Patient Registration Form

Name:_____ Today's Date _____

Sex_____ Age _____ Birth Date: ____/____/____ Social Security #:_____-_____-_____

Address: _____Unit# _____ City_____ State _____ ZIP_____

Home Phone:_____ Work Phone: _____ Cell Phone: _____

Seasonal, Primary Address or Post Office Box Address (Other than the previous address given)

Address: _____Unit# _____ City_____ State _____ ZIP_____

EMAIL ADDRESS _____

Marital Status (Circle One): Married Single Divorced Widowed Separated Common Law Living Together Domestic Partner Registered Domestic Partner Legally Separated Annulled Interlocutory

Lauguage (Circle One): English French German Vietnamese Italian Mandarin Spanish

Race (Circle One): Asian Black or African American Caucasian Hispanic Native American Indian or Alaska Native

Ethnicity (Circle One): Non-Hispanic or Latino Hispanic or Latino Other or Undetermined

EMERGENCY CONTACT:

Name:_____ Phone: _____ Relationship: _____

FOR MINORS:

Responsible Party/ Guardian: _____ Relationship: _____

Birth Date:____/____/____ Social Security #: _____ Telephone # _____

Address (If different than Patients) _____

INSURANCE (Circle One or fill in): Medicare BCBS Aetna UHC Cigna Other :_____

Are you the primary insured/policy holder? YES NO (if no please fill out the next area)

Name:_____ Relationship: _____

Birth Date: ____/____/_____ Social Security # (this is required)_____

Primary Care Doctor: _____

Referring Doctor: _____

Pharmacy: _____

ENT ASSOCIATES
(239) 939-2621

Otolaryngology Clinic Procedures

We are able to provide you with the latest technology available to assist with your diagnosis and treatment. These procedures are quick, painless and are invaluable for providing you the most comprehensive and advanced care possible. Please be aware that many of these procedures may be considered as a surgical procedure by your insurance company. Because of this, there may be a separate co-pay/deductible. The two most common procedures are Diagnostic Nasal Endoscopy, CPT 31231, Flexible Laryngoscopy , CPT 31575 and Video Stroboscopy, CPT 31579. Please check with your insurance company if there is any question. Thank you for helping us care for you.

I, _____ understand the above
Patient Signature

I, _____ understand the above
If Minor: Parent or Legal Guardian Signature

_____
Signature of Witness

Patient name: _____ Medical Record #_____

Date: _____

CONFIDENTIAL PATIENT INFORMATION

I authorize any holder of medical information or other information about me to be leased to Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to the billing agent of this doctor, any information needed for this or a related Medicare claim and/or my Private Health Insurance claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party whom accepts assignment. I understand that this is a lifetime signature authorization. I understand that this authorization may be used to release medical information if necessary to process my insurance claims and pay the provider direct. I understand this also applies to my private and/or group health insurance as applicable.

_____ _____

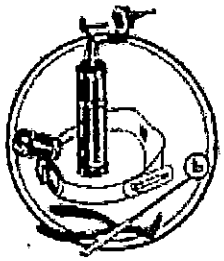
Signature of Patient or Guardian Date of Birth (Patient)

_____ _____

Print Name of Signer if NOT Patient Relationship to Patient

_____

Date



EAR, NOSE & THROAT ASSOCIATES, MD PA

9711 COMMERC CENTER COURT, SUITE 101
FORT MYERS, FLORIDA 33908
(239) 939-2621

Consent to E-Prescribing

E-Prescribing is defined as a physician's ability to electronically send error free, accurate, and understandable prescriptions directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program.

