EAR, NOSE, & THROAT CENTERS OF NORTH TEXAS *C*

PATIENT INFORMATION

NAME_____ TODAY'S DATE____/____/____
First MI Last

ADDRESS_____CITY_____ ST_____ZIP_____

PHONE (Home)_____(Work)_____(Cell)_____

DATE OF BIRTH ____/____/____ SS # _____ MARITAL STAUS: M D W S SEX: M F

RACE _____ ETHNICITY : HISPANIC/LATINO NOT HISPANIC/LATINO

OCCUPATION_____EMPLOYER_____

PRIMARY DR_____ DID ANY DR REQUEST YOUR VISIT TODAY? _____

IF YES, PLEASE NAME_____ WHERE IS DR LOCATED?(City) _____

HAVE ANY OF OUR DOCTORS SEEN YOU OR ANOTHER MEMBER OF YOUR IMMEDIATE FAMILY?_____

IF YES, WHO? _____ RELATIONSHIP TO YOU_____

HOW WOULD YOU LIKE TO BE CONTACTED FOR APPOINTMENT REMINDERS ONLY? (SELECT ONLY ONE)

□ HOME □ CELL (CALL) □ CELL (TEXT) □ EMAIL _____

INSURANCE POLICYHOLDER INFORMATION

NAME_____ RELATION TO PATIENT_____
First MI Last

ADDRESS_____ CITY_____ ST_____ ZIP_____

PHONE (Home)_____(Work)_____(Cell)_____

DATE OF BIRTH ___/____/____ SS# _____ MARITAL STAUS: M D W S SEX: M F

OCCUPATION_____EMPLOYER_____

*If patient is a minor please see next page for additional needed information.

EMERGENCY CONTACTS

NAME_____ PHONE_____Relationship_____

NAME_____ PHONE_____Relationship_____

I, the undersigned, certify that I (or my dependent) have medical insurance coverage and assign directly to my doctor all insurance benefits for today's charges. I hereby authorize my doctor to release information necessary to secure the payment for these benefits. I authorize the use of this signature on all insurance submissions.

I also understand that knowledge of my insurance plan requirements are my responsibility. In the event payment is not made by my insurance company, I understand that I am ultimately responsible for the payment on this account.

_____ _____
Signature Date

EAR, NOSE, & THROAT CENTERS OF NORTH TEXAS

INFORMATION PAGE FOR MINOR CHILDREN

PATIENT NAME_____ DATE OF BIRTH____/____/____

FIRST RESPONSIBLE PARTY (PARENT OR GUARDIAN OF MINOR)

NAME_____ RELATION TO PATIENT_____
First MI Last

ADDRESS_____ CITY_____ ST_____ ZIP_____

PHONE (Home)_____(Work)_____(Cell)_____

DATE OF BIRTH ___/____/____ SS# _____ MARITAL STAUS: M D W S SEX: M F

OCCUPATION_____EMPLOYER_____

SECOND RESPONSIBLE PARTY (PARENT OR GUARDIAN OF MINOR)

NAME_____ RELATION TO PATIENT_____
First MI Last

ADDRESS_____ CITY_____ ST_____ ZIP_____

PHONE (Home)_____(Work)_____(Cell)_____

DATE OF BIRTH ___/____/____ SS# _____ MARITAL STAUS: M D W S SEX: M F

OCCUPATION_____EMPLOYER_____

DIVORCED PARENTS/SHARED CUSTODY:

In the case of divorced parents or shared custody arrangements, the court specifies the healthcare responsibilities for the child and boundaries of the involved parties. If the patient is a child of divorced parents or shared custody, please answer the following questions based on the court documents that specify the child's healthcare needs.

According to the decree, who may consent to treatment and coordination of healthcare needs? _____

According to the decree, who may give consent for surgical procedures (invasive)?_____

Please be aware it is our office policy to assign financial responsibility to the parent/ guardian that accompanies the child to the initial visit and completes all forms. This is further explained in our financial policy.

We must have information regarding both guardians. To restrict access to the account to a parent we must have court documents to support.

_____ _____
Guardian Signature Date

E.N.T. CENTERS OF NORTH TEXAS , 2600 N US HWY 75, SHERMAN, TEXAS 75090

PATIENT MEDICAL HISTORY

Patients: Please complete ALL sections above "Clinical Use" line

NAME: _____ AGE: _____ MALE or FEMALE DATE: _____
HEIGHT: _____ WEIGHT: _____ REFERRING DR. _____
REASON FOR TODAY'S VISIT: _____
DATE PROBLEM STARTED? _____ RELATED TESTS/ LAB/ XRAYS? _____
RELATED TREATMENT / MEDICINES: _____

PAST OR CURRENT MEDICAL CONDITIONS: (Please *circle* or list) NONE

AIDS/HIV	Bleeding Disorder	Diabetes	Heart Disease	Mental Disorder	Seizures
Allergies	Blind/Glaucoma	Down's Syndrome	Hepatitis	Meningitis	Sleep Apnea
Allergy Shots/Test	Cancer	Fibromyalgia	Hernia	Migraines	Stroke
Aneurysm	Cerebral Palsy	GERD/Ulcer	High Blood Pressure	Multiple Sclerosis	Thyroid
Arthritis	COPD	Head Injury	Kidney Disease	Pacemaker	Tinnitus
Asthma	Deaf	Heart Attack	Lung Disease	Prosthesis	Tuberculosis

