Atlanta Institute for ENT

5670 Peachtree Dunwoody Road, Suite 1280
Atlanta GA, 30342
404-257-1589

New Patient Information

First Name_____ Middle Initial_____ Last Name_____

Address_____

City_____ State_____ County_____ Zip Code_____

Home Phone #_____ Work Phone #_____ Cell Phone #_____

Social Security #_____ Date of Birth_____ Sex ❑ Male ❑ Female

Email_____ Employer_____ Marital Status_____

Primary Care Provider_____ Referring Doctor_____

Primary Insurance

Insurance Company_____ Employer_____

Effective Date_____ Expiration Date_____

Name of Subscriber_____ Certification #_____

Group Name_____ Group #_____ Policy Phone #_____

Guarantor Relation to Patient_____ Subscriber Date of Birth_____

Secondary Insurance

Insurance Company_____ Employer_____

Effective Date_____ Expiration Date_____

Name of Subscriber_____ Certification #_____

Group Name_____ Group #_____ Policy Phone #_____

Guarantor Relation to Patient_____ Subscriber Date of Birth_____

Additional Information

Race_____ Are you Hispanic or Latino? ❑ Yes ❑ No

(The above questions are required for federal reporting purposes only)

Emergency Contact Name_____ Emergency Contact Phone #_____

Emergency Contact Relationship to Patient_____

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Pharmacy Information

Please list what pharmacy would you like to have on file:

(Name) (Phone/Address)

_____

Past Medical History

Please list all past or active medical history below: (If none, please check box ❑)

(Condition/Disease) (Year)

_____ _____

_____ _____

_____ _____

_____ _____

Ear, Nose & Throat

Allergy Issues ❑ Yes ❑ No
Hearing Loss ❑ Yes ❑ No
Ménière's Disease ❑ Yes ❑ No
Snoring/Sleep Apnea ❑ Yes ❑ No
Other_____

Respiratory

Asthma ❑ Yes ❑ No
Emphysema ❑ Yes ❑ No
Pneumonia ❑ Yes ❑ No
Other_____

Liver Problems

Liver Disease ❑ Yes ❑ No
Hepatitis ❑ Yes ❑ No
Other_____

Cardiopulmonary

Heart Attack ❑ Yes ❑ No
Stroke ❑ Yes ❑ No
Heart Disease ❑ Yes ❑ No
High Blood Pressure ❑ Yes ❑ No
Other_____

Bleeding/Oncology

Thyroid Cancer ❑ Yes ❑ No
Easy Bleeding/Bruising ❑ Yes ❑ No
Frequent Infections ❑ Yes ❑ No
Other_____

Neurology Problems

Seizures ❑ Yes ❑ No
Depression ❑ Yes ❑ No
Weakness ❑ Yes ❑ No
Schizophrenia ❑ Yes ❑ No
Other_____

Allergies

Do you have any known medication allergies? ____No ____yes

If you indicated YES Please list medications (including over-the-counter) that you have had adverse reactions to

(Medication) (Reaction)

_____ _____

_____ _____

_____ _____

Immunizations- please check all that apply

❑ Hepatitis B ❑ Diphtheria, Tetanus, Pertussis (DTP) ❑ Oral Polio Vaccine (OPV) ❑ MMR ❑ HIB

❑ EIPV ❑ Other_____

The above information is true and accurate to the best of my knowledge.

Signature (Guardian if under 18 years of age):_____ Date:_____

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Family Medical History

Please list all family medical history: (If none, please check box ❑)

(Condition/Disease)	(Family Member Affected)

Social History

Any recent international travel? ❑ Yes ❑ No If yes, when? _____

Tobacco use? ❑ Yes ❑ No If yes, for how many years? _____ How many packs/day? _____

Alcohol Use? ❑ Yes ❑ No

Current Medications

Please list all medications that you are currently taking: (If none, please check box ❑)

(Name of Medication)	(Strength)	(# Taken)	(Doses/day)	(Reason)

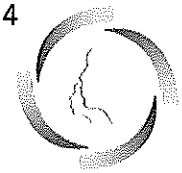
Please use the back of this page should you run out of space to write all of your current medications.

Gynecological History (Females)

Date of last menstrual period_____ # of Pregnancies_____ # of Deliveries_____

The above information is true and accurate to the best of my knowledge.

Signature (Guardian if under 18 years of age):_____ Date:_____



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Past Surgical History

Please list **all surgical medical history** below: **(If none, please check box ❑)**

(Name of surgery)	(Date)	(Complications if any)

Review of Symptoms – Please check all that apply.

