New Patient Form Huntsville ENT Physicians

PATIENT INFORMATION

Patient's Name _____
Last Name First Name Middle Name Name you go by

Address _____
City State Zip

Home Phone _____ Cell Phone _____ Email: _____

Sex _____ Birth Date _____ SSN _____ Driver License # _____Marital Status _____

Mother's Name _____
Last Name First Name Middle Name Name goes by

Mother's Employer_____ Occupation _____ Work Phone _____

Father's Name _____
Last Name First Name Middle Name Name goes by

Father's Employer_____ Occupation _____ Work Phone _____

EMERGENCY CONTACT

Contact's Name _____ Relationship _____ Phone _____

REFERRED BY

Referring Physician _____ Family Physician _____

How did you hear about us? _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____

Policy # _____ Group # _____ Copay _____

Subscriber Name _____ Relationship to Patient _____

Subscriber Sex _____ Subscriber DOB _____ Subscriber SSN_____

SECONDARY INSURANCE _____

Policy # _____ Group # _____ Copay _____

Subscriber Name _____ Relationship to Patient _____

Subscriber Sex _____ Subscriber DOB _____ Subscriber SSN_____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Signature _____ Date _____

I hereby authorize Huntsville ENT Physicians, P.C. to apply benefits on my behalf for the covered services rendered by the office, or by the office's order. I request that payment from my insurance company be made directly to Huntsville ENT Physicians, P.C. or to the party who accepts assignment. I certify that the information I have reported with regard to my insurance coverage is correct.

Signature _____ Date _____

PATIENT QUESTIONNAIRE

PATIENT NAME:_____ D.O.B._____

Address: _____ Phone: _____

PLEASE LIST ANY MEDICATIONS TAKEN ON A REGULAR BASIS: (INCLUDING EYE DROPS & OTC)	PLEASE LIST DRUG ALLERGIES & DESCRIBE THE REACTION BELOW: IF NONE, PLEASE WRITE "NONE"	PLEASE LIST YOUR PAST SURGERIES & DATES:

MEDICAL HISTORY: (*Please check the box next to the illnesses you currently have or had previously.*)

- ☐ TUBERCULOSIS
- ☐ HEPATITIS
  - TYPE: _____
  - WHEN?_____
- ☐ HIV / AIDS
- ☐ ENVIRONMENTAL ALLERGIES
- ☐ ON ALLERGY SHOTS
  - BY WHOM: _____
  - STARTED: _____
- ☐ ASTHMA
- ☐ COPD / EMPHYSEMA
- ☐ DVT / LEG CLOTS
- ☐ PULMONARY EMBOLUS
- ☐ CPAP USE
- ☐ ELEVATED CHOLESTEROL / HYPERLIPIDEMIA
- ☐ HYPERTENSION / HIGH BLOOD PRESSURE
- ☐ ATRIAL FIBRILLATION
- ☐ MITRAL VALVE PROLAPSE
- ☐ HEART ATTACK / CORONARY DISEASE
- ☐ CARDIAC STENT
- ☐ PACEMAKER / DEFIBRILLATOR
- ☐ DIABETES – □ TYPE I □ TYPE II
- ☐ CURRENTLY TAKING INSULIN
- ☐ HYPOTHYROIDISM
- ☐ FIBROMYALGIA
- ☐ RHEUMATOID ARTHRITIS
- ☐ LUPUS
- ☐ SARCOIDOSIS
- ☐ HEMOPHILIA / FACTOR DEFICIENCY
- ☐ VON WILLEBRAND'S DISEASE
- ☐ GASTROESOPHAGEAL REFLUX
- ☐ LIVER DISEASE
- ☐ EPILEPSY / SEIZURES
- ☐ MIGRAINES
- ☐ CATARACTS
- ☐ HIATAL HERNIA
- ☐ ULCER
- ☐ GLAUCOMA
- ☐ ORTHOPAEDIC HARDWARE/PLATES
- ☐ KIDNEY STONES
- ☐ PROSTATE ENLARGEMENT
- ☐ RAYNAUD'S DISEASE
- ☐ SJÖGREN'S SYNDROME
- ☐ NOSE BLEEDS
- ☐ STROKE
- ☐ MYASTHENIA GRAVIS
- ☐ COVID 19

