NEW Patient Form

PATIENT NAME: Last__________________________ **First**________________**MI**_____________________________
Date of Birth_____/____/_____ **Age**__________ **□Female □Male** **Last 4-SSN:** ________
Marital Status: □S □M □D □W Race: _____________ Ethnicity: ___________ Language: ________________
Address____
City____________________________ State___________ Zip___________ County______________________________
Home Phone__________________ Day Phone _____________________ Cell______________________________________
Phone____ Email_____________________________________
Name of Spouse/ Parent / Legal Guardian ____________________________DOB_________ SSN__________________
Which Provider are you seeing today? □Dr. Aaron Fletcher □ PA Lindsey Parks ____________________________
Name & Address of Primary Care (Family) Physician/Pediatrician ____
Referring Physician Name and Address (If different) ____

Employer_________________________________ Employer Address_____________________________________
What is your occupation?____ Retired? □ Yes □ No

□Check if self and skip section
Responsible Party Name: Last__________________ First_________________ MI__________ DOB: ___/____/_____
□Male □Female Patient's relationship to Policyholder □Spouse □Child □Other____________
Home Phone (____) _____-_________ Work Phone (____) _____-_________ Ext._______
Street Address____
Zip Code: ____________________ City______________________________ State_____________________________

Primary Insurance Co.____ Policy Holder______________________________
Policy ID #____ Group No. (if applicable) _________________________
Ins. Co. Address____ Ins Co. Phone number______________________
Secondary Insurance Co.____ Policy Holder_______________________________
Policy ID #____ Group No. (if applicable) _________________________
Ins. Co. Address____ Ins Co. Phone number______________________
Is this visit covered by workers comp?______ No fault? _______Claim #________________Date of Injury? __________
If yes, who is your workers comp adjuster and contact?______________________ Adjuster's Phone ________________

PAYMENT OF ALL CO-PAYMENTS, DEDUCTIBLES, AND ANY OTHER PATIENT RESPONSIBILITY FEES ARE DUE WHEN SERVICES ARE RENDERED. IF YOU HAVE A QUESTION ABOUT FEES, PLEASE CHECK WITH US.

I WILL BE PAYING BY □ Cash □Check □Credit Card

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Georgia Center for ENT & Facial Plastic Surgery to diagnose and treat me. I also authorize Georgia Center for ENT & Facial Plastic Surgery to release medical and/or any other information to my insurance carrier, and/or Centers for Medicare and Medicaid Services or its intermediaries or carriers, any information needed for payment on Medicare/Insurance Company Claims for services rendered by Georgia Center for ENT & Facial Plastic Surgery and/or its physicians/providers. I permit a copy of this authorization to be used in place of the original, and request assignment of payment of medical insurance benefits either to Georgia Center for ENT & Facial Plastic Surgery and/or its physicians/providers. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for treatment. (Section 1128B of the SS Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information). I have also been informed of my rights to privacy via posters and handouts contained within this office as mandated under the current federal HIPAA laws. I also acknowledge receipt and understanding of the Georgia Center for ENT & Facial Plastic Surgery Financial Policy and Patient Notification for Payer Payment Policies for Certain In-Office Procedures

____ ___________________________
Patient or Legal Guardian Signature (if patient under 18 years old) **Date**

Patient Confidentiality/HIPPA Acknowledgement

Georgia Center for ENT & Facial Plastic Surgery follows HIPAA guidelines to ensure the integrity of your privacy. I, ________________________ acknowledge that **Georgia Center for ENT and Facial Plastics**, has made their Notice of Privacy Practices available for my view in the waiting room. This notice describes how **Georgia Center for ENT and Facial Plastic**, may use and disclose my (or my child's) healthcare information. Certain restrictions on the use and disclosure of my (or my child's) healthcare information, and my rights that I may have regarding my (or my child's) protected health information. We need your help in ensuring your privacy by providing us with the following information. In the event that I, ___________________ cannot be reached personally, Georgia Center for ENT may leave any diagnoses, test results, lab results, appointment information, or other confidential medical or financial information to the following designated individuals:

Name	Relationship to Patient	Date of Birth (mm/dd)	Contact Phone	Emergency Contact Yes/No

□Do not release my information to anyone

Release of your protected health information (PHI) to anyone other than the patient or parent/legal guardian will be restricted to those individuals listed above or individuals otherwise listed on the Notice of Privacy Practices.

