Dear Patient and Family Members:

Welcome to Florida E.N.T. and Allergy, a Division of Select Physicians Alliance. We would like to take this opportunity to welcome you to our practice. This letter contains answers to some of the most commonly asked questions by patients entering our practice. We hope you find this information useful.

Our office hours are Monday through Friday from 8:30 am to 5:15 pm. Our office telephone number for Hillsborough: **(813) 879-8045** and for Pinellas: **(727) 341-0551**. In the event of an emergency outside of our normal business hours, please contact the office and the call service will contact the doctor on call for you.

We understand that in today's busy world occasionally situations come up that are beyond your control. In those instances, we request you extend us the courtesy of a 24-hour notice. This courtesy allows us to continue to operate efficiently and use the time that was reserved for you to help other patients in need. It is our policy that you call our office at least 24-hour prior to your appointment time. If you fail to contact our office in advance three times over the course of one year, you will be discharged from the practice.

Patients should complete, sign and bring the following items to your first appointment:

- Plan to arrive 20 minutes prior to your appointment time to finalize paperwork.
- Bring healthcare insurance ID cards and picture ID.
- Bring authorizations or referrals as required by your insurance carrier.
- Complete and sign the Patient information, Notice of Privacy Practices, Medical History/Medication List, Policies and Guidelines, Prescription Consent Form.
- Complete the name, phone number, and address of your preferred pharmacy on the form.
- Have your referring physician office fax pertinent medical records, diagnostic and lab testing, or bring them with you.
- Bring a CD or Film of your most recent MRI and/or CT if applicable.

On subsequent visits, our front office staff will review your demographic and insurance information with you to ensure we maintain your correct information on file. This allows us to submit claims to your insurance carrier in a timely manner.

We are contracted with several insurance carriers for the benefit of our patients. You will want to check your benefits booklet or with the benefits department of your employer to verify if our physicians are listed as providers within your network.

As part of our contract with the insurance companies, we are legally required to collect any co-pays or deductibles from you at the time of service. We ask that you be prepared to pay your copay at the time of check-in prior to being seen by our providers. We accept cash, check, American Express, Discover, MasterCard, Visa, and CareCredit.

WELCOME and THANK YOU for choosing Florida E.N.T. and Allergy for your healthcare needs.

We have exciting news regarding your health care!!

As we continue in our efforts to provide you, our patients, with the highest quality of care and convenient access to your health records, we are excited to announce that our practice now offers a "Patient Portal". This will allow you the opportunity to use the power of the web to track all aspects of your health care through our office.

As part of the Affordable Care Act implemented by the Federal Government, we are required by law to provide our patients access to communicate with our practice easily, safely, and securely over the internet by means of a "Patient Portal".

During your visit, our office will provide you with your personal "Login Credentials" which consists of the Login URL, your user ID and your password. Our staff is dedicated to ensuring that you are knowledgeable regarding the portal features and that you have access prior to leaving.

However, TIME is of utmost importance for our office!

If for any reason, you are not able or do not want to access the portal while at our office, please take a few minutes to login once you get home.

Due to governmental regulations and guidelines regarding Meaningful Use, our patients are required to login within 4 days of their office visit. However, although you have access to your medical records, please be mindful that our physicians will need adequate time to complete your visit summary prior to availability on the portal.

Should you encounter an issue in completing this process, please allow one of our qualified staff to assist you by calling the office number for Hillsborough: **(813) 879-8045** and for Pinellas: **(727) 341-0551**.

Once again, we welcome you to our Florida E.N.T. and Allergy healthcare family!

