐	☐	Nose bleeds
☐	☐	Mouth sores
☐	☐	Bleeding gums
☐	☐	Bad breath or bad taste
☐	☐	Sore throat or voice change
☐	☐	Swollen glands in neck
☐	☐	Frequent tonsil stones
☐	☐	Frequent tonsil/throat infections

		Cardiovascular
☐	☐	Heart trouble
☐	☐	Chest pains
☐	☐	Sudden heartbeat changes
☐	☐	Swelling of feet, ankles or hands

		Respiratory
☐	☐	Frequent coughing & spitting up blood
☐	☐	Shortness of breath
☐	☐	Asthma or wheezing

		Gastrointestinal
☐	☐	Loss of appetite
☐	☐	Change in bowel movements
☐	☐	Nausea or vomiting
☐	☐	Frequent diarrhea
☐	☐	Painful bowel movements or constipation
☐	☐	Blood in stool
☐	☐	Stomach pain
☐	☐	Genitourinary
☐	☐	Frequent Urination
☐	☐	Burning or painful urination
☐	☐	Blood in urine
☐	☐	Change in force or strain when urinating
☐	☐	Incontinence or dribbling
☐	☐	Kidney stones

Yes	No	Musculoskeletal
☐	☐	Joint pain
☐	☐	Joint stiffness or swelling
☐	☐	Weakness of muscle or joints
☐	☐	Muscle pain or cramps
☐	☐	Back pain
☐	☐	Cold extremities
☐	☐	Difficulty in walking

		Skin
☐	☐	Rash or itching
☐	☐	Change in skin color
☐	☐	Change in hair or nails
☐	☐	Varicose Veins
☐	☐	Breast pain
☐	☐	Breast lump
☐	☐	Breast discharge

		Neurological
☐	☐	Frequent or recurring headaches
☐	☐	Light-headed or dizzy
☐	☐	Convulsions or seizure
☐	☐	Numbness or tingling sensations
☐	☐	Tremors
☐	☐	Paralysis
☐	☐	Stroke

		Psychiatric
☐	☐	Memory loss or confusion
☐	☐	Nervousness or anxiety
☐	☐	Depression
☐	☐	Sleep problems

		Endorcine
☐	☐	Glandular or hormone problem
☐	☐	Thyroid disease
☐	☐	Excessive thirst or urination
☐	☐	Heat or cold intolerance
☐	☐	Dry skin
☐	☐	Change in hat or glove size

		Hematologic/Lymphatic
☐	☐	Slow to heal after a cut
☐	☐	Easily bruise or bleed
☐	☐	Anemia
☐	☐	Phlebitis
☐	☐	Past transfusion
☐	☐	Enlarged glands

		Allergies
☐	☐	Seasonal allergies
☐	☐	Food allergies

Patient Signature

Name: _____

DOB: _____

Elite ENT
General Ear, Nose & Throat
Allergy – Sinus – Audiology – Hearing Aids

Hearing Health Questionnaire

The onset of hearing loss is usually very gradual. It may take place over 25-30 years, or it may happen more rapidly if you are exposed to loud noises at work or through hobbies. Because it usually occurs slowly, you may not even be aware that you have a problem until someone brings it to your attention. Here is a simple test you can take to determine if you have a hearing loss.

1. Do others complain that you watch television with the volume too high? ❑ Yes ❑ No

2. Do you frequently have to ask others to repeat themselves? ❑ Yes ❑ No

3. Do you have difficulty understanding what is being said when in groups or noisy situations? ❑ Yes ❑ No

4. Do you have to sit up front in meetings, church or other social gatherings in order to hear a speaker's words? ❑ Yes ❑ No

5. Do you have difficulty understanding women or young children? ❑ Yes ❑ No

6. Do you have trouble knowing where sounds come from? ❑ Yes ❑ No

7. Are you unable to understand when someone talks to you from another room? ❑ Yes ❑ No

8. Have others told you that you don't seem to hear them? ❑ Yes ❑ No

9. Do you avoid family gatherings or social situations because you "can't understand"? ❑ Yes ❑ No

10. Do you have ringing or other noises (tinnitus) in your ears? ❑ Yes ❑ No

11. Does anyone in your family have any of the above issues? ❑ Yes ❑ No

Elite ENT
General Ear, Nose & Throat
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Sinus Health Questionnaire