General ❑ Fever ❑ Night Sweats ❑ Weight Loss >10 lbs (unintentional) ❑ Other

Skin ❑ Dryness ❑ Rash ❑ Other

Head and Neck ❑ Headache ❑ Head Injury ❑ Eye Pain ❑ Vision Loss ❑ Deafness ❑ Earache
❑ Ear Discharge ❑ Ear Infection ❑ Decreased Hearing ❑ Tinnitus (ringing or noise in ear)
❑ Dizziness ❑ Nasal Bleeding ❑ Runny Nose ❑ Sinus Pain ❑ Hoarseness
❑ Sore Throat ❑ Voice Changes ❑ Swollen Glands ❑ Other

Respiratory ❑ Cough ❑ Coughing Blood ❑ Coughing Mucus ❑ Wheezing ❑ Other

Cardiovascular ❑ Chest Pain ❑ Hypertension ❑ Heart Palpitations ❑ Shortness of Breath ❑Other

Gastrointestinal ❑ Difficulty Swallowing ❑ Nausea ❑ Vomiting ❑ Other

Neurologic ❑ Headache ❑ Tingling/Numbness ❑ Seizures ❑ Visual Changes ❑Weakness ❑ Other

Psychiatric ❑ Anxiety ❑ Depression ❑ Hypersomnia ❑ Insomnia ❑ Inability to Concentrate ❑ Other

Endocrine ❑ Cold Intolerance ❑ Heat Intolerance ❑ Hair Changes ❑ Other

Hematology ❑ Easy Bruising ❑ Enlarged Lymph Nodes ❑ Nasal Bleeding ❑ Prolonged Bleeding ❑ Other

Reason for Visit- Please let us know what brings you in today

The above information is true and accurate to the best of my knowledge.

Signature (Guardian if under 18 years of age):_____ Date:_____

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Medical Wellness Questionnaire

Hearing – Please mark the situations that sound familiar to you.

Do you often have to ask people to repeat what they said?	❑ Yes	❑ No
Do others say you turn up the volume of the television too loud?	❑ Yes	❑ No
When you are in a group or in a crowded place, is it difficult for you to follow the conversation?	❑ Yes	❑ No
Has someone close to you mentioned that you may have a problem with your hearing?	❑ Yes	❑ No
Do you have difficulty hearing on the phone?	❑ Yes	❑ No
Have you had a hearing test in the past 6 months?	❑ Yes	❑ No
Have you noticed a change in hearing since your last hearing test?	❑ Yes	❑ No

Allergy – Do you suffer from any of the following?

Sneezing, Nasal Congestions, Runny Nose	❑ Yes	❑ No
Sore Throat, Cough, Post Nasal Drip	❑ Yes	❑ No
Hives, Eczema, Food Intolerance	❑ Yes	❑ No
Itchy, Watery Eyes	❑ Yes	❑ No
Seasonal Symptoms	❑ Yes	❑ No

Sinus – Do you suffer from any of the following?

Headache (forehead, eyes or cheek)	❑ Yes	❑ No
Runny nose or dripping from the back of your nose into the throat	❑ Yes	❑ No
Persistent or recurrent symptoms despite taking antibiotics or nasal sprays	❑ Yes	❑ No
Difficulty breathing through nose or nasal congestion	❑ Yes	❑ No
Coughing, Sore Throat, Ear Symptoms, Teeth Pain	❑ Yes	❑ No
Symptoms lasting longer than 90 days or 4 or more episodes in a year	❑ Yes	❑ No

Sleep/Snoring – Do you have any of the following symptoms?

Snore Loudly	❑ Yes	❑ No
Been observed to stop breathing, choke, or gasp while sleeping	❑ Yes	❑ No
Feel Tired, Fatigued, or Sleepy during the daytime	❑ Yes	❑ No

Reason For Visit – Please let us know what brings you in today.

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Financial Consent

I hereby authorize Atlanta Institute for ENT PC (AIENT PC) 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 AIENT PC 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 in the event that 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.

Consent for Treatment: I hereby voluntarily consent to outpatient care at AIENT PC, encompassing routine diagnostic procedures, examination, and medical treatment including, but not limited to, routine laboratory work (such as blood, urine and other studies), endoscopy, CTs, 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, examination and rendering of medical treatment by the physicians and their assistants, 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.

Signature of Patient or Patient Representative	Date	Relationship to Patient

PBM Consent/Electronic Information Exchange

By signing this consent form, I am authorizing AIENT PC to request and use my prescription medication history from other health care providers and/or third party pharmacy payers 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/Marketing Emails: AIENT PC uses a third party appointment reminder and marketing email system to notify patients of their upcoming appointments and treatment options via email, text message and phone.

Signature of Patient or Patient Representative	Date	Relationship to Patient

Medicare Consent – applies to Medicare Beneficiaries ONLY

I certify that the information given by me in applying for payment under Title SVIII and/or Title XIX, of the Social Security Act, is correct. I authorize any holder of medical or other information about me to release 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.