Kind Regards,

The Physicians and staff of

Florida E.N.T. and Allergy

FLORIDA ENT and ALLERGY *A Division of Select Physicians Alliance* **Demographics**

PATIENT INFORMATION

Patient Last Name:				First Name:				MI:	
Date of Birth:		Sex:	❒ Female ❒ Male		Social Security #:				
Address:			City:		State:		Zip:		
Home Phone:		Cell Phone:			Work Phone:				
Email:		❒ No Email	Preferred Method of Contact:		❒ Home ❒ Work ❒ Cell				
Marital Status:	❒ S ❒ M ❒ D ❒ W ❒ P ❒ SEP		Preferred Language:						
Race:	❒ Asian ❒ Asian Indian ❒ African American ❒ White ❒ Other _____				Ethnicity: ❒ Hispanic ❒ Non-Hispanic				
Occupation:					Phone:				
Primary Care Physician (PCP):			Referring Physician:						
Emergency Contact:		Phone:			Relationship:				
Employment Status:	❒ Employed ❒ Retired ❒ Student ❒ Disabled		How did you hear about us:						

I give my permission for: Detailed voice messages to be left ❒ on my **Voicemail** ❒ with a **Household Member** ***To receive text messages*** ❒ Yes ❒ No

INSURANCE INFORMATION

Primary Insurance Name:		Phone:	
Policy/ID Number:		Group #:	
Secondary Insurance Name:	❒ N/A	Phone:	
Policy/ID Number:		Group #:	

RESPONSIBLE PARTY INFORMATION ❒ Check if the patient above is the responsible party

Last Name:			First Name:				MI:		
Date of Birth:		Sex:	❒ Female ❒ Male		Social Security #:				
Address:		City:			State:		Zip:		
Relationship:		Phone:			Email:				

Our office prefers to send new prescriptions and refills electronically to your pharmacy, whenever possible. Please make sure to supply us with your primary and mail order (if applicable) pharmacy information below.

Pharmacy:		Location:		Phone:	
Mail Order Pharmacy:		Phone Number:			

Pharmaceutical History Consent

I hereby give my consent to have Florida ENT and Allergy access my external medications so they can give me the best treatment and reduce the risk of unfavorable reactions to medications and treatments ❒ I Give Consent ❒ I Decline at this time ***Initial:*** _____

Authorization of Release of Information

I authorize the following person/people to discuss any necessary appointments, treatments, medications, test results, or anything else related to my medical care and/or appointment scheduling. I authorize the following person/people to bring in my child in for treatment and to discuss any appointments, treatments, medications, test results or anything else related to their medical care and/or appointment scheduling.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I certify that all the information I have provided above is current and accurate to my knowledge. I acknowledge that I am responsible to make your office aware of any changes to my personal information. I agree that unless I give specific instructions otherwise, medical information regarding me, or my minor child's care, may be released to the biological parents, step parents, referring physicians or other practitioners, and my insurance company. I authorize Florida ENT & Allergy and its personnel to provide medical services such as medical examination, treatment, and/or testing as they deem best for me, or my minor child's physical or mental welfare.

Patient Signature: _____ Date: _____

Patients Name: _____ Date of Birth: _____

OFFICE GUIDELINES

I acknowledge that I have received and read the ***Office Guidelines*** *in its entirety*. I understand and agree to the policies and guidelines that have been listed out in the guidelines.

Initial _____

FINANCIAL AGREEMENT

I acknowledge that I have received and read the ***Financial Agreement*** *in its entirety*. I understand and accept full financial responsibility for any and all patient balances incurred for myself and/or dependents.

Initial _____

FLORIDA CENTER FOR VOICE AND SWALLOWING

Please be advised if you are coming in to see our speech pathologist with the Florida Center for Voice and Swallowing for a voice or swallow evaluation, there may be additional patient responsibility associated with the visit that could be up to $750.00 depending on your insurance coverage. This will be in addition to any regular co-pay or charges for an office visit with the physician. Please contact the Florida Center for Voice and Swallowing for any additional fees associated with the evaluations at 813-879-8045.

Initial _____

ASSIGNMENT OF INSURANCE BENEFITS

I acknowledge that I have received and read the ***Assignment of Benefits*** Policy. I hereby authorize the Release of any information relating to any and all claims for benefits on behalf of myself and/or dependents.

