Ear, Nose and Throat Surgery

Audiology - Hearing Aids

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Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with hoe your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this physician's office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this physicians office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2. The patient has a right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the request to revoke consent, but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purposes of treatment, payment and health care operations, this physician's office has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and Procedures.

_____	_____	_____
Name of Patient (Print)	Signature	Date

PATIENT INFORMATION FORM
(All Information Confidential)

PLEASE PRINT

WELCOME TO OUR OFFICE

Date_____

Name_____ Soc Sec # _____M_____F_____
Address_____ City _____ Zip Code_____
Date of Birth _____Age_____Preferred Phone Number_____Marital Status: M S D W
Race_____Spoken Language_____Ethnicity: ❑Hispanic, ❑Non-Hispanic, ❑Refused
Occupation_____ Employer _____ Telephone # _____
Address _____ City _____ Zip Code _____
Email Address _____ Do You Wish To Receive Appt Reminders Via Email? ❑Yes, ❑No
Spouse's Name _____ Spouses Employer/Address_____
_____ Ages of People Living With You _____
Emergency Contact (NOT LIVING WITH YOU): Name_____ Telephone # _____
Referred by: ❑PHYSICIAN ❑INDIVIDUAL ❑HOSPITAL ❑OTHER Name _____
Family Physician _____ Telephone #_____
Address_____ City _____ Zip Code_____

Pharmacy Name _____ Telephone # _____
Address _____ City _____ Zip Code _____

#1 PRIMARY INSURANCE (fill out only if you do not have card)
Name_____
ID#_____
Group # _____

#2 SECONDARY INSURANCE (if you do not have card)
Name _____
ID # _____
Group # _____

HEALTH SYSTEM REVIEW (Please circle no, or yes if currently a problem)

CONSTITUTIONAL	Fevers	Y	N	Weight Loss	Y	N	Anesthesia Problems	Y	N
EYES	Blurred Vision	Y	N	Double Vision	Y	N	Dry Eyes	Y	N
HEART	Chest Pain	Y	N	Irregular Heartbeat	Y	N	Mitral Valve Prolapse	Y	N
LUNGS	Cough	Y	N	Asthma	Y	N	Shortness of Breath	Y	N
DIGESTIVE	Heartburn	Y	N	Nausea	Y	N	Diarrhea	Y	N
SKIN	Rash	Y	N	Itching	Y	N	Dry Skin	Y	N
URINARY	Pain with Urination	Y	N	Frequent Urination	Y	N	Blood In Urine	Y	N
NEUROLOGIC	Headache	Y	N	Slurred Speech	Y	N	Muscle Weakness	Y	N
HEMATOLOGIC	Anemia	Y	N	Abnormal Bleeding	Y	N	Abnormal Bruising	Y	N
PSYCHOLOGICAL	Depression	Y	N	Anxiety	Y	N	Insomnia	Y	N

FAMILY HISTORY (involving your father, mother, brothers or sisters)

ALLERGY	Y	N	HEART DISEASE	Y	N	BLEEDING PROBLEMS	Y	N	THROAT CANCER	Y	N
SINUS	Y	N	DIABETES	Y	N	THYROID CANCER	Y	N	LYMPHOMA	Y	N
HEARING LOSS	Y	N	NEUROLOGIC	Y	N	ESOPHAGEAL CANCER	Y	N	MELANOMA	Y	N

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES TO ME INCLUDING THE BALANCE REMAINING AFTER PAYMENT OF INSURANCE BENEFITS
I HAVE COMPLETED THIS FORM FULLY AND COMPLETELY AND CERTIFY THAT THE PATIENT OR DULY AUTHORIZED REPRESENTATIVE COMPLETED THIS FORM

SIGNED_____ DATE_____

MEDICAL HISTORY FORM

NAME_____DATE_____AGE_____

REASON FOR TODAY'S VISIT(cc) _____

HEIGHT_____ WEIGHT_____

PAST MEDICAL HISTORY: (please circle yes or no and elaborate if necessary)

			DESCRIBE
HIGH BLOOD PRESSURE	Y	N	
HEART DISEASE	Y	N	
ASTHMA	Y	N	
COPD/EMPHYSEMA	Y	N	
ALLERGIES	Y	N	
CHRONIC BACK/NECK PAIN	Y	N	
KIDNEY DISEASE	Y	N	
GASTROINTESTINAL PROBLEMS	Y	N	
MIGRANE HEADACHES	Y	N	
STROKE/TIA/MINI STROKE	Y	N	
DEPRESSION/ANXIETY	Y	N	
NEUROLOGIC DISORDER	Y	N	
CANCER (list type/treatment/date)	Y	N	
DIABETES	Y	N	
THYROID DISEASE	Y	N	
VISION/EYE PROBLEMS	Y	N	
AUTOIMMUNE DISEASE	Y	N	
SERIOUS CHILDHOOD ILLNESS	Y	N	
OTHER			
RECENT OPERATIONS or PREVIOUS ENT SURGERY	Y	N	

CURRENT MEDICATIONS: (use back of form for additional, or attach list)

MEDICATION	DOSE	DIRECTIONS FOR USE	REASON FOR USE	DATE STARTED

ALLERGIES: (list medication and reaction) _____

TOBACCO USE: ❑ non-smoker, ❑ former smoker, ❑current smoker, ❑smokless tobacco

TYPE_____AMOUNT/DAY_____HOW MANY YEARS_____YEAR ENDED_____

ALCOHOL USE: Average amount daily _____ Heavier in Past? _____

RECREATIONAL DRUGS: Type_____ Current or Past _____

CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY/E-PRESCRIBING CONSENT FORM

By authorizing Dr. Lawrence Katin and/or Dr. Charles Gawthrop, you allow us to view your external prescription history via the RxHub service. This will provide the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my provider and staff here, and it may include prescriptions back in time for several years.

By signing this consent form you are agreeing that Dr. Lawrence Katin and Dr. Charles Gawthrop can request and use your prescription medication history from other healthcare providers and/or third party benefit payers for treatment purposes.

My signature certifies that I read and understand the scope of my consent and that I authorize access.

❑ I Accept ❑ I Refuse

_____ _____

Signature of Patient or Legal Guardian Date

_____

Print Patient's Name

_____

Print Legal Guardian, if applicable