This **Release of Information** will remain in effect until the termination by me in writing.

Please Call □ My home □My Work □My cell phone □Other: ___________________

If Unable to reach me:

□ You may leave a detailed message

□ Please leave a message asking for me to return your call

□____

The best time to reach me is (day)______________________________ between (time) _____________________

Patient Consent for the Use of Email Communication & Photography Release

To better serve our patients, Georgia Center for ENT allows patients to communicate with the staff via email. Email should only be used for routine matters that do not require an immediate response. **Should you require urgent or immediate attention, email is not appropriate.** We strive to respond to all email communication within two business days if a response is not received within the expected timeframe, please call our office for immediate assistance.

When communicating via email, **please put the purpose of your message in the subject line** so that we may process it more efficiently. **Also, be sure to include your name and return phone number in the body of your message.** We also ask that you acknowledge receipt of emails coming from our office. All email communications related to your health and treatment may be filed in your medical record. Georgia Center for ENT is not liable for improper disclosure of information or breaches of confidentiality caused by the patient (i.e. printing or forwarding emails), third parties or technical factors beyond the practices control. In addition, Georgia Center for ENT has no control over the security or management of third-party email systems, if used. The patient understands and agrees that Georgia Center for ENT will make its best effort to minimize the risk of confidentiality breaches for factors within its control, but cannot guarantee the unencrypted information will not be intercepted, altered, or read by an unintended recipient.

□yes □ No **Georgia Center for ENT & Facial Plastic can send me emails with exclusive offers and updates**

Photographs are an important part of your medical record and may be taken before, during and after a procedure. Photographs can be used in any print or broadcast media, including, but not necessarily limited to newspapers, pamphlets, educational films, internet and television. Photographs are used for the education of future patients, professional clinical presentations and medical journals.

Please initial the following:

_____I understand and agree to the above email policy. I understand that the Georgia Center for ENT is not responsible for information loss or delay, or for breach of confidentiality, due to technical factors beyond the practice's control. I am agreeing that Georgia Center for ENT may send medical related correspondence to me via email, and may respond to my emails via email.

_____I consent to having my photographs used in any print or broadcast media, including, but not necessarily limited to newspapers, pamphlets, educational films, internet and television.

Patient Signature ____ **Date** __________________________

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name: ____________________________ Patient DOB:_________________

Patient's Phone #: ____________________________ Today's Date:_________________

Street Address: ____

City: _______________________________ State: ____________ Zip: ___________________________

I hereby authorize (please list physician name and/or facility) to release my records to Georgia Center for ENT & Facial Plastic Surgery. Records can be faxed to: 678-815-1548. This form also serves as authorization for Georgia Center for ENT & Facial Plastic Surgery to request medical records on my behalf from relevant medical providers/facilities not specifically listed below. Examples may include but are not limited to: Referring Provider, PCP, other ENT, Audiology, Sleep Study Specialists, Hospital Records where relevant imaging/procedures were performed.

Facility Name:___________________________ Physician's Name: _______________________________

Phone Number:__________________________ Fax: ____

Address____

City: ____________________________ State:___________ Zip code:________________________

______ All Records ________ CT/Ultra Sound _________ Sleep Study: _______ Audio Testing

________ Labs ___________ Surgery OP-Notes & Pathology

I understand that I may revoke this consent at any time, except where information has already been released. This authorization is valid for a sixty (60) day period from the date it is signed.