CURRENT SYMPTOMS: (Please review each symptom and *** *CIRCLE* YES or NO ****)

CONSTITUTIONAL:
WEIGHT LOSS ..... YES / NO
WEIGHT GAIN ..... YES / NO
LOSS OF APPETITE ..... YES / NO
FEVER ..... YES / NO
CHILLS ..... YES / NO
SWEATS ..... YES / NO
FATIGUE ..... YES / NO

ENT:
NASAL CONGESTION ..... YES / NO
POOR SENSE OF SMELL ..... YES / NO
FACIAL PAIN ..... YES / NO
FREQUENT SINUS INFECTIONS ..... YES / NO
HOW MANY INFECTIONS IN PAST YR ..... _____
OF ANTIBIOTIC COURSES IN PAST YR..... _____
HOARSENESS ..... YES / NO
THROAT PAIN ..... YES / NO
THYROID NODULES ..... YES / NO
NECK MASSES..... YES / NO
LOOSE TEETH ..... YES / NO
CAPPED TEETH / DENTURES..... YES / NO
NOISE / RINGING IN EARS..... YES / NO
FIRST BEGAN? _____
INTERMITTENT / CONSTANT
LEFT EAR / RIGHT EAR / BOTH
HEARING LOSS..... YES / NO
FIRST BEGAN? ..... _____
LEFT EAR / RIGHT EAR / BOTH
EAR PRESSURE / FULLNESS..... YES / NO
FIRST BEGAN? ..... _____
INTERMITTENT / CONSTANT
LEFT EAR / RIGHT EAR / BOTH

EYES:
BLURRED VISION..... YES / NO

RESPIRATORY:
COUGH ..... YES / NO
PHLEGM / COLOR: _____ ..... YES / NO
LOUD SNORING ..... YES / NO
DAYTIME FATIGUE / SLEEPINESS ..... YES / NO

GI:
TROUBLE SWALLOWING..... YES / NO
NAUSEA ..... YES / NO
VOMITING ..... YES / NO
BLOOD IN YOUR VOMIT..... YES / NO

GU:
A BURNING SENSATION WITH URINATION ..... YES / NO
BLOOD IN URINE (HEMATURIA) ..... YES / NO

EXT:
JOINT PAIN ..... YES / NO
JOINT SWELLING..... YES / NO

NEURO:
HEADACHES ..... YES / NO
NUMBNESS / WEAKNESS IN ARM / LEG ..... YES / NO
DIZZINESS ..... YES / NO
FIRST BEGAN? ..... _____
DURATION OR EACH EPISODE? _____
FREQUENCY OF EPISODES? _____
DESCRIBE ACTUAL SYMPTOMS WHEN DIZZY: _____
_____
_____

INTEG:
RASH ..... YES / NO
BRUISING ..... YES / NO

CV:
CHEST PAIN ..... YES / NO
SHORTNESS OF BREATH ..... YES / NO
HEART MURMUR ..... YES / NO
HEART PALPITATIONS..... YES / NO

PATIENT NAME: _____D.O.B._____

ALLERGY	*YES*	*NO*
HAVE YOU OR A CLOSE RELATIVE HAD A SERIOUS REACTION TO A LOCAL OR GENERAL ANESTHETIC?		
HAVE YOU TAKEN ANY "CORTISONE" OR STEROIDS IN THE LAST 6 MONTHS? (ORAL OR INJECTION)		

HEMATOLOGY / ONCOLOGY	*YES*	*NO*
HAVE YOU EVER BLED EXCESSIVELY FROM A TOOTH EXTRACTION, WOUND, OR FOLLOWING SURGERY?		
ARE YOU ANEMIC?		
ARE YOU A FREE BLEEDER?		
HAVE YOU EVER DEVELOPED HIVES IN COLD WEATHER?		
HAVE YOU EVER HAD A BLOOD TRANSFUSION?		
HAVE YOU EVER HAD CANCER? TYPE? _____		
HAVE YOU EVER HAD CHEMOTHERAPY?		

