Patient Name:
DOB:
Age:
Gender:

# Clinical

Date of Visit:

## Past Medical History

Past Medical History *

- [ ] None
- [ ] Other
- [ ] Asthma
- [ ] Acoustic Neuroma
- [ ] Anemia
- [ ] Diabetes Mellitus
- [ ] Dizziness
- [ ] Disorder of the Larynx
- [ ] Disorder of the Nose
- [ ] Ear Infections
- [ ] Migraines / Headaches
- [ ] Nose Bleeds
- [ ] Cancer
- [ ] Reflux
- [ ] Ringing in the ear(s)
- [ ] Sinus Disease
- [ ] Sleep Apnea
- [ ] Thyroid Nodule
- [ ] Vertigo
- [ ] High blood pressure

## Family History

Family Medical History Condition List *

- [ ] Substance Abuse
- [ ] Cervical Cancer
- [ ] Asthma
- [ ] Kidney Disease
- [ ] Heart Attacks
- [ ] Thyroid Disorders
- [ ] Allergies
- [ ] Spinal Fusion
- [ ] Prostate Cancer
- [ ] Emphysema
- [ ] Heart Failure
- [ ] Cleft Palate
- [ ] Coronary Artery Disease
- [ ] Esophageal Cancer
- [ ] Sleep Apnea
- [ ] Neuropathy
- [ ] Breast Cancer
- [ ] Hearing Loss
- [ ] Smoking
- [ ] Thyroid Disease
- [ ] Cancer of Oral Cavity
- [ ] None
- [ ] Other / Not Listed
- [ ] High blood pressure

## Allergies

Drug Allergies *

- [ ] Crestor
- [ ] Iodinated Contrast Media
- [ ] None
- [ ] Other / Not Listed (Prednisone)
- [ ] Penicillins
- [ ] Sulfa
- [ ] Amoxicillin
- [ ] Aspirin
- [ ] Ceftazidime
- [ ] Insulin
- [ ] Iodine
- [ ] Latex

Drug Allergy Reaction *

| | Anaphylaxis | Diarrhea | Dizziness | Fatigue | Rash | Shortness of breath | Nausea | Angioedema | GI Upset | Hives | Liver Toxicity | Swelling | Weal | Other/Not Listed |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Other / Not Listed | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

## Medications

Medications Reconciliation

- [ ] dextroamphetamine-amphetamine (capsule,extended release 24hr)
- [ ] EpiPen 2-Pak (auto-injector)
- [ ] triamcinolone acetonide (aerosol,spray)

Medications Confirmation *

Supplements *

## Physicians / Referrals

Primary Care Physician *

Referring Physician Same As Primary Care Physician *

Referring Physician *

Patient Name:
DOB:
Age:
Gender:

# Clinical

Date of Visit:

## Pharmacy

Pharmacy Name *

Pharmacy Address *

Pharmacy Phone *

## Surgical History

Surgeries or Procedures *

- ☐ None
- ☐ Cesarean Section
- ☐ Spinal Surgery
- ☐ Hysterectomy
- ☐ Hernia Repair
- ☐ Appendectomy
- ☐ Gallbladder Surgery
- ☐ Colon / Bowel Surgery
- ☐ Coronary artery bypass grafting
- ☐ Heart valve repair
- ☐ Mastectomy
- ☐ Lumpectomy of breast
- ☐ Breast reduction
- ☐ Joint Replacement
- ☐ Adenoid Excision
- ☐ BAHA- Bone anchored Hearing Aid
- ☐ Closed reduction of nasal fracture
- ☐ Cochlear device implantation w/ mastoidectomy
- ☐ Cochlear implant magnet
- ☐ Cochlear implant system
- ☐ Complete primary rhinoplasty
- ☐ Balloon sinuplasty
- ☐ Excision of cervical lymph node
- ☐ Excision of lesion of oral cavity
- ☐ Excision of skin
- ☐ Excision of submandibular gland
- ☐ Excision of thyroglossal duct cyst
- ☐ Functional endoscopic sinus surgery
- ☐ Nasal sinus surgery
- ☐ Incision of trachea
- ☐ Mastoidectomy
- ☐ Modified radical neck dissection
- ☐ Repair of tympanic membrane
- ☐ Myringotomy and insertion of tympanic ventilation tube
- ☐ Nasal septoplasty
- ☐ Operation on nose
- ☐ Parathyroidectomy
- ☐ Parotidectomy
- ☐ Procedure on ear
- ☐ Procedure on head AND/OR neck
- ☐ Reduction of nasal turbine
- ☐ Removal of acoustic neuroma
- ☐ Repair of prominent or protruding ear
- ☐ Stapedectomy
- ☐ Thyroidectomy
- ☐ Tonsillectomy
- ☐ Total laryngectomy
- ☐ Tympanotomy
- ☐ Type 1 tympanoplasty
- ☐ Uvulopalatopharyngoplasty
- ☐ Other

## Social History

| | | | | |
|---|---|---|---|---|
| Alcohol Intake Frequency * | ☐ daily | ☐ socially | ☐ rarely | ☐ never |
| Number of Drinks per Day * | | | | |
| Currently Smoke Confirmation * | ☐ daily | ☐ socially | ☐ rarely | ☐ never |
| Second Hand Smoke * | ☐ daily | ☐ socially | ☐ rarely | ☐ never |

FLORIDA E.N.T. & Allergy

Breathe Well. Hear Well. Be Well.

