

To Our New Patients

Welcome to our practice.

The following forms are included in your new patient packet. We ask that you bring in *all* completed forms on the day of your appointment.

- Patient or Dependent Patient Information Form
- Patient's Personal Medical History Form
- Review of Systems Form
- HIPPA Notice of Privacy Form
- Privacy Policy Acknowledgement Form
- Financial Policy Sheet

These forms are *important* as they will become a part of your permanent medical record. Should you need additional space for your responses, please use the backside of the form. Also, please bring any *Test Results* or *X-Rays* relating to your appointment for our doctor's review

Next, read and sign our *Financial Policy Sheet*. **All outstanding deductibles and co-payment amounts are due at the time of service.** As a courtesy to our patients, our office will file all insurance claims. In an effort to help control healthcare costs, ENT Associates are contracted with several managed care insurance plans which allow our patients financial flexibility. To insure that we have the most current insurance information, **please have your insurance cards available at each visit.**

If you are unable to keep your appointment for any reason, please call our office (870)424-4200 or (800)272-4180 **24 hours** in advance.

We look forward to participating in your medical care.

**Ear, Nose & Throat Associates of Mountain Home
Physicians and Staff**

**EAR, NOSE & THROAT ASSOCIATES OF MOUNTAIN HOME
DEPENDENT PATIENT INFORMATION**

NAME: _____ AGE: _____
FIRST MIDDLE LAST

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____ Sex: ___ Male ___ Female
mm/dd/yyyy

MAILING ADDRESS _____
STREET APT# CITY STATE ZIP CODE

TELEPHONE: _____ EMAIL: _____

HOME
EMERGENCY CONTACT PERSON: _____ TELEPHONE/CELL: _____

PARENT INFORMATION

MOTHER'S NAME: _____ DATE OF BIRTH: _____ SSN: _____

CELL PHONE: _____ WORK PHONE: _____ EMPLOYER: _____

FATHER'S NAME: _____ DATE OF BIRTH: _____ SSN: _____

CELL PHONE: _____ WORK PHONE: _____ EMPLOYER: _____

MARITAL STATUS: (CIRCLE ONE) S M D W SEPARATED THIS CHILD LIVES WITH: _____

INSURANCE INFORMATION

Please present your insurance card(s) at check in so that we can file your insurance.

INSURANCE COMPANY _____ POLICY HOLDER'S NAME _____

POLICY HOLDER'S DATE OF BIRTH: _____ RELATIONSHIP TO PATIENT _____

ARKANSAS MEDICAID NUMBER (if applicable): _____ PRIMARY CARE PHYSICIAN _____

MEDICAL REFERRAL INFORMATION

FAMILY DOCTOR: _____ PHARMACY: _____

How did you find us? ___ referred by other doctor ___ self-referred ___ recommended by friend ___ website ___ phone book.

Authorization to Release Information

I authorize the release of the medical information necessary to process my insurance claims, to physicians the child may be referred to in the future, and the physician who referred the child to this medical practice.

Signature _____ Date _____

Authorization of Payment

I authorize payment of medical benefits to Ear, Nose & Throat Associates of Mountain Home, P.A. for medical services provided. I understand that I am responsible for all fees regardless of my insurance coverage excluding those fees which are processed on assignment through contractual agreements.

Signature _____ Date _____

EAR, NOSE & THROAT ASSOCIATES OF MOUNTAIN HOME PATIENT'S PERSONAL MEDICAL HISTORY

PATIENT NAME: _____ AGE: _____

HEIGHT _____ WEIGHT _____

CHIEF COMPLAINT (Why are you here?) _____

DRUG ALLERGIES: _____

FOOD ALLERGIES: _____

ENVIRONMENTAL ALLERGIES: _____

LIST ALL PRESCRIPTIONS AND MEDICATIONS:

NAME	DOSAGE (mg)	TIMES PER DAY (daily, twice daily, every 4 hours, etc.)

LIST ANY OVER-THE-COUNTER MEDICATIONS AND/OR HERBALS:

NAME	DOSAGE (mg)	TIMES PER DAY (daily, twice daily, every 4 hours, etc.)