These include:

- **Formulary and benefit transactions** - Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** – Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification** – Allow the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that Ear, Nose & Throat Associates, may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

Understanding all the above, I hereby provide informed consent to Ear, Nose & Throat Associates to enroll me in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

I give consent to Ear, Nose & Throat Associates, including their medical staff members and employees involved in my care, to access, use and disclose my protected heath information for my treatment, payment for my treatment and for health care operations consistent with the federal HIPAA privacy regulations. I consent to the disclosure of my prescription medical information by any provider, pharmacy, insurer, and prescription benefits manager, specifically including any state of federal health benefits program to Ear, Nose & Throat Associates, for the purpose of my treatment. I am aware that the privacy practices of Ear, Nose & Throat Associates are described in its Notice of Privacy Practices. This Consent is subject to my revocation at any time except to the extent it has already been acted on.

_____	_____
Patient Name (Print)	Patient Date of Birth
_____	_____
Signature of Patient or Legal Representative	Date and Time Signed
_____	_____
Print Patient Representative Name	Relationship to Patient

Acknowledgment of Receipt of Notice of Privacy Policy

I hereby acknowledge that I was offered to read or take with me a copy of the Privacy Policy issued by ***Ear, Nose & Throat Associates***, on the date indicated below.

Signature _____ Date _____

If you are not the patient, please state relationship:

- ☐ Parent (s)
- ☐ Legal Guardian
- ☐ Son or Daughter
- ☐ Facility Caretaker
- ☐ Other_____

To respect your privacy please tell us how we may contact you:

Home Phone

- ☐ You may leave a message with the following person(s) if I am not available:
- ☐ You may leave DETAILED Information on my answering machine.
- ☐ You may leave your NAME and PHONE NUMBER ONLY and I will return your call.

Work Phone

- ☐ You may call my work place
- ☐ You may leave DETAILED Information on my answering machine.
- ☐ You may leave your NAME and PHONE NUMBER ONLY on my answering machine and I will return your call.
- ☐ You may not call my work place.

Cell Phone

- ☐ You may leave DETAILED Information on my voice mail.
- ☐ You may leave your NAME and PHONE NUMBER ONLY and I will return your call.
- ☐ You may not call my cell phone.

Please list spouses, family, friends, caretakers, etc…that WE may communicate with in regards to your personal medical and financial information. This will include but not limited to: test results, prescriptions, billing information. Only the names that are listed below will be able to receive your information. Do not include your physicians on this list.

(1)_____ (2)_____
(3)_____ (4)_____
(5)_____ (6)_____

Unless you notify us in writing stating otherwise the above person(s) will always be able to receive information about you.

Patient/Guardian Signature _____ Date _____

EAR, NOSE AND THROAT ASSOCIATES

FINANCIAL POLICY

Ear, Nose & Throat Associates, is dedicated to providing our patients with the best possible care. We ask your help by understanding and cooperating with our financial policy. We must emphasize that as physicians, our relationship is with you, not with your insurance company. Out of courtesy we will file a claim to your insurance for any services rendered in our office or outpatient services done by our physicians. If we are a network provider, with a signed contract with your insurance plan, we will accept the insurance allowed fee schedule. If we are not providers with the insurance all charges will be your responsibility, even though we submit a claim on your behalf. We will make every effort to verify your insurance prior to the visit. However, sometimes we will need your assistance in this process and you may always call the insurance company to verify we are a participating provider as well. We understand that temporary financial problems arise and effect timely payments. If this happens we encourage you to contact us promptly for assistance with management of your account.
A copy of this policy will be provided to you upon request.

CANCELLATIONS: We require 24 hours' notice of a cancellation. If you do not show up for your appointment or cancel in less than 24 hours, there will be cancellation fee will be added to your account. This payment will be due prior to scheduling another appointment. New Patient appoints will be given over the phone notice of this policy, The cancellation policy fee for a new patient appointment is $50.00, for established patients seen within the last 3 years $25.00.