ENDOCRINE	*YES*	*NO*
IF FEMALE, COULD YOU BE PREGNANT?		
DO YOU HAVE PITUITARY OR ADRENAL DISEASE?		
HAVE YOU HAD PRIOR HEAD AND NECK RADIATION THERAPY?		

PSYCHIATRIC	*YES*	*NO*
ARE YOU BEING TREATED FOR DEPRESSION OR ANY OTHER MENTAL ILLNESS? NAME OF ILLNESS:_____		

IF COMPLETING FORM FOR A CHILD	*YES*	*NO*
WHEN FEEDING, DID FLUIDS REGURGITATE FROM THE NOSE DURING THE FIRST FEW YEARS?		
IS THERE A HISTORY OF A CLEFT LIP OR CLEFT PALATE IN THE CHILD OR ANY OTHER FAMILY MEMBERS?		

VACCINE	*YES*	*NO*
HAVE YOU RECEIVED A DOSE OF A COVID-19 VACCINE?		
IF YES, WHICH VACCINE PRODUCT DID YOU RECEIVE? ☐ PFIZER ☐ MODERNA ☐ JANSSEN (JOHNSON & JOHNSON)		

Do you have FAMILY MEMBERS with any of the following: (Please name relation; MOTHER, FATHER, ETC.)

_____ DIABETES _____ STROKE _____ CANCER

_____ASTHMA _____ALLERGIES _____MENIERES DISEASE

_____HEARING LOSS _____THYROID DISEASE _____HEART DISEASE

_____EXCESSIVE BLEEDING DURING OR AFTER SURGERY

SOCIAL HISTORY

Do you smoke? YES / NO Packs per day? _____ How long? _____ If No, when did you quit?_____

Do you use e-cigarettes? Yes / No How long? _____ If No, when did you quit?_____

Do you use smokeless tobacco? Yes / NO How long? _____ If No, when did you quit?_____

Do you drink alcohol? YES / NO Amount / Frequency?_____

Are you a student?_____ Grade?_____ What is your occupation? _____

SIGNATURE:_____ DATE:_____

LEGAL GUARDIAN (IF UNDER 18) _____ RELATION TO PATIENT: _____

HUNTSVILLE EAR, NOSE, AND THROAT PHYSICIANS, P.C.

Center for Ear and Sinus Care

Neeta Kohli-Dang, M.D., F.R.C.S. (C)
John R. LaFrentz, M.D., F.A.C.S.

Board Certified • Otolaryngology – Head and Neck Surgery
285 Chateau Dr., Huntsville, AL 35801
Phone: (256) 882-0165 • Fax: (256) 882-7846

AUTHORIZATION FOR TREATMENT AND MEDICAL INFORMATION RELEASE

The purpose of medical care is to treat disease, injury and disability by examination, testing and use of procedures in the aid of diagnosis or treatment, and also to obtain information needed in diagnosing and examining patients.

We cannot render services on the assumption that our charges will be paid by an insurance company. **However, as a courtesy to our patients, we will submit a claim to your insurance company and in doing so; the responsible party authorizes his/her insurance company to pay directly to the doctor and medical service provider.**

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. All bills are due and payable at the time services are rendered. Any other arrangements must be made in advance. We reserve the right to add a late charge on overdue balances and to add Collection fees to the balance should the account have to be placed with a Collection agency or other such service.

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or other health practitioners (including but not limited to the family doctor).

I acknowledge that I have read the above authorization/release.

_____/ _____ _____

Print Patient Name | Patient signature (parent if minor) | Date

Person Responsible for payment and co-pay_____

Relationship to patient_____

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Patient Name: _____ Date of Birth: _____

Please list anyone you give permission to have access to lab/test results, medical records, including appointment dates and times from your physician: (if none – please write "**NONE**")

_____

_____

If patient is a **minor**, please list anyone you give permission to **bring your child** to appointments or **act on your behalf**: (if none – please write **"NONE")**

_____

_____

I give my permission for Dr. Neeta Kohli-Dang or Dr. John R. LaFrentz and staff to call in prescriptions to the pharmacy listed below:

Pharmacy: _____

General Location: _____

There is a $10 fee for the completion of FMLA/Short term disability forms.
There is a $50 fee for missed appointments or cancelled with less than 24 hours' notice.
There is a $50 for in-office tests missed or cancelled with less than 48 hours' notice.