Other: _____

SURGERY HISTORY: (Please *circle* or list) NONE

Abdominal	Bladder	Ear	GYN	Hip	Mastectomy	Sinus	Vasectomy
Adenoid	Brain	Eye	Hand	Hysterectomy	Nasal	Throat	Wrist
Appendix	C-Section	Foot	Heart	Kidney	Neck	Thyroid	
Arm	Cosmetic	Gallbladder	Hemorrhoid	Knee	Prostate	Tonsil	
Back	Dental	Gastric/Colon	Hernia	Leg	Shoulder	Trach	

Other: _____

FAMILY HISTORY: (*Circle*) NONE DIABETES CANCER HEART DISEASE
UNKNOWN OTHER: _____

ADULT SOCIAL HX: ALCOHOL USE: (*Circle One*) NEVER RARE OCCASIONAL FREQUENT
TOBACCO USE: (*Circle One*) NEVER QUIT – (HOW MANY YEARS AGO? _____)
SMOKE - (AMOUNT_____ HOW LONG?_____)
CHEW/DIP - (AMOUNT _____HOW LONG?_____)

CHILD SOCIAL HX: TOBACCO EXPOSURE: (*Circle One*) NEVER RARE FREQUENT DAILY
DAYCARE: (*Circle One*) NONE YES - (DAYS / WEEK _____ # CHILDREN? _____)

PHARMACY (include town): _____
ARE YOU ALLERGIC TO ANY MEDICATIONS? (*Circle One*) NO YES - (PLEASE LIST): _____
_____
CURRENT MEDICATIONS: (*Circle One*) NONE YES - (PLEASE LIST): _____
_____
_____
_____

**************************************DO NOT WRITE BELOW THIS LINE – CLINICAL USE ONLY:**************************************

VITALS: B/P: _____P:_____T:_____ New _____ LS _____

HPI:

DX:

TX:

EARS:

NOSE:

OROPH:

NASOPH:

LARYNX:

NECK:

NEURO:

ADD DATA: AUDIO ____ TYMP ____ SCOPE ____ BX ____ PREV REC ____

F/U: DAYS ____ WKS ____ MOS ____ YR ____ PRN _____ P.O. _____ PRO ____ S/P _____

Revised 11-14-2012

EAR NOSE AND THROAT CENTERS OF NORTH TEXAS
REVIEW OF SYSTEMS

NAME: _____ DOB: _____ DATE: _____

Please <u>circle each symptom</u> you are experiencing <u>related</u> to this visit:

GENERAL: **fever, chills, sweats, anorexia, fatigue, malaise, weight loss, sleep disorder /apnea**

EYES: **blindness, vision changes, redness, itching, discharge, swelling, blurring, pain, double vision, sensitive to light**

EARS: **hearing changes, vertigo, earache, ringing, ear discharge, hearing loss, fullness**
Ear infections: how many episodes? _____ how many years? _____

NOSE: **nosebleeds, post nasal drainage, congestion, nasal drainage, pain, pressure, sore**

THROAT: **sore, difficulty swallowing, hoarse, infections, debris, snoring, dry, mass, burning**
Tonsil infections: how many episodes? _____ how many years? _____

MOUTH: **lesion, cyst, mass, dryness, infection, coating, tongue-tied, sore, burning**

HEART: **chest pain, short of breath, body swelling, palpitations**

LUNGS: **cough, wheezing, spitting up blood, shortness of breath, excessive sputum**

GI: **abdominal pain, constipation, blood in stool, diarrhea, nausea, vomiting**

MUSC/SKEL: **back pain, joint pain, joint swelling, recent injuries, muscle cramps /weakness**

SKIN: **lesions, masses, color changes, infection, injury**

NEURO: **headaches, vertigo, dizziness, weakness, numbness, seizures, tremors, fainting spells, disequilibrium/ gait changes, temporary paralysis**

HEMATO/ LYMPH: **abnormal bruising, abnormal bleeding, enlarged lymph nodes**

ALLERGY: **allergy symptoms, immunologic deficiency, HIV exposure, hay fever, rash, persistent sinus infections, sneezing, itchy watery eyes**
Sinus infections: how many episodes? _____ how many years? _____

OTHER:

Acknowledgment of Review of Notice of Privacy Practices

Ears, Nose and Throat Centers of North Texas reserves the right to modify the privacy practices outlined in this notice.

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Medical Record Access Authorization

I authorize the following person(s) to access my medical records or speak to a staff member of Ear, Nose & Throat Centers of North Texas regarding care or on my behalf. This will be in effect from the date signed on this authorization for one year, or until a new form is completed.

I understand this is an authorization to allow the parties below to discuss my appointments, treatment of care, lab results, test results and any other information obtained at Ear, Nose & Throat Centers of North Texas.