INSURANCES: We participate with many insurance companies. Please don't hesitate to check with our staff if we are in network with your insurance. If you have your insurance card please provide us a copy. It will help with determining whether we are a provider or not. If we do participate with your insurance policy, we will gladly submit the charges to your insurance. We do require a copy of all insurance cards that you wish us to file a claim to. Once we submit a claim to your insurance and receive the Explanation of Benefits indicating how the services rendered are covered under your policy, you will receive a statement for the charges your insurance has applied to your responsibility. All insurance carriers have a schedule of fees from which they will pay; however the doctor's fee will be more than what the insurance company will allow. If we are a provider with that insurance (have a contract to accept their fees) we write the difference off according to the contract. If we are not contracted with the insurance company the difference will be your responsibility.

CO-PAYS/ DEDUCTIBLES & OUTSTANDING BALANCES: All co-pays & deductibles are due at the time of the appointment. What you are responsible for is determined by your insurance plan. Failure to collect co-payment or any deductible from you can be considered fraud on our part. We have signed a contract with the insurance company that we must abide by. We ask your cooperation with make any payments that are due at the time of service.

REFERRALS & AUTHORIZATIONS: If your insurance requires a referral or an authorization, you are required to provide us with any prior authorization or referral from your Primary Care Physician before your appointment, if by any chance we do not receive the required authorization or referral prior to the scheduled appointment we will need to re-schedule the appointment until it is received.

PROOF OF INSURANCE: All patients must complete our patient information forms before seeing the doctor. We must have a current copy of your insurance cards & photo ID. If your insurance has changed, it is your responsibility to provide us with the correct insurance information in order for us to submit to your claim correctly. All cards cannot be altered in any way, this is your insurance and we need all the information on that card, to file your claim correctly. We are not able to file a claim 90 days past the date of service. Failure to provide us with insurance changes in a timely manner could cause you to be responsible for any balances due. Updating your insurance information must be done timely.

FAMILY LEAVE & DISABILITY INSURANCE FORMS: Our office will complete your FMLA or Disability forms; there is a $25.00 charge fee for every form. Payment must be made in advance; once payment is received we will gladly complete these forms for you. All forms will be completed in 7- 10 business days. These forms take time from the doctors and nurses to fill out. Please allow us the time needed to do this correctly.

MINORS: Under the age of 18 you must be accompanied by a parent/guardian. The person (Parent/Guardian) signing our financial policy and providing the financial information, will also be financially responsible for the minors account.

COLLECTION ACCOUNTS: Our office will make every effort to communicate with you about your account and will present reasonable options for payment. In the event a bill goes unpaid without contacting the billing department to discuss payment options, the account will be turned over to a collection agency. If your account is sent to a collection agency, a collection charge of 25% will be added to the balance of your account. If your account is turned over to an attorney, you will be responsible for any and all attorney fees plus court costs. In signing, you agree to the collection agency contacting you regarding your account. They may contact you at any number associated with your account, including but not limited to your wireless phone number, text messaging and emails, which could result in charges to you. Methods of contact may include using pre-recorded/ artificial voice messages and /or automated dialing devices.

SELF PAY POLICY: PAYMENT IS DUE AT THE TIME OF SERVICES.

COPIES OF RECORDS: When requesting records, a medical record release form must be signed by the patient or guardian,(if under the age 18). As a courtesy we will forward your patient information to your physicians. If you wish to have a copy of your records there is a minimal charge of $5.00 to cover employee time, paper expense and cost for the copies or you are now able to login to our web portal to print out what you want from your own home. Please speak to our receptionist about this.

I HAVE READ AND AGREE TO THE FINANCIAL POLICY OF EAR, NOSE, AND THROAT ASSOCIATES, MD, PA. I ALSO AGREE THAT THE TERMS OF THIS FINANCIAL POLICY MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATION TO THE PATIENT.