I hereby acknowledge that I have received a copy of the "Notice of Privacy Practices" adopted by Huntsville Ear, Nose, and Throat Physicians, P.C. I understand if I have any questions about the "Notice of Privacy Practices," I may contact the Practice Compliance Officer at (256) 882-0165.

_____ _____

Patient Signature or Legal Guardian Date

Revised 04/01/2022

HUNTSVILLE EAR, NOSE, AND THROAT PHYSICIANS, P.C.

NOTICE OF PRIVACY PRACTICES

Established Pursuant to the Health Insurance Portability and Accountability Act ("HIPAA")

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

Understanding Your Health Record/Information

Each time you visit Huntsville Ear, Nose and Throat Physicians, P.C. (or any hospital, physician, or other health care provider) a record of your visit is made. Typically this record contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care or treatment. This information, often referred to as your medical record, serves as a:

- Basis for planning your care and treatment with legal documentation describing the care you received
- Means of communication among health professionals who contribute to your care
- Means by which you or a third-party payer can verify that services billed were actually provided
- A tool in the education of health professionals and source of data for medical research
- A source of information for public health officials charges with improving the health of the nation
- A source of data for facility planning and marketing
- A tool we can assess and continually work to improve the care we render and outcome we achieve

Understanding what is in your record and how it is used, helps you to:

- Ensure its accuracy and make more informed decisions in authorizing disclosure to others
- Better understand who, what, when, where, and why others may access your health information

Your Health Information Rights

Although your health record is the physical property of the practitioner or facility that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information as provided by 45CFR 164.522; however, you must make such a request in writing
- Obtain a paper copy of the notice of privacy practices upon request
- Inspect and obtain a copy of your health record as provided for in 45CFR 164.524; however you must make such a request in writing and we have 30 days to respond
- Amend your health record as provided in 45CFR 164.526; however, you must make the request to amend your health record in writing and provide a reason for the requested amendment.
- Obtain an accounting of disclosures of your health information as provided in 45CFR 164.528; however, you must make such a request in writing
- Request communications of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information except when action has already been taken.

Our Responsibilities

Huntsville Ear, Nose and Throat Physicians, P.C. is required by law to:

- Maintain the privacy of your health information
- Provide you with a notice of our legal duties and privacy practices with respect to information we collect and maintain about you and abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post a copy of such changes and make a copy available to you upon request. We will not use or disclose your health information without your authorization, except as described in this notice.

For More Information or to Report a Problem

If you have questions or would like additional information, you may contact Compliance Officer at 256-882-0165. Our address is: Huntsville Ear, Nose and Throat Physicians, P.C., 285 Chateau Drive SW, Huntsville, Alabama 35801. If you believe your privacy rights have been violated, you can file a complaint with our Compliance Officer or with the Secretary of Health and Human Services. You may file a complaint with our compliance Officer by providing a written complaint at the address listed above. There will be no retaliation for filing a complaint.

Examples of Disclosures for Treatment, Payment, and Health Operations

We will use your health information for treatment

For example: Information obtained by a nurse, physician, or other member of your healthcare team will be recorded and used to determine the course of treatment that should work best for you. Your physician will document in your record their expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. This way, the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent healthcare provider who has or will be treating you (including, but not limited to, you family doctor, the physician who referred you to us, hospitals, other physicians or healthcare professionals involved in your treatment) with copies of certain or all of your records and reports that should assist them in treating you.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer (such as in insurance company, Medicaid, or Medicare). The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used. If requested by your third-party payer, we will provide them with access to your specific medical records in order to facilitate payment.