Signature of Patient or Patient Representative	Date	Relationship to Patient

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Assignment of Benefits

Financial Responsibility: I have read, understand, and agree to AIENT PC's Financial Policy. I understand that charges not covered by my insurance company, as well as any applicable co-payments and deductibles are my responsibility. All professional services rendered are charged to the patient and are due at the time-of-service, unless other arrangements have been made in advance by either the patient or his/her health insurance carrier. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits: I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to AIENT PC, affiliated companies or authorized billing agent for medical services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information: I hereby authorize AIENT PC to: 1.) Release any information necessary to insurance carriers regarding my illness and treatments; 2.) To process insurance claims generated in the course of examination or treatment; and 3.) To allow photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

I have requested medical services from AIENT PC on behalf of myself and/or my dependent(s), and understand that by making this request that I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I understand that I will be responsible for any court costs or collection fees should it become necessary to take action to collect for services/supplies rendered.
I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in-full and immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Request for Summary Plan Description: ERISA grants a plan beneficiary/participant the right to require the plan administrator to provide certain specified documents by making a written request. This right is granted by 29 U.S.C. 1024(b)(4) which provides as follows:

The administrator shall, upon written request of any participant or beneficiary, furnish a copy of the latest updated summary, plan description, and the latest annual report, any terminal report, the bargaining agreement, trust agreement, contract, or other instruments under which the plan is established or operated.

A plan administrator's failure to provide this information within 30 days results in a cause of action in favor of the beneficiary/participant against the administrator for the recovery of a penalty of up to $110 per day for each day of noncompliance. 29 U.S.C. 1132(c)(1)(B). The statute sets the amount at $100 per day, but a federal regulation, 29 CFR § 2575.502c-1, effective August 1999, authorizes up to $110 per day

By signing below, I request that a copy of all contracts of which I participate for health care coverage, including but not limited to, Summary Plan Descriptions, Summary Benefit Descriptions, Insurance Contracts, Health Insurance Contracts, Amendments to Plan Documents for the current benefit plan year be mailed directly to: Atlanta Institute for ENT at 5670 Peachtree Dunwoody Road NE, Suite 1280, Atlanta, GA 30342. I am requesting this information be sent directly to my provider's office, pursuant to my rights under ERISA.

Signature of Patient or Patient Representative	Date	Relationship to Patient

Consent Forms Acknowledgement

Consent Forms Acknowledgement: I, the patient, hereby have read and understand the following:

Financial Consent, Message Consent, & Consent for Treatment
PBM Consent & Electronic Information Exchange
Medicare Consent (if applicable)

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

In addition, I have been given the opportunity to review AIENT's Privacy Policy. It will be made available to me upon request at the front desk.

[illegible] of Patient or Patient Representative	Date	Relationship to Patient

Atlanta Institute for ENT
5670 Peachtree Dunwoody Road, Suite 1280
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Notice of Privacy Practices

ATLANTA INSTITUTE FOR ENT PCs NOTICE OF PRIVACY PRACTICES

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.

I. Our Duty to Safeguard Your Protected Health Information:

We understand that medical information about you is personal and confidential. Be assured that we are committed to protecting that information. We are required by law to maintain the privacy of protected health information and to provide you with this Notice of our legal duties and privacy practices with respect to protected health information. We are required by law to abide by the terms of this Notice, and we reserve the right to change the terms of this Notice, making any revision applicable to all the protected health information we maintain. If we revise the terms of this Notice, we will post a revised notice and make paper and electronic copies of this Notice of Privacy Practices for Protected Health Information available upon request. We are required by law to notify you in the event of a breach of your protected health information.

In general, when we release your personal information, we must release only the information needed to achieve the purpose of the use or disclosure. However, all of your personal health information that you designate will be available for release if you sign an authorization form, if you request the information for yourself, to a provider regarding your treatment, or due to a legal requirement. We will not use or sell any of your personal information for marketing purposes without your written authorization.

II. How We May Use and Disclose Your Protected Health Information:

For uses and disclosures relating to treatment, payment, or health care operation, we do not need an authorization to use and disclose your medical information:

For treatment: We may disclose your medical information to doctors, nurses, and other health care personnel who are involved in providing your health care. We may use your medical information to provide you with medical treatment or services. For example, your doctor may be providing treatment for a heart problem and need to make sure that you do not have any other health problems that could interfere. The doctor might use your medical history to determine what method of treatment (such as drug or surgery) is best for you. Your medical information might also be shared among members of your treatment team, or with your pharmacist(s). To obtain payment: We may use and/or disclose your medical information in order to bill and collect payment for your health care services or to obtain permission for an anticipated plan of treatment. For example, in order for Medicare or an insurance company to pay for your treatment we must submit a bill that identifies you, your diagnosis, and the services provided to you. As a result, we will pass this type of heath information on to an insurer to help receive payment for your medical bills. For health care operations: We may use and/or disclose your medical information in the course of operating our practice. For example, we may use your medical information in evaluating the quality of services provided, or disclose your medical information to our accountant or other professionals for audit purposes.