Name: _____

Date of Birth: _____

Circle "yes" if you have had any of the following symptoms for 10 days or longer:

Facial pressure or pain	Yes	No
Headache pain	Yes	No
Congestion or stuffy nose	Yes	No
Think, yellow-green nasal discharge	Yes	No
Low fever (99-100 degrees)	Yes	No
Bad breath	Yes	No
Pain in your teeth	Yes	No

Duration and Frequency

Have you experience these symptoms for 12 or more weeks?	Yes	No
In the past year, have you experience these symptoms for 10 days or longer on 4 separate occasions-with interim periods of no symptoms	Yes	No

Consent to Treatment, Authorization and Medical Release

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Allergy – Sinus – Audiology – Hearing Aids

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F: 602-802-8245

This notice describes how medical information about you may be used, disclosed and how you can get access to this information. Please review it carefully.

I authorize Elite ENT to give me reasonable and proper medical care by todays standards.

I consent to Elite ENT's use and disclosure of all individually identifiable personal health, financial and demographic information (known as protected health information or PHI) for the purpose of:

- Providing medical treatment
- Obtaining payment and reimbursement
- Requesting authorizations from other providers
- Cooperating with other providers in my medical treatment
- Fulfilling requests for information when specifically authorized by me
- Doing all other things directly related to providing healthcare to me
- Communicating and promoting all locations and services available through Elite ENT

The above purpose and all other uses are known collectively as treatment, payment and other healthcare operations, or TPO. I authorize any physician or healthcare facility to provide upon request any PHI to Elite ENT when needed for the purpose of TPO. I authorize release of my medical records to Elite ENT including human immunodeficiency virus, psychiatric, drug/alcohol records, venereal disease and other statutory protected disease, as necessary for continued medical care.

Send to Elite ENT discussing any or all of my medical care, including my evaluation, treatment and diagnosis, even if related to psychosocial impairments, substance abuse, human immunodeficiency virus (HIV), HIV-related opportunistic infections, pregnancy, billing or appointments, with the following person(s):

Please list responsible person(s) that we can release your information to, in the event you are not able to receive results of any examination ordered by Elite ENT.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I consent to allow Elite ENT to leave a message on my answering machine or voicemail regarding my appointment, bill, or test results. I also take responsibility for providing enough information for the office staff to contact me efficiently by mail, telephone and other forms of communication.

My preferred contact phone number is 1._____ 2._____
I understand my rights to restrict the use and disclosure of PHI and to revoke this consent at any time in writing. I understand that should I choose not to consent to the terms and conditions of Elite ENT, the practice has the right to and will withhold treatment, except where required by law.

Patient Name (Print): _____ Date of Birth: _____

Patient Signature (or Guardian):_____ Date:_____

The Health Insurance Portability and Accountability Act of 1996 prohibits the use and disclosure of protected health information for treatment, payment and other healthcare operations without a signed consent and prohibits the use and disclosure of protected health information for non-healthcare related activities without specific and explicit authorization.

Elite ENT
Financial Policy

Elite ENT
General Ear, Nose, & Throat
Allergy – Sinus – Audiology – Hearing Aids

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We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

1. Payment is due at the time of service unless arrangements have been made in advance by your insurance carrier. We accept Visa™, MasterCard™, American Express™, Cash and Checks.
2. Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim for you and assign the benefits to the doctor - in other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period (90 days), you will be responsible for payment. If we later receive a check from your insurer, we will refund any overpayment to you.
3. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them, and you are required to pay a co-payment at the time of your visit.
4. If you are insured by a plan that we do not have a prior arrangement with, we will prepare and send the claim for you on an assigned basis. This means the insurer will send the payment directly to you. Therefore, charges for your care are due at the time of service.
5. Not all insurance plans cover all services. In the event that your insurance plan determines a service to be "not covered" you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
6. We will bill your insurance company for all services provided in the hospital. You are responsible for any balance due.
7. In the event your account is referred to a collection service due to lack of payment, you agree to pay all collection/legal fees that may be added to your account.
8. There is a $40 no-show fee for canceling your appointment with less than 48 hours notice.
9. There is a $250 surgery cancellation/no-show fee if canceled within 48 hours of scheduled time.