SIGNATURE OF PATIENT/GUARDIAN

DATE

Name: _____ DOB_____

Medical History

Please check off any of the following medical conditions that you currently have:

- ☐ Cancer: __Skin __Other_____
- ☐ Cardiac: _____
- ☐ Endocrine: __Diabetes __Type 1 __Type 2 __Other_____
- ☐ Gastro: __Reflux __Other_____
- ☐ Urology: __Kidney __Other_____
- ☐ OB/GYN: _____
- ☐ Immuno: __Deficiency __HIV __Other_____
- ☐ Lymph: __Anemia __Bleeding __Other_____
- ☐ Ortho: __Arthritis __Degenerative Joint __Other_____
- ☐ Neuro: __Autism __Migraine __Other_____
- ☐ Ophth: __Glaucoma __Macular Degeneration __Other_____
- ☐ Psych: __Depression __Other_____
- ☐ Pulm: __Asthma __COPD __Obst Sleep Apnea __Other_____
- ☐ Rheum: __Gout __Lupus __Sjorgren's syndrome __Other_____
- ☐ Vasc: __Carotid stenosis __Other_____

SURGICAL HISTORY

Please list any surgeries you have had and approximate year:

- ☐ _____ Year_____
- ☐ _____ Year_____
- ☐ _____ Year_____
- ☐ _____ Year_____
- ☐ _____ Year_____
- ☐ _____ Year_____
- ☐ _____ Year_____

MEDICATIONS:

Drug_____ Dosage _____ Frequency _____

Drug_____ Dosage _____ Frequency _____

Drug_____ Dosage _____ Frequency _____

Drug_____ Dosage _____ Frequency _____

Drug_____ Dosage _____ Frequency _____

Drug_____ Dosage _____ Frequency _____

Allergies

Please list all known allergies (environment, drug, food), as well as the type of reaction and level of severity:

Allergy:_____ Reaction:_____ Severity:_____

Allergy:_____ Reaction:_____ Severity:_____

Allergy:_____ Reaction:_____ Severity:_____

ENT History

Please check off any of the following procedure you have had and provide date of procedure:

ENT Disease History

- ☐ None
- ☐ Cancer: Head and neck Cancer - specify location
- ☐ Cancer: Lymphoma, neck nodes
- ☐ Cancer: Sinus or nasal cavity
- ☐ Cancer: Skin - basal cell carcinoma
- ☐ Cancer: Skin - Melanoma
- ☐ Cancer: Skin - other type - specify
- ☐ Cancer: Skin - squamous cell carcinoma
- ☐ Ear: Acoustic neuroma
- ☐ Ear: Cholesteatoma
- ☐ Ear: Hearing loss
- ☐ Ear: Mastolditis
- ☐ Ear: Other
- ☐ Ear: Otitis externa (swimmer's ear)
- ☐ Ear: Otitis media (middle ear infection)
- ☐ Ear: Otosclerosis
- ☐ Ear: Tinnitus (ringing or other noise of the ear)
- ☐ Ear: Vertigo
- ☐ General: Facial fractures
- ☐ General: Other
- ☐ General: reflux
- ☐ Larynx/trachea: Papillomas
- ☐ Larynx/trachea: Subglottic stenosis
- ☐ Larynx/trachea: Tracheal stenosis
- ☐ Larynx/trachea: Vocal cord nodules
- ☐ Larynx/trachea: Vocal cord paralysis
- ☐ Larynx/trachea: Vocal cord polyps
- ☐
- ☐ Larynx: Other
- ☐ Nasal: Deviated septum
- ☐ Nasal: Epistaxis (nose bleeds)
- ☐ Nasal: Loss of smell
- ☐ Nasal: Nasal fracture
- ☐ Nasal: Nasal obstruction
- ☐ Nasal: Other
- ☐ Nasal: Polyps
- ☐ Nasal: Rhinitis (allergies)
- ☐ Nasal: Septal perforation
- ☐ Nasal: Sinusitis
- ☐ Nasal: Turbinate hypertrophy
- ☐ Neck: Branchial cleft cyst
- ☐ Neck: Hyperparathyroidism
- ☐ Neck: Neck mass
- ☐ Neck: Other
- ☐ Neck: Parotid tumor
- ☐ Neck: Sialoadenitis (infected or inflamed salivary gland)
- ☐ Neck: Sialolithiasis (stone of the salivary gland)
- ☐ Neck: Thyroglossal duct cyst
- ☐ Neck: Thyroid nodules
- ☐ Oral: other
- ☐ Oral: Sleep apnea
- ☐ Oral: Tonsilitis
- ☐ Oral: Ulcers
- ☐ Other _____

