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

Consent to Treatment

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 today's 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.

Financial Policy

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™, and cash.
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 72 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.

By signing below, you are verifying you've read, understand, and agree to all conditions listed above.

Patient/Guardian Signature: _____ Today's Date: ____/____/_____

HIPPA Notice of Privacy Practices

We are required by law to maintain the privacy of protected health information, give you notice of our legal duties and privacy practices regarding your health, and 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:

- You have the right to inspect and copy your medical and billing records by written request to Elite ENT.
- You have the right to request an amendment to your records by written request to Elite ENT.
- You have a right to an accounting of certain disclosures by written request to Elite ENT.
- 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.
- 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.
- 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.

Acknowledgment of HIPPA Privacy Policies

I hereby give permission to disclose this information to:

Name: _____ Relationship: _____ Phone Number: _____

Patient/Guardian Signature: _____ Today's Date: ____/____/_____