Georgia Ear, Nose & Throat SPECIALISTS

Patient History & Physical

Today's Date: _____

Patient Name: _____ Age: _____
Last First Middle

What is the reason for today's visit? _____

Date symptoms first started: _____ Was this job-related? ☐ Yes ☐ No

Primary Care Physician: _____ Who may we thank for referring you? _____

Have x-rays been made? _____ Where and When? _____

Please list any medical problems you have: _____

_____

_____

Past Hospitalizations and/or Surgeries: _____

_____

Family History: (Check all that apply)

☐ Heart Disease ☐ Diabetes ☐ Bleeding Disorders

☐ High Blood Pressure ☐ Problem w/anesthesia ☐ Cancer (Type: _____)

☐ Other: _____

Drug allergies: (Please check one) ☐ Yes ☐ No If Yes, please list: _____

Current Medications	Dose	Current Medications	Dose

Pharmacy Name: _____ Address: _____

City: _____ State: _____ Phone Number: _____

Do you smoke? (check one) ☐ Yes ☐ No If Yes, how much? _____ How many years? _____

Do you drink alcohol? (check one) ☐ Yes ☐ No If Yes, how much? _____

Please check any box below to indicate whether you have had, or are currently having, any of these problems:

☐ Headaches ☐ Double vision ☐ Blocked nose ☐ Asthma ☐ Hayfever ☐ Shortness of Breath ☐ Stomach pain ☐ Ulcers ☐ Nausea	☐ Vomiting ☐ Blood in stools ☐ Pain on urination ☐ Chest pain ☐ Heart murmur ☐ High blood pressure ☐ Diabetes ☐ Arthritis	☐ Reaction to anesthesia _____ Does anyone in your family? ☐ Weight loss ☐ Fever ☐ Chills	☐ Difficulty swallowing ☐ Pain on swallowing ☐ Hoarseness ☐ Coughing up blood ☐ Earache	☐ Bleed or bruise easily _____ Does anyone in your family? ☐ Seizures ☐ Recent Trauma

Have you taken any aspirin in the last two weeks? ☐ No ☐ Yes If yes, when? _____

Have we ever seen any other member of your family? ☐ No ☐ Yes If yes who? _____

Patient Information

Patient Name:_____ Social Security #:_____

Address:_____ Occupation:_____

Mailing Address:_____ Employer:_____

City, State:_____ ZIP:_____ Work Address:_____

Home Phone #:_____ City, State:_____ ZIP:_____

Cell #:_____ Work Phone #:_____

Date of Birth:_____/_____/_____ Age:_____ Sex:_____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Race:_____ Primary Language:_____ Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Email Address:_____ Do you want email updates? ☐ Yes ☐ No

Responsible Party (If different from patient) ~ Parent or guardian if patient is a minor

Name:_____ Social Security #:_____ Date of Birth:____/____/____

Address:_____ Occupation:_____

Mailing Address:_____ Employer:_____

City, State:_____ ZIP:_____ Work Address:_____

Home Phone #:_____ Cell #:_____ City, State:_____ ZIP:_____

Email Address:_____ Work Phone #:_____

Spouse or Other Parent

Name:_____ Social Security #:_____ Date of Birth:____/____/____

Address:_____ Occupation:_____

Mailing Address:_____ Employer:_____

City, State:_____ ZIP:_____ Work Address:_____

Home Phone #:_____ Cell #:_____ City, State:_____ ZIP:_____

Email Address:_____ Work Phone #:_____

Insurance Information: (Please allow receptionist to copy cards)

Primary Insurance:_____ Policy #:_____

Name of Policy Holder:_____ Group #:_____

DOB:____/____/____ S.S. #:_____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other:_____

Secondary Insurance:_____ Policy #:_____

Name of Policy Holder:_____ Group #:_____

DOB:____/____/____ S.S. #:_____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other:_____

Emergency Contact Name:_____ Phone #(s):_____ Relationship:_____

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Financial Policies

Financial Agreement

I hereby agree to pay for all office visits at the time services are rendered unless I make arrangements in advance. If hospitalization is necessary, I understand that payment is due upon receipt of statement indicating the balance is due and payable by me. I also understand that insurance does not relieve me of the responsibility to pay.

Authorization to Release Information

I hereby authorize Georgia Ear, Nose & Throat Specialists to furnish my insurance company(s), hospital, referring physicians, and attorneys all information with regard to my medical care. This may include information related to HIV, substance abuse, sexually transmitted diseases, or psychiatric treatment.