ENT Surgical History

- ☐ None
- ☐ Ear: Acoustic neuroma resection
- ☐ Ear: Mastoidectomy
- ☐ Ear: Myringotomy and tubes (specify ear)
- ☐ Ear: Myringotomy (specify ear)
- ☐ Ear: Other - specify
- ☐ Ear: Otoplasty
- ☐ Ear: Stapedectomy
- ☐ Ear: Tympanoplasty (repair ear drum)
- ☐ Head and neck: Lymph node biopsy
- ☐ Head and neck: Neck dissection
- ☐ Head and neck: Other - specify
- ☐ Head and neck: Parathyroidectomy
- ☐ Head and neck: Parotidectomy
- ☐ Head and neck: Resection in mouth or throat - specify
- ☐ Head and neck: Skin graft
- ☐ Head and neck: Skin resection
- ☐ Head and neck: Submandibular gland excision
- ☐ Head and neck: Thyroglossal duct cyst excision
- ☐ Head and neck: Thyroidectomy
- ☐ Head and neck: Tracheotomy
- ☐ Nose: Balloon sinuplasty
- ☐ Nose: Endoscopic sinus surgery
- ☐ Nose: Nasal fracture repair
- ☐ Nose: Other - specify
- ☐ Nose: Rhinoplasty
- ☐ Nose: Septoplasty
- ☐ Nose: Turbinate reduction
- ☐ Throat: Adenoidectomy
- ☐ Throat: Other - specify
- ☐ Throat: Sleep apnea surgery - uvulopalatopharyngoplasty (UPPP)
- ☐ Throat: Tonsillectomy
- ☐ Other _____

ENT Family History

- ☐ None
- ☐ Otitis Media
- ☐ Sinusitis
- ☐ Smoking
- ☐ Thyroid Cancer
- ☐ Thyroid Disease
- ☐ Other _____

ENT Pediatric History

- ☐ None
- ☐ Cleft Lip
- ☐ Cleft Palate
- ☐ Otitis Media
- ☐ Other _____

Social History

Smoking Status:

- ☐ NEVER
- ☐ Former Smoker
- ☐ Light Tobacco Smoker
- ☐ Heavy Tobacco Smoker
- ☐ Current Some Day smoker
- ☐ Current Everyday Smoker
- ☐ Cigar Smoker
- ☐ Chewing Tobacco User

If applicable:

When did you start smoking? _____

When did you quit smoking? _____

Number of packs per day: _____

Total number of years smoking: _____

Alcohol Consumption:

- ☐ None
- ☐ Less than 1 Drink per Day
- ☐ 1-2 Drinks per Day
- ☐ 3+ Drinks per Day

Other:

Driving Status:

- ☐ Drives in the Daytime
- ☐ Drives at Night

Employer & Occupation: _____

Place of Residence: _____

FAMILY HISTORY

Please list any family history of illness or disease:

Disease/Illness: _____ Relationship: _____ Deceased? Yes No

Disease/Illness: _____ Relationship: _____ Deceased? Yes No

Disease/Illness: _____ Relationship: _____ Deceased? Yes No

Disease/Illness: _____ Relationship: _____ Deceased? Yes No

Pharmacy and Referrals

Name, Location & Telephone #: _____

Primary Care Physician's Name, Location & Telephone #: _____

Referring Physician's Name, Location & Telephone #: _____

If you are under the care of any specialists, please provide their Names, Locations, & Telephone #s:

_____