I understand that Ear, Nose & Throat Centers of North Texas **WILL NOT** speak to anyone regarding your account for any reason unless the requesting party is listed below or listed on the patient information form. (i.e. guarantor, insurance policyholder, or emergency contacts)

☐ **Please check if only authorizing people already listed on patient information form.**

Authorized Party	Date of Birth	Relationship To Patient
Authorized Party	Date of Birth	Relationship To Patient
Authorized Party	Date of Birth	Relationship To Patient

Please list ANY limitations or restrictions to access your records below:

_____

_____

_____ (Initial) I have read and understand the office **Financial Policy**, and am aware I am entitled to a copy if requested.

_____(Initial) I have read and understand the office **NO SHOW Policy**, and am aware I am entitled to a copy if requested.

Name of Patient (please print)	Date
Signature of Patient or Patient Representative	Relationship of representative to patient

Revised 2/20/2013

Ear, Nose, & Throat Centers of North Texas Financial Policy

Thank you for choosing Ear, Nose, & Throat (ENT) Centers of North Texas as your health care provider. We are committed to providing excellent health care services to you, our patient. As a part of our professional relationship, it is important that you have an understanding of our financial policy

All patients must read and sign this form prior to receiving services.

- **It is your responsibility to provide us with your most current insurance information.**
  - If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim. If the claim is denied, you will be financially responsible for services rendered.
  - We must emphasize that, as medical providers, our relationship is with you, the patient, and not your insurance company. **Your insurance is a contract between you, your insurance company, and possibly your employer. It is your responsibility to know and understand the level of services covered by your insurance company**.
  - Please be aware that some or perhaps all of the services provided may not be covered in full by your insurance company.
  - Before receiving services, **<u>you</u>** must verify that we are participating providers for your insurance company. It is also necessary that if a primary care physician must be listed with your insurance company, you are responsible for obtaining and maintaining a current referral to the doctor you are seeing from the physician listed with your insurance. Without a current referral payment must be made in full at the time services are rendered for the total amount charged
  - We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
  - Co-payments, coinsurances (%'s) and/or deductibles are due at the time of service. We will estimate the amount you owe based on information we receive from your insurance company. However, you are responsible for paying the full amount determined by your insurance company once they have paid your claim—regardless of our estimation.

- **It is your responsibility to provide us with your most current billing information**
  - You must provide your most current billing address, all available telephone numbers and any other important contact information. If your address or contact information changes, it is your responsibility to contact us with the updated information. • We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance, it is your responsibility to contact our business office within 30 days after receipt of your first statement. You may call (903)416-6250.
  - **Payment is due upon receipt of the first statement**. If payment is not received in a timely manner your account may be referred to a professional collection agency and/or attorney for further collection activity.
  - If you are not able to pay the balance in full, you may contact our billing office to discuss a mutually agreed upon payment arrangement at (903)416-6250.
  - If your account is assigned to a professional collection agency you will be notified by mail that you will no longer be able to receive services from any of the physicians at our office. Failure to accept this letter (and/or pick it up at the post office) serves as termination of services.
  - In the event that you submit payment by check and the bank returns the check for any reason, we will add $35.00 to your original balance. In addition we may seek all legal remedies provided to us under Texas law.

•We may charge you a "No Show" fee of $25.00 if you fail to cancel or reschedule your appointment. Please see the back of this page for our complete 'No Show Policy'.

- **Failure to keep your account balance current may require us to cancel or reschedule your appointment!**
- **Full payment is due at time of service. <u>We accept cash, check, and credit cards (Visa, MasterCard, Discover and American Express ONLY).</u>**

- **Responsible Party for Minors (18 years and under)**

•We assign all financial responsibility to the parent /guardian that completes and signs the patient registration form. Any amount due at the time of service is expected from the parent /guardian accompanying the minor at the visit. In the event that a divorce decree assigns distinct financial responsibility for medical bills to another individual, we still hold the registering parent /guardian responsible. We will provide you with receipts showing payment to assist you in the recovery of such payment, however we do not get involved in separation/divorce disputes.

No Show Policy

Due to the large amount of patients needing to be seen and an increasing amount of appointments that are 'no-showed' we have been forced to implement the following policy. A 'no-show' appointment is when you have an appointment scheduled and the patient does not show up, or call prior to the appointment time to cancel. We understand that sometimes there are valid reasons for missing an appointment and those will be addressed on a case by case basis. The policy is as follows:

1st No Show— There will be a $25.00 charge posted to your account.
2nd No Show— There will be another $25.00 charge posted to your account and you will receive a warning letter in the mail.
3rd No Show— You may be dismissed from the practice.

Dismissal from the practice is at the doctor's discretion. If this occurs you will be notified by certified letter.

To prevent any of this from happening please contact our office as soon as you know you will be unable to attend your appointment. This will allow time for someone else to be seen by the doctor in your absence.

Please note that we do have a reminder service that will call to remind you of your appointment 2 days prior to your scheduled appointment date. This is a **courtesy ONLY,** it is your responsibility to keep up with scheduled appointments. Not getting a reminder call is not a valid reason for a fee to be removed from your account.