ONGOING MEDICAL CONDITIONS:

	YES	NO		YES	NO
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Type _____		
Other _____					

LIST ALL SURGERIES:

LIST ALL INJURIES OR ACCIDENTS:

FAMILY HISTORY:

	LIVING	DECEASED	AGE OR AGE AT DEATH	CAUSE OF DEATH
FATHER	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
MOTHER	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
BROTHER(S) # _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
SISTER(S) # _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

IS THERE A HISTORY OF ANY OF THE FOLLOWING IN BLOOD RELATIVES OF YOURS? (CIRCLE ALL THAT APPLY)

HEART DISEASE HIGH BLOOD PRESSURE DIABETES STROKE CANCER (TYPE: _____) HEARING LOSS
ALLERGIES ASTHMA BLEEDING DISORDER ANESTHESIA REACTION OTHER _____

PERSONAL HISTORY:

HAVE YOU EVER SMOKED? YES NO No. of packs per day _____ No. of Years _____
IF QUIT, WHEN? _____ DO YOU USE SMOKELESS TOBACCO? _____

DO YOU DRINK? NEVER OCCASIONAL REGULARLY DID YOU EVER DRINK HEAVILY? YES NO

DO YOU USE ILLEGAL DRUGS? YES NO

DO YOU HAVE A HISTORY OF: POSITIVE TEST FOR HIV / AIDS? YES NO POSITIVE TEST FOR HEPATITIS? YES NO

REVIEW OF SYSTEMS: PLEASE INDICATE ANY PERSONAL HISTORY BELOW:

CONSTITUTIONAL SYMPTOMS

	Y	N
Good general health lately	<input type="checkbox"/>	<input type="checkbox"/>
Recent weight change	<input type="checkbox"/>	<input type="checkbox"/>
Decreased appetite	<input type="checkbox"/>	<input type="checkbox"/>
Fever/night sweats	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue/weakness	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>

EYES

Eye disease or injury	<input type="checkbox"/>	<input type="checkbox"/>
Wear glasses/contact lenses	<input type="checkbox"/>	<input type="checkbox"/>
Blurred or double vision	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma/cataracts	<input type="checkbox"/>	<input type="checkbox"/>

EARS/NOSE/THROAT

Hearing loss or ringing	<input type="checkbox"/>	<input type="checkbox"/>
Earaches or drainage	<input type="checkbox"/>	<input type="checkbox"/>
Chronic sinus problem	<input type="checkbox"/>	<input type="checkbox"/>
Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>
Mouth sores	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat or voice change	<input type="checkbox"/>	<input type="checkbox"/>
Swollen glands in neck	<input type="checkbox"/>	<input type="checkbox"/>
Snoring	<input type="checkbox"/>	<input type="checkbox"/>

CARDIOVASCULAR

Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>
Passing out	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain or angina pectoris	<input type="checkbox"/>	<input type="checkbox"/>
Irregular heartbeat	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath with walking or lying flat	<input type="checkbox"/>	<input type="checkbox"/>
Swelling of feet, ankles or hands	<input type="checkbox"/>	<input type="checkbox"/>

RESPIRATORY

Chronic or frequent coughs	<input type="checkbox"/>	<input type="checkbox"/>
Spitting up blood	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Asthma or wheezing	<input type="checkbox"/>	<input type="checkbox"/>

GASTROINTESTINAL

Swallowing problem	<input type="checkbox"/>	<input type="checkbox"/>
Indigestion/heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>
Changes in bowel movements	<input type="checkbox"/>	<input type="checkbox"/>
Nausea or vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Frequent diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Blood in stool/black tarry stools	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>
Peptic ulcer (stomach or duodenal)	<input type="checkbox"/>	<input type="checkbox"/>

HEMATOLOGIC/LYMPHATIC

Bleeding or bruising tendency	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>
Blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>
Enlarged glands	<input type="checkbox"/>	<input type="checkbox"/>

GENITOURINARY

	Y	N
Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>
Awaken at night to urinate	<input type="checkbox"/>	<input type="checkbox"/>
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>
Change in force of stream when urinating	<input type="checkbox"/>	<input type="checkbox"/>
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>
Female - last menstrual period	_____	
Female - # of pregnancies	_____	
Female - # of miscarriages	_____	
Other symptoms not listed:	_____	