Name: _____

DOB: _____

Date: _____

# Uses and Disclosures of Your Protected Health Information (PHI)

I understand that as part of my health care, the practice originates and maintains paper and/or electronic records describing my health history, symptoms, examination, test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the health professionals who contribute to my care, such as referrals
- A source of information for applying my diagnosis and treatment information to my bill
- A means by which a third-party payer can verify that services billed were actually rendered
- A tool for routine health care operation, such as assessing quality and reviewing the competence of staff

I have been provided with a "Notice of Patient Privacy Practices" that provides a more complete description of information uses and disclosures.

Tell us with whom we may discuss your protected health information:

| Name | Relation | Phone Number |
|---|---|---|
| Name | Relation | Phone Number |
| Name | Relation | Phone Number |
| Name | Relation | Phone Number |

☐ **Check this box if you wish to share your PHI with NO ONE.**

Patient or Legal Guardian Signature: _____ Date: _____

FLORIDA E.N.T. & Allergy
Breathe Well. Hear Well. Be Well.

Name: _____

DOB: _____

## Financial Consent

I hereby authorize said assignee to release all information necessary to secure payment.

I certify that the information given by me for payment by my insurance plan(s) is correct. I authorize any holder of medical or other information about me to release to the above plan or its intermediaries or carriers any information needed for this or any related insurance claim. I request that the payments of authorized benefits be made to ENT and Allergy Associates of Florida, P.A. on my behalf. I assign the benefits payable for medical services to the physician or organization furnishing the services and authorize such physician/organization to submit a claim to the above insurance on my behalf.

I understand that I am financially responsible for all charges whether or not paid by my insurance, including any deductibles, co-pays, and co-insurance, and that payments are due at the time services rendered.

I understand and agree that if I fail to make payment for services rendered to me, my name and account may be turned over to an attorney and/or a 3rd party collection agency and I agree to pay the additional collection fee of 30% of the outstanding amount owed, including any court cost, and/or reasonable attorney fees that may be incurred in the collection of any outstanding balance.

## Privacy Consent

I have been provided a copy or access to a copy of the Practice's Notice of Privacy Practices.

## Consent for Treatment

I hereby voluntarily consent to outpatient care at ENT and Allergy Associates of Florida, P.A., encompassing routine diagnostic procedures, examination, and medical treatment including, but not limited to, routine laboratory work (such as blood, urine and other studies), endoscopes, CT's, audiology testing, allergy testing and treatment, and administration of medications prescribed by the physician. I understand that the above diagnostic procedures and testing are separate from my office visit and may be subject to deductible and co-insurance.

I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the physicians and their mid-level providers, including audiologist, medical assistants, or their designees as is necessary in the physician' judgment.

## Message Consent

It is our policy to verbally notify you, the patient, of all test results ordered by your care provider and to confirm scheduled appointments. By indicating a response below, you are authorizing our staff to leave a detailed message on your voicemail and/or answering machine.

**Please check response: Yes No**

Name: _____

DOB: _____

## PBM Consent

By signing this consent form I am authorizing ENT and Allergy Associates of Florida, P.A. to request and use my prescription medication history from other health care providers and/or third-party pharmacy payors for treatment purposes.

Pharmacy Benefits Managers (PBM) are third party administrators, prescriptions programs, whose primary responsibility is processing and paying prescription drug claims. They also develop and maintain formularies which are lists of dispensable drugs covered by a particular benefit plan.

## Appointment Reminders

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders and/or information. If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications and/or information at that email or text address from the Practice. Based on the information being communicated, there may be a potential of multiple texts in order to provide necessary information. I acknowledge and consent to receive text messages from the practice to my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing or choose to opt out. The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details.

## Consent Forms Acknowledgement

I, the patient, hereby have read and understand the following:

- Financial Consent
- Privacy Consent
- Consent for Treatment
- PBM Consent
- Message Consent
- Appointment Reminders

Furthermore, I acknowledge I have been given the opportunity to ask questions regarding these Consents.

**Patient/ Guardian Signature: _____ Date: _____**

## Medicare Consent (applies to Medicare beneficiaries ONLY)

I certify that the information given by me in applying for payment under Title XVIII and/or Title XIX, of the Social Security Act, is correct. I authorize any holder of medical or other information about me to release to the social Security Administration or its intermediary carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician/audiology services. I understand that I am responsible for my health insurance deductibles and co-insurance.

**Patient/ Guardian Signature: _____ Date: _____**

FLORIDA E.N.T. & Allergy
Breathe Well. Hear Well. Be Well.

Name: _____

DOB: _____

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, speech evaluations and/or therapy** you will be subject to a **$100.00** no show fee. We require a 48-hour notice for all **in-office procedures, audio exams, VNGs, allergy testing, CT scans** or you will be subject to a **$200.00** no show fee. All surgery cancellations also require at least 72-hour notice or you will be subject to a **$200.00** 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 completed 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 $400 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.**

**Patient/ Guardian Signature: _____ Date: _____**