Signature:______________________________ Date________________________

Financial Agreement

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at this time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

We will request a photocopy of your insurance card and photo for your file.

- **Appointments** -A 48-hour notice must be provided in the event you cannot keep an appointment. Should you not provide this notice; a cancellation fee of $25 will then be added to your account.
- **In-office Procedures Include:**
  - **Flexible Laryngoscopy:** This procedure involves passing a long thin flexible fiber optic scope through the nasal cavity and into the throat. The fiber optic scope enables the provider to visualize areas of the throat not readily seen using the laryngeal mirrors.
  - **Nasal Endoscopy:** This procedure uses the flexible or rigid scope attached to a light source to view area of the nasal cavities that cannot be viewed by the provider using the standard nasal speculum and head mirror
  - **Nasal Endoscopy with debridement or biopsy:** This is the same procedure as above with the removal of crusting or tissue.
  - **Other procedures include:** Tympanogram, CT scan, Balloon Sinuplasty, Inferior Turbinate reduction, Septoplasty
- **Surgery -** Insurance will be verified including deductible and coinsurance prior to your pre-operative surgical visit. A deposit will be required if insurance benefits are assigned to the doctor due to individual policy deductible and percentage of coverage. Payment in full is required in advance if insurance benefits are not assigned or if no insurance. Any overpayment will be promptly refunded to the patient/guardian or insurance company. Other financial arrangements may be discussed with our Billing Specialist.
- **Surgery Rescheduling/Cancellation –** Due to frequent re-scheduling and or cancellations of surgeries, it has become necessary to apply an administrative fee for surgery changes. A patient who reschedules or cancels surgery with less than 48 hours' notice for any reason other than a medical condition or death in the immediate family will be charged $150 which will not be applied toward surgical fees and it's nonrefundable.
- **Referrals –** If your plan requires a referral from your primary care physician, it **is your responsibility to obtain it prior to your appointment** and have it with you at the time of your visit if you do not have your referral, we will gladly reschedule your appointment for you so that you may obtain it.
- **Co-Payments -** By law we must collect your carrier designated copayment. This payment is expected at the time of service. Please be prepared to pay the copayment at each visit.
- **Self-Pay patients –** For patients who are not using insurance for their office visit, $150 fee will be due at check-in.
- **Medicare –** We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% coinsurance, which can be billed to a secondary insurance if you have one. Medicare Lifetime signature on file: I request a payment of authorized Medicare benefits be made on my behalf to Georgia Center for ENT for any services furnished to me. I authorize any holder of medical information about me to release to the CMS and its agents any information to determine these benefits payable for related services. This information will be used for the purpose of evaluating and administering claims of benefits.
- **Collection Fees, Bank Fees and Credit Reporting –** Accounts more than 60 days old are subject to a monthly administrative fee not to exceed $10 per month. Accounts 90 days old are subject to being sent to an outside collection agency and reporting to the credit bureau. In addition, banks charge a fee for checks that do not clear or cannot be cashed. You agreed to be liable for all such fees with a minimum charge of $35.
- **Insurance Claims –** If applicable we will submit claims to your insurance carrier. You agree to allow our practice to "accept assignment" of benefits and receive payment directly from your insurance company. In the event your insurance company carrier does not make that payment prompt, you will guarantee payment for all charges herein occurred. In the event your insurer sends payment for a claim from our office to you directly, you agreed to endorse the payment to our practice in full for any amount due within 10 days of postmark.
- **Divorced Separated Parents of Minor Patients-** The parent who consents to the treatment of a minor child is responsible for payment of services rendered. Georgia Center for ENT will not be involved with the separation or divorce disputes.

I have read and understand the above terms and conditions and by my signature below, I attest that I fully understand each item and agree to the terms above.