In addition, unless you object we may use your health information to send you appointment reminders or information about treatment alternatives or other health –related benefits that may be of interest to you. For example, we may look at your medical record to determine the date and time of you next appointment with us, and then send you a reminder or call to help you remember the appointment. Or, we may look at your medical information and decide that another treatment or a new service we offer may interest you.

We may also use and/or disclose your medical information in accordance with federal and state laws for the following purposes:

We may disclose your medical information to law enforcement or other specialized government functions in response to a court order, subpoena, warrant, summons, or similar process.
We may disclose medical information when a law requires that we report information about suspected abuse, neglect, or domestic violence, or relating to suspected criminal activity, or in response to a court order. We must also disclose medical information to authorities who monitor compliance with these privacy requirements.
We may disclose medical information when we are required to collect information about disease or injury, or to report vital statistics to the public health authority. We may also disclose medical information to the protection and advocacy agency, or another agency responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.
We may disclose medical information relating to an individual's death to coroners, medical examiners or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.
In certain circumstances, we may disclose medical information to assist medical research.

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Notice of Privacy Practices

In order to avoid a serious threat to health or safety, we may disclose medical information to law enforcement or other persons who can reasonably prevent or lessen the threat of harm, or to help with the coordination of disaster relief efforts.
If people such as family members, relatives, or close personal friends are involved in your care or helping you pay medical bills, we may release important health information about you to those people. We may also share medical information with these people to notify them about your location, general condition, or death.
We may disclose your medical information as authorized by law relating to workers' compensation or similar programs.
We may disclose your medical information in the course of certain judicial or administrative proceedings.

Other uses and disclosures of your medical information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you provide permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our record of the care that we provided you.

III. Your Rights Regarding Your Medical Information:

You have several rights with regard to your health information. If you wish to exercise any of these rights, please contact our Privacy Officer at 404-257-7215. Specifically, you have the following rights:

You have the right to ask that we limit how we use or disclose your medical information. You have the right to ask that we send you information at an alternative address or by an alternative means. We will consider your request, but are not legally bound to agree to the restriction. We will agree to your request as long as it is reasonably easy for us to do so. To request confidential communications, you must make your request in writing to our medical records department. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted.

You have the right to restrict disclosure of medical information to a health plan in the event that you have paid out of pocket in full for such service or healthcare item.
With a few exceptions (such as psychotherapy notes or information gathered for judicial proceedings), you have a right to inspect and copy your protected health information if you put your request in writing. If we deny your access, we will give you written reasons for the denial and explain any right to have the denial reviewed. We may charge you a reasonably fee if you want a copy of your health information. You have a right to choose what portions of your information you want copied and to have prior information on the cost of copying.
If you believe that there is a mistake or missing information in our record of your medical information you may request that we correct or add to the record. Your request must be in writing and give a reason as to why your health information should be changed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your medical information. If we approve the request for amendment, we will amend the medical information and so inform you.
In some limited circumstances, you have the right to ask for a list of the disclosures of your health information we have made during the previous six years. The list will not include disclosures made to you; for purposes of treatment, payment or healthcare operations, for which you signed an authorization or for other reasons for which we are not required to keep a record of disclosures. There will be no charge for such list in each 12-month period. There may be a charge for frequent requests.
You have a right to receive a paper copy of this Notice and/or an electronic copy from our Web site. If you have received an electronic copy, we will provide you with a paper copy of the Notice upon request.

IV. How to Complain about our Privacy Practices:

If you want more information about our privacy practices or have questions or concerns, we encourage you to contact us.
If you think we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, we encourage you to speak or white to our Privacy Officer. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services at the Office for Civil Rights Region IV office. We will provide the mailing address at your request.

We support your right to the privacy of your health information.
If you have questions about this Notice or any complains about our privacy practices, please contact our Privacy Officer, either by phone or in writing at:
AIENT Privacy Officer, 5670 Peachtree Dunwoody Road NE, Suite 1280, Atlanta, GA 30342, 404-257-1589

Signature of Patient or Patient Representative	Date	Relationship to Patient

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Authorization for Release of Information

Patient Name: _____ Date of Birth: _____

Many of our patients allow family members such as their spouse, parents, children or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's written consent. If you wish to have your medical and/or billing information released to family members you must sign this form. Signing this form will only give information to the individuals indicated below.

I authorize Atlanta Institute for ENT to release my medical and/or billing information to the following individuals:

1. _____ Relation to Patient: _____
2. _____ Relation to Patient: _____
3. _____ Relation to Patient: _____

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient.

You have the right to revoke this consent in writing.

Patient Signature: _____ Date: _____