Authorization for Assignment of Benefits

I hereby authorize payment directly to Georgia Ear, Nose & Throat Specialists surgical and/or medical benefits, if any, otherwise payable to me under the terms of my insurance.

Authorization for Medicare Benefits

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Georgia Ear, Nose & Throat Specialists for any services furnished by the physician/supplier. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents to determine these benefits payable to related services.

I understand my signature request that payment be made authorized and release of medical information necessary to pay the claim. If items 9 or HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge; I am responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductibles are based upon charge determination of the Medicare carrier.

Champus Release

I request that payment of authorized benefits be made either to me or on behalf to Georgia Ear, Nose & Throat Specialists for any services furnished by that physician. I authorize any holder of medical information about me to be released to Champus and its agents to determine the benefits payable for related services.

Cancellation and No Show Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. It is therefore requested that if you must cancel your appointment you provide 24 hours notice. Office appointments which are cancelled with less than 24 hours notification may be subject to a $25 cancellation fee. Patients who do not show up for their appointment without a call to cancel will be considered a NO SHOW. Patients are subject to a $25 fee for office appointment No Show and $100 Surgical Procedure No Show fee. This fee is the sole responsibility of the patient and must be paid in full before the patient's next appointment. We understand that Special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

Signature: _____ **Date:** _____ **Time:** _____

Georgia Ear, Nose & Throat SPECIALISTS

Managed Care mandates that you use in-network physicians, hospitals, labs and services in order to receive in-network payment.

Failure to notify your provider of in-network requirements will result in nonpayment or penalty of payment by your insurance company and will result in your being billed for services rendered.

If referral numbers and/ or authorization for services requests are required by your plan, please notify this office prior to and services being rendered so that you will not be penalized. It is your responsibility to obtain referral numbers and/ or authorization from your primary care provider.

Please check your INSURANCE Company's preferred place of service.

Hospital:

☐ **Memorial Health University Medical Center**

☐ **St. Joseph's/ Candler Health System**

Labwork:

☐ **Quest**

☐ **Memorial Hospital Laboratory**

☐ **Lab Corp (BCBS, HMO, POS)**

☐ **St. Joseph's/ Candler**

If you are unable to provide us with this information before you leave, we will send your labs to the most cost effective laboratory. This may NOT be the lab your insurance company prefers or will pay for.
I have read the above information and I understand that I am responsible for bills that may arise due to inaccurate information given at this time.

Patient Signature: _____

Date of Birth: _____

Today's Date: _____

Georgia Ear, Nose & Throat SPECIALISTS

PATIENT RECORD OF DISCLOSURES

In general, HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of protected health information (PHI). The individual is also provided the right to request confidential communications of PHI by alternative means, such as sending correspondence to the individual's office instead of their home.

I wish to be contacted in the following manner:

(check all that apply):

☐ **Work Telephone**
- ☐ o.k. to leave message with detailed information
- ☐ leave message with call-back number only

☐ **Home Telephone**
- ☐ o.k. to leave message with detailed information
- ☐ leave message with call-back number only

☐ **Written Communication**
- ☐ o.k. to mail to my home address
- ☐ o.k. to mail to my work/office
- ☐ o.k. to fax to this telephone number: _____

☐ **Email Address:** _____

You may leave messages with, discuss my treatment, appointments or other scheduling that may occur or give other information as necessary with the following family, friends or personal representatives. You may release a copy of my medical records to the person(s) listed below. I understand that Georgia Ear, Nose & Throat Specialists will refuse to discuss my information with anyone not listed below, except in an emergency. I also understand that this consent does not apply to medical providers.

PLEASE PRINT

1. _____
2. _____
3. _____
4. _____
5. _____

Patient's signature: _____ **Date:** _____

Please print name: _____

Acknowledgment of Receipt of Privacy Notice

I have been presented with a copy of Georgia Ear, Nose & Throat Specialists Notice of Privacy Practices, detailing how information may be used and disclosed as permitted under federal and state law.

Signed: _____ **Date:** _____

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship: _____ Witnessed by: _____

(FOR GEORGIA EAR, NOSE & THROAT SPECIALISTS)

If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient and sign here:

Presented by: _____
(name & title)

Date: _____ Time: _____