MUSCULOSKELETAL

Joint pain	<input type="checkbox"/>	<input type="checkbox"/>
Joint stiffness or swelling	<input type="checkbox"/>	<input type="checkbox"/>
Weakness of muscles or joints	<input type="checkbox"/>	<input type="checkbox"/>
Muscle pain or cramps	<input type="checkbox"/>	<input type="checkbox"/>
Back pain	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty walking	<input type="checkbox"/>	<input type="checkbox"/>

INTEGUMENTARY

Rash or itching	<input type="checkbox"/>	<input type="checkbox"/>
Change in skin lesion	<input type="checkbox"/>	<input type="checkbox"/>
Change in hair or nails	<input type="checkbox"/>	<input type="checkbox"/>
Change in skin color	<input type="checkbox"/>	<input type="checkbox"/>

NEUROLOGICAL

Leg or arm weakness	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Frequent or recurring headaches	<input type="checkbox"/>	<input type="checkbox"/>
Light headed or dizzy	<input type="checkbox"/>	<input type="checkbox"/>
Convulsion or seizures	<input type="checkbox"/>	<input type="checkbox"/>
Numbness or tingling sensations	<input type="checkbox"/>	<input type="checkbox"/>
Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Head injury	<input type="checkbox"/>	<input type="checkbox"/>
Speech problem	<input type="checkbox"/>	<input type="checkbox"/>

PSYCHIATRIC

Memory loss or confusion	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness / anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>

ENDOCRINE

Glandular or hormone problem	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes (insulin or non-insulin)	<input type="checkbox"/>	<input type="checkbox"/>
Excessive thirst or urination	<input type="checkbox"/>	<input type="checkbox"/>
Heat or cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>

ALLERGIC/IMMUNOLOGIC

History of skin reaction or other adverse reaction to:		
Penicillin or other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Novocaine or other anesthetics	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin or other pain remedies	<input type="checkbox"/>	<input type="checkbox"/>
Tetanus antitoxin or other serums	<input type="checkbox"/>	<input type="checkbox"/>
Iodine, merthiolate or other antiseptic	<input type="checkbox"/>	<input type="checkbox"/>
Other drugs/medications	<input type="checkbox"/>	<input type="checkbox"/>

PATIENT'S NAME: _____

REVIEWED BY: _____

HIPAA Notice of Privacy Practices

Ear, Nose & Throat Associates of Mountain Home, P.A.
626 Burnett Drive
Mountain Home, Arkansas 72653
870/424-4200

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may 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 Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and 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 or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

2. Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact **Deana Black, Office Manager and Privacy Compliance Officer** at **870/424-4200** prompt **9**. Should you believe your privacy rights have been violated by our office, you may file a written complaint with Deana Black at our office or with the Secretary of Health and Human Services. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our Main Phone Number.

This notice was published and becomes effective on/or before **April 14, 2003.**

EAR, NOSE & THROAT ASSOCIATES OF MOUNTAIN HOME
FINANCIAL POLICY SHEET

OUR PRACTICE FINANCIAL POLICY

We are dedicated to providing you with the best possible care and service, and regard your understanding of our financial policies as an essential element of your care and treatment. To assist you, we have the following financial policy. If you have any questions, please feel free to discuss them with our staff.

Unless other arrangements have been made in advance by either you or your health coverage carrier, full payment is due at the time of service. For your convenience we accept VISA and MasterCard.

YOUR INSURANCE

We have made prior arrangements with many insurers and other health plans. We will bill those plans with which we have an agreement and will collect any required co-payment at the time of service. The co-payment will be collected when you arrive for your appointment. In the event your health plan determines a service to be "not covered", you will be responsible for the complete charge. In that event we will bill you, and payment is due upon receipt of that statement.

If you have insurance coverage with a plan with which we do not have a prior agreement, we will file your insurance for you, on an unassigned basis. In this case, your insurer will send the payment directly to you. Therefore charges for your care and treatment are due at the time of service.

We will also bill your health plan for all services that we provide in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.

MINOR PATIENTS

For all services rendered to minor patients, the adult accompanying the patient is responsible for payment.

MISSED APPOINTMENTS

In order to provide the best possible service and availability to all our patients, **it is your responsibility to cancel your appointment at least one day prior**. Please call us as early as possible if you know you will need to reschedule your appointment.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

Signature of Patient or Responsible Party if a Minor

Date

Signature of Co-responsible Party

Please print the name of the Patient