At the patient's written request, physicians may not disclose information about care the patient has paid for out-of-pocket to health plans, unless for treatment purposes or in the rare event the disclosure is required by law. Previously, while physicians could refuse to abide by any such request, the new rule *requires* physicians and other health care providers to abide by a patient's request not to disclose PHI to a health plan for those services for which the patient has paid out-of-pocket and requests the restriction.

We will use your health information for regular health operations.

For example: Members of our medical staff, employees of Huntsville Ear, Nose and Throat Physicians, P.C. and/or public health officials may use information in your health record to assess the care and outcome in your case.

Business Associates: There are services provided in our organization through contacts with business associates. Examples include physician services in the area of radiology, laboratory tests, dictation services, record storage facilities, and copy services. When these services are contracted, we may disclose your health information to our business associate to bill you or your third-party payer for services rendered. To protect your health information, we require the business associate to appropriately safeguard your information. Physicians no longer must report failures of their BAs to the government when termination of the agreement is not feasible, as HHS has concluded that the BA's direct liability for these violations is sufficient. BAs are now responsible for their subcontractors. BAs must comply with the Security and Breach Notification Rules. Physicians are liable for the actions of their BAs who are agents, but not for the actions of those BAs that are independent contractors.

Directory: Unless you notify us that you object, we may use your name, location in the facility, and general condition for directory purposes. This information may be provided to people who ask for you by name.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals (including our physicians and nurses), using their best judgment, may disclose to a family member, close personal friend or any other person that you identify, health information relevant to your care or payment related to your care.

Research: We may disclose information to researchers when their research is in compliance with all applicable laws and further in compliance with established protocols to ensure the privacy of your health information.

Funeral directors/Government Officials: We may disclose health information to funeral directors or government officials consistent with applicable law to carry out their duties.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Generally speaking, the only time a physician may tell a patient about a third-party's product or service without the patient's written authorization is when: 1) the physician receives no compensation for the communication; 2) the communication is face to face; 3) the communication involves a drug or biologic the patient is currently being prescribed and the payment is limited to reasonable reimbursement of the costs of the communication (no profit); 4) the communication involves general health promotion, rather than the promotion of a specific product or service; 5) the communication involves government or government-sponsored programs. Physicians are also still permitted to give patients promotional gifts of nominal value (e.g. pamphlet).

Sale of PHI: The new rules clarify that the prohibition on the sale of PHI in the absence of the patient's written authorization extends to licenses or lease agreements, and to the receipt of financial or in-kind benefits. It also includes disclosures in conjunction with research if the remuneration received includes any profit margin. On the other hand, the prohibition on PHI sales does not extend to permitted disclosures for payment or treatment nor to permitted disclosures to patients or their designees in exchange for a reasonable cost-based fee. (We do not sell PHI)

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers' Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to the workers' compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Correctional Institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Medical and Legal Review: We may disclose health information in connection with any review of your treatment by any medical or legal authority, including our attorneys. Such disclosure may include consultation with our legal counsel, and any such disclosures potentially in whole or in part would be subject to the attorney-client privilege as established by law.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena or request for medical records allowed under the laws of the State of Alabama.

Written Permission: If you execute any written document authorizing disclosure about and beyond that provided above, we may honor such request.

Breach notification requirements: The obligation to notify patients if there is a breach of their PHI is expanded and clarified under the new rules. Breaches are now presumed reportable unless, after completing a risk analysis applying four factors, it is determined, that there is a "low probability of PHI compromise." The physicians must consider **all** of the following four factors:

- the nature and extent of the PHI involved – issues to be considered include the sensitivity of the information from a financial or clinical perspective and the likelihood the information can be re-identified;
- the person who obtained the unauthorized access and whether that person has an independent obligation to protect the confidentiality of the information;
- whether the PHI was actually acquired or accessed, determined after conducting a forensic analysis; and
- the extent to which the risk has been mitigated, such as by obtaining a signed confidentiality agreement from the recipient.

Reports to oversight officials: Federal law makes provision for your heath information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

Effective Date: 10/10/2003 Revised 09/23/2013