I have read and understand the practice's financial policy, and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

_____ _____

Signature of Patient/Guardian Date

_____

Print Patient Name

Phone Message Consent

Elite ENT
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In an effort to protect your privacy as our patient, we have a privacy policy around leaving medical information messages.

- We will NOT leave any information on voicemail with specific instructions, other than appointments reminders.
- We will NOT leave messages with anyone except the patient or legal guardian, unless otherwise instructed.

PLEASE READ BELOW AND CONSIDER CAREFULLY WHO YOU WANT TO HAVE ACCESS TO YOUR MEDICAL INFORMATION.

I give Elite ENT my permission to leave phone messages regarding my medical care with the following people. I fully understand that this consent will remain in effect until revoked in writing.

Elite ENT may leave voice message on:

PHONE NUMBER	PRIVACY REQUESTED	INITIALS
My Cell: _____	☐	_____
My Home: _____		
My Work: _____		
My Spouse's Work: _____		
My Spouse's Cell: _____		
Adult Child's Parent: _____		

_____ _____

Patient Signature **Today's Date**

_____

Patient Name (Please Print)

HIPAA Notice of Privacy Practices

Effective Date: January 13th, 2017

Elite ENT
General Ear, Nose, & Throat
Allergy – Sinus – Audiology – Hearing Aids

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This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions about this notice, please contact Elite ENT.

This notice describes the privacy practice at our office.

We are required by law to:

- Maintain the privacy of protected health information.
- Give you this notice of our legal duties and privacy practices regarding your health.
- Follow the terms of the notice currently in effect.

Use and Disclosure of Your Health Information

Treatment. We may use and disclose your health information for your treatment and to provide you with treatment-related healthcare services. For example, we may disclose your health information to doctors, nurses, technicians or other personnel including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Students in Training. There may also be students in training present during your evaluation/treatment. Students may also take an active role in your treatment.

Payment. We may use and disclose your health information so that we, or others, may bill and receive payment from you, an insurance company or a third party for the treatment and services you receive. For example, we may give information to your health plan so that they will pay for your treatment.

Healthcare Operations. We may use and disclose your health information to evaluate and improve our medical care and to operate and manage our office. For example we may use and disclose information to a peer review organization. We may call you by name in the waiting room when your practitioner is ready to see you. We may also use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law; Public Health issues as required by law, Communicable Disease; Health Oversight, Abuse or Neglect; Food and Drug Administration requirements; Legal Proceeding; Law Enforcement; Coroners, Funeral Directors and Organ Donations; Research; Criminal Activity; Military Activity and National Security; Worker's Compensation; Inmates; Required Uses and Disclosure. Under the law, we must make disclosures to you when required by the Secretary of Health and Human Services to investigate or determine our compliance with requirements of Sections 164.500.

Other permitted, 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 physician, practitioner or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights Regarding Your Health Information

Right to Inspect and Copy. You have the right to inspect and copy your medical and billing records by written request to Elite ENT.

Right to Amend. You have the right to request an amendment to your records by written request to Elite ENT.

Right to an Accounting of Disclosure. You have a right to an accounting of certain disclosures by written request to Elite ENT.

Right to Request Restrictions. You have the right to request restriction or limitation on your health records as required by law. We will disclose your health information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose your health information when necessary to prevent a serious threat to the health and safety of you, another person or the public. Disclosures will be made only to someone who can prevent the threat.

Complaints. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy was violated by us. You may file a complaint with us by notifying our privacy officer of your complaint. We will not retaliate against you for filing a complaint.

Written Acknowledgment of Receipt of HIPAA Privacy Policies

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I, _____ _____
Patient Name DOB

I hereby give permission to release my protected information: *(check all that apply)*

☐ All Medical Information ☐ All Billing and Statement Information

☐ Other _____

I hereby give permission to disclose this information to: (family member, spouse or friend)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____
Signature of Patient/Guardian Date

_____
If guardian, describe relationship

.....

☐ The patient's condition prohibits the individual from signing an acknowledgment at this time. It will be obtained as reasonably practicable after the patient's condition improves.

☐ Acknowledgment was unable to be obtained.

Reason: _____

_____ _____
Employee Signature Date