Initial _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

By law, we are required to make available to you a copy of our Notice of Privacy Practices. By initialing below, you acknowledge that you have received or have been offered and declined a copy of the notice. A current copy of this notice is also posted in the office, or is available to you upon request. If the Notice is revised, you may review and obtain the new version at any time.

Initial _____

PERMISSION FOR TREATMENT

I hereby give my consent for any and all examinations, treatment, therapy, care, anesthetics, ear cleaning, administration of medications, and diagnostic procedures including scopes, during the course of my care. The risks and complications may include but are not limited to bleeding, infection, damage to adjacent tissues or organs, swelling, pain, anesthesia, or medication reactions.

Initial _____

MEDICAL RESEARCH

Florida ENT and Allergy participates in medical research. You may be contacted if you are selected as a potential candidate. It is your right to accept or decline participation.

Initial _____

MEDICAL RECORDS

This section will allow us to be able to take a verbal consent from you to be able to send your records to any medical institution, attorney's office, government institutions, etc. I authorize my physician to send my records to medical institutions, diagnostic centers, sleep centers, etc, without obtaining my signature on each and every medical release form; that I would be bound by this initial as though the undersigned. I agree that unless I give specific instructions otherwise, medical information regarding my treatment, or my child's treatment, may be released to the biological parents, step parents, referring physicians, and other practitioners, and my insurance company.

Initial _____

FLORIDA ENT and ALLERGY ***A Division of Select Physicians Alliance*** **Patients Review of Symptoms**

Patient Name:		Date of Birth:		Height:		Weight:	

CHIEF COMPLAINT(s) *List below each reason for your visit today and when the problem started*

1)	2)	3)

CURRENT MEDICATION *Please list ALL prescription and non-prescription medications, vitamins, & nutritional supplements below* ☐ List Attached

If you do not have room, please list on the back of this page.

Medication	Dosage	Frequency	Medication	Dosage	Frequency

MEDICAL HISTORY OF

☐	Thyroid Disease	☐	High Blood Pressure	☐	Tuberculosis	☐	Malignant Hyperthermia
☐	Blood/Bleeding Disorder	☐	Stroke/CVA/TIA	☐	Ear Infections	☐	Chicken Pox/Shingles/Fever Blisters
☐	Migraines	☐	High Cholesterol	☐	Sinus Infections	☐	Reflux/GERD/Hiatal Hernia
☐	Asthma	☐	Heart Disease	☐	HIV	☐	Irritable Bowel/Crohn's Disease/ Colitis
☐	Lung Disease	☐	Kidney Disease	☐	Mental Illness	☐	Hepatitis/Liver Disease
☐	Emphysema/COPD	☐	Diabetes	☐	Depression	☐	Could you be pregnant? ☐Yes ☐ No
☐	Rheumatic Heart Disease	☐	Cancer Type:	☐	Arthritis	☐	Other:
☐	Skin Disease/Psoriasis	☐	Sleep Apnea	☐	Osteoporosis		

ALLERGIES / INTOLERANCES ☐ NO KNOWN DRUG ALLERGIES (NKDA)

Medication:	Reaction:	Medication:	Reaction:

SURGICAL / HOSPITALIZATION HISTORY ☐ See Attached List

Type of Surgery:	Surgery Date:	Type of Surgery:	Surgery Date:

Hospitalized for:	Name of Hospital:	Date:	Hospitalized for:	Name of Hospital:	Date:

FAMILY HISTORY *Has any member of your family (including parents, grandparents, and siblings) ever had any of the following*