Patient's/ Guardian's Signature:____ **Date:** _____________

Medical History

Mark if you have ever been diagnosed with ANY of the following:

□ ADD/ADHD
□ Alcoholism
□Allergies
□Alzheimer's disease
□Asthma
□Arthritis
□Blood disease
□Chronic Lung Disease
□CAD (Coronary Artery Disease)
□Cancer Type: ______________
□CVA (stroke)
□COPD
□Depression
□Developmental Delay
□Diabetes
□Ear infections (recurrent)
□GERD (acid reflux)
□Heart attack
□Heart disease
□Hearing deficiency
□Headaches/Migraines
□High blood pressure (HTN)
□Learning disability
□Mental Illness
□Migraines
□Nasal Polyps
□Obesity
□Osteoarthritis/osteoporosis
□Peripheral Vascular Disease (PVD)
□Renal Disease
□Seizure Disorder
□Sleep Apnea
□Strep throat/tonsillitis (recurrent)
□Skin disorder/rashes
□Tuberculosis
□Thyroid Disease
□Vertigo
□Other: ______________________

Social History

Do you consume alcohol? □Yes □No □Former How often? ________________________

Do you use tobacco? □Yes □No □Former Type: ________ How many years? ______ How many packs per day? ______

Exposed to secondhand smoke? □Yes □No

Any caffeine consumption? □Yes □No Type: _____________________ Amount per day: ________oz

Any recreational drug use? □Yes □No □Former How often? ________________________

Do you have a Pacemaker? □Yes □No

Do you have a Cardiologist (Heart Doctor)? □Yes □No If Yes Doctors Name/Facility Name______________________

Family History

Has a family member been diagnosed with any of the following:

□ ADD/ADHD
□ Alcoholism
□Allergies
□Alzheimer's disease
□Asthma
□Blood disease
□CAD (Coronary Artery Disease)
□Cancer Type: ______________
□CVA (stroke)
□Depression
□Developmental Delay
□Diabetes
□Hearing deficiency
□High blood pressure (HTN)
□Learning disability
□Mental Illness
□Migraines
□Obesity
□Osteoarthritis/osteoporosis
□Peripheral Vascular Disease (PVD)
□Renal Disease
□Seizure Disorder
□Skin disorder/rashes
□Thyroid Disease
□Other: ______________________

Medications: Please list ALL CURRENT medications (prescription, over the counter, or herbal)

Name	Dose	Frequency

★ **Pharmacy Name (include address and phone number): ____**

Surgeries

Year	Type of surgery	Reason	Hospital

Hospitalizations

Year	Reason	Hospital

Allergies

Allergy	Reaction

Current Symptoms: Please mark ALL that apply

General Symptoms
□Fatigue
□Fever
□Night sweats
□Weight loss
□Weight gain

Eye symptoms
□Double vision
□Itchy/watery eyes
□Redness

Ear symptoms
□Drainage
□Pain
□Sensation of room spinning
□Hearing loss
□Ringing noise
□Dizziness
□Itchiness

Allergy/Skin symptoms
□Hives
□Rash
□Itchy skin

Nose/Sinus symptoms
□Congestion
□Facial pain/pressure
□Mouth breathing
□Nose bleeds
□Sneezing
□Runny nose
□Post nasal drip/drainage

Mouth/Throat symptoms
□Difficulty swallowing
□Painful swallowing
□Snoring
□Hoarseness
□Sores/Ulcers in mouth

Heart/Circulation symptoms
□Chest pain
□Blacking out
□Swelling of Ankles/edema
□Irregular Heartbeat/palpitations

Lung/Respiratory symptoms
□Cough
□Shortness of breath
□Wheezing

Musculoskeletal symptoms
□Leg pain

Stomach symptoms
□Abdominal pain
□Nausea
□Vomiting
□Constipation
□Diarrhea
□Heartburn

Brain/Nervous system symptoms
□Headache
□Seizure
□Focal weakness
□Numbness

Glands/Hormone symptoms
□Heat intolerance
□Cold intolerance
□Neck enlargement/goiter

Blood/Lymph node symptoms
□Easy bleeding
□Easy bruising