Illness	**Alive/Deceased**	Family Member(s)	Illness	**Alive/Deceased**	Family Member(s)
☐ Cancer Type:	☐ / ☐		☐ Glaucoma	☐ / ☐	
☐ Hypertension (High Pressure)	☐ / ☐		☐ Bleeding Disorder	☐ / ☐	
☐ Diabetes	☐ / ☐		☐ Hearing Loss	☐ / ☐	
☐ Heart Disease	☐ / ☐		☐ Allergies	☐ / ☐	
☐ Condition influencing health status	☐ / ☐		☐ Asthma	☐ / ☐	
☐ Mental Illness	☐ / ☐		☐ Thyroid Disease	☐ / ☐	
☐ Migraine	☐ / ☐		☐ CVA (Cerebral infarction)	☐ / ☐	
☐ Drug or Alcohol Abuse	☐ / ☐		☐ Dizziness	☐ / ☐	
☐ Stroke	☐ / ☐		☐ Other	☐ / ☐	

SOCIAL HISTORY **Allergies to Pets?** ☐ Yes ☐ No

Tobacco Use:	☐ Never ☐ Former ☐ Current Type: ☐ Cigarettes ☐ Pipe ☐ Chew	2nd Hand Smoke Exposure? ☐Yes ☐ No
Alcohol Consumption:	☐ Never ☐ Rare ☐ Occasionally ☐ Socially	How many per day?

REVIEW OF SYSTEMS *Please indicate if you are currently having problems with any of the following* ☐ Additional Information Written on the Back

☐	Fever	☐	Visual Disturbance	☐	Hearing Loss	☐	Difficulty Swallowing	☐	Shortness of Breath
☐	Recent Weight Gain	☐	Dry Eyes	☐	Chest Pain	☐	Easy Bruising	☐	Cough
☐	Recent Weight Loss	☐	Double Vision	☐	Irregular Heart Rhythm	☐	Bleeding Disorder	☐	Headache
☐	Night Sweats/Chills	☐	Nosebleed	☐	Murmur	☐	Anemia	☐	Stroke
☐	Fatigue	☐	Change in Voice	☐	Leg Swelling	☐	Blood Transfusions	☐	Paralysis
☐	Skin Cancer	☐	Ringing in Ears	☐	Sleep Problems	☐	Arthritis	☐	Weakness
☐	Healing Problems	☐	Allergies	☐	Temperature Intolerance	☐	Pain in Jaw with Chewing	☐	Tingling Numbness
☐	Rash	☐	Snoring	☐	Excessive Thirst	☐	Muscle Weakness	☐	Seizures
☐	Skin Discoloration	☐	Ear Pain or Itch	☐	Loss of Appetite	☐	Leg Cramps	☐	Dizziness
☐	Hives	☐	Throat Pain	☐	Nausea or Vomiting	☐	Neck Pain	☐	Memory Loss
☐	Allergic Reactions	☐	Sinus Problems	☐	Heartburn	☐	Muscle Aches	Y N	Have you had any falls in the last year?
☐	Glaucoma	☐	Ear Drainage	☐	Change in Bowel	☐	Asthma	Y N	Have you had any falls with injury in the past year?

I certify that I have disclosed all of my medical history known to me. I acknowledge that I am responsible to make your office aware of any changes to my health.

Patient Signature: _____ **Date:** _____

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FLORIDA ENT and ALLERGY *A Division of Select Physicians Alliance* **Office Guidelines: Patient Copy**

Thank you for choosing our doctors for your ENT care. While it is our desire to provide you with the best care possible, there are some limitations and restrictions that your managed care or insurance plan may impose which we cannot control. Because of this, there are certain policies and guidelines that we want you to be aware of, and agree when dealing with our office as outlined below:

1. Payment is due at time of service.
    a. This will include any copays, deductibles, or any out of pocket charges per your insurance plan. Florida ENT and Allergy does verify your insurance before arrival; check in will let you know what to expect. Charges will vary per the type of insurance plan; **the office visit charge will be collected at check in**. **We will do our best to let you know the amounts of the procedures. Please keep in mind that if your plan is all deductible then that would not include the office visit charge.**
2. Cancellation Policy: We require that you give our office at least 24-hour notice if you need to cancel or reschedule an appointment. For **office visits,** you will be subject to a **$50.00** no show fee, and for all in office procedures, such as, **(VNG), allergy testing, CT scans, and speech evaluations** you will be subject to a **$100.00** no show fee. All surgery cancellations also require at least 72-hour notice or you will be subject to a **$100.00** charge.
3. Obtain authorization (if necessary) prior to your visit to avoid delays or rescheduling.
    a. **Florida ENT and Allergy will assist (in this); ultimately, it is your responsibility to obtain this information prior to your visit.**
4. We expect that any lab test, x-rays, surgery, or other diagnostic exams that we order will be done within 7- 10 days. We are not party to, or agree with your insurer, or managed care plan if they deny authorization or coverage. If your plan denies authorization for our recommendations, we ask that you initiate an appeal with them immediately, and notify us in writing. If they require a letter from us, we will provide it.
5. **Make a follow-up appointment within one week after you have done any diagnostic test (i.e. lab, x-ray, CT scans, biopsies, etc.) to discuss the results and recommendations. Do not wait for us to call you. We do not call patients with the results.**
6. You are responsible to contact the physician or his staff for an appointment if your condition does not improve within two weeks.
7. Your condition may require further procedures and examinations as part of the workup for your medical problem; however, most insurance carriers require prior approval. You will be financially responsible for all fees that your healthcare insurance deems as non-covered services, or not medically necessary; services must be paid at time of service.
8. Self-pay patients' **initial payment is $250 which includes all services but speech evaluation, ear tubes, or CT**. You will be responsible for in-office procedures. The patient, child's parents, or responsible person will be made aware of any additional out-of-pocket expenses prior to the provider performing the procedure; must be paid at time of service.
9. Managed care, with its multiplicity of rules that govern the practice of medicine, make it difficult for all parts involved to be sure they are being followed. It is not our intention to bill contrary to your plan. If you discover any errors in billings (surgical, laboratory, x-ray, or even ours) please inform us, so that we can correct or help you to correct them.
10. There will be a charge for any and all medical leave papers (FMLA) filled out by this office. As a courtesy, a one-page diagnostic report will be furnished upon request.
11. **You can expect to be treated with respect and professionalism at all times. If you have a problem with any of our staff, please notify the doctor, or the office manager**

Financial Agreement

In consideration of the services rendered to the patient, the undersigned agrees to accept full financial Responsibility for the patient's account in accordance with the regular rates and terms of the facility. Should the account be referred for collection procedures, the undersigned shall pay responsible attorney's fees and collection expenses. At present, that fee is a minimum of 30% of the charges collected and is payable before the patient is seen in the offices of Florida E.N.T. and Allergy at the next visit.

Assignment of Insurance Benefits

The undersigned herby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my initials on the policy acknowledgement form authorizes my physician to submit claims for benefits, for services rendered, or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this initial as though the undersigned. I further authorize my insurance company to pay and herby assign directly to Florida E.N.T. and Allergy all benefits, if any, otherwise payable to me for services as described that any insurance benefits, when received by and paid to Florida E.N.T and Allergy, will be credited to my account in accordance with the above said assignment.

Standing Consent to Access External Prescription History

This is to acknowledge that my initials on the policy acknowledgement form authorizes all pharmacies and insurers to access database of all my medicines I have used in the past 2 years. It is in our best interest to obtain a list of all your medicines to give the best treatment, and reduce the risk of unfavorable reactions to medicines and treatments. This consent authorizes all pharmacies, insurers, and personnel in drug administrations to download the list of medicines for which they are registered. Please note that the database may be incomplete if your pharmacy does not participate with it.

Therefore, this list does not include medicines without prescriptions, or vitamins that you have used. This list does not contain information about the treatment process, or reasons for which you have discontinued certain drugs. To a certain extent, if you have informed pharmacies that participate with this database, about any allergy to any medication you have, the database will have the list. However, if you have reactions to medicines and do not report it to the pharmacy with access to the database, they will not be shown on the list. Likewise, we need you to provide a list of all your medicines, supplements, or vitamins you take, as well as a list of allergies with the types of reactions to get accurate and correct information