Century Ear, Nose and Throat
Head and Neck Surgery

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GENERAL HISTORY

Patient Name: _____

DOB: _____ Sex: _____ If under 18, Guarantor: _____

Patient Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Social Security No. (last 4 digits) _____ Ht. _____ Wt. _____

Race: _____ Language: _____ Ethnicity: _____

E-mail address: _____

Primary Care Physician: _____ Referring Physician: _____

Pharmacy Name: _____ Pharmacy Location: _____

Emergency Contact:_____Phone:_____

MEDICATION ALLERGIES: _____ No known drug allergies _____

List any DRUG reactions and side effects experienced (e.g., shortness of breath, swelling, itching, hives, nausea, vomiting, diarrhea): _____
_____

List all **MEDICATIONS** you are taking or attach list (prescription and over-the-counter). None _____

Medication	Dosage	How often taken

FAMILY HISTORY Please check all that apply.

Bleeding disorder _____
Anesthesia reaction _____
Heart disease _____
High cholesterol _____
Environmental allergies _____
High blood pressure _____

Hearing loss _____
Diabetes _____
Asthma _____
Seizures _____
CVA (stroke) _____
Cancer _____ Type: _____

Other: _____

MEDICAL HISTORY Have you been diagnosed with any of the following? Please check all that apply.

Anemia _____
Anesthesia reaction _____
Asthma/COPD _____
Auto-immune disorder _____
Bleeding disorder _____
Cancer _____
Type: _____
CVA (stroke) _____
Diabetes _____
Environmental allergies _____
Gastroesophageal reflux _____
Heart disease _____
Hepatitis _____
High cholesterol _____
High blood pressure _____
HIV or AIDS _____
Joint replacement _____
Kidney disease _____
Liver disease _____
Pacemaker/defibrillator _____
Sickle cell disease _____
Sleep apnea _____
Seizures _____
Thyroid disease _____
Tuberculosis _____
No medical history _____ Other: _____

SURGICAL HISTORY Please check any EAR, NOSE or THROAT surgeries.

EAR
Ear tubes _____
Tympanoplasty (ear drum) _____
Mastoidectomy (mastoid) _____

NOSE
Septoplasty (deviated septum) _____
Rhinoplasty (nose reconstruction) _____
Turbinate reduction _____
Nasal polyp removal _____
Nasal fracture repair _____

SINUS
Balloon sinuplasty _____
Traditional sinus surgery _____

THROAT
Tonsillectomy _____
Adenoidectomy _____
Tracheostomy _____
Excision of neck mass _____
Tonsil/palate surgery _____
Laryngoscopy _____
Larynx (voice box) _____
Thyroid _____
Cleft lip/palate _____

Other: _____

SOCIAL HISTORY Please check all that apply.

Tobacco use? Yes _____ No _____ Former _____
Exposed to second hand smoke? Yes _____ No _____
Alcohol consumption? Occasional _____ Often _____ None _____
Recreational drug use? Yes _____ No _____

PEDIATRIC HISTORY Complete if patient is under 18.

Was patient born premature? Yes _____ No _____ If yes, number of weeks premature _____
Require intubation or oxygen after delivery? Yes _____ No _____
Was child breastfed? Yes _____ No _____ If yes, for how long _____
Has your child had any feeding/dietary problems? Yes _____ No _____
Any difficulties with growth or weight gain? Yes _____ No _____
Does child have noisy breathing? Yes _____ No _____
Has your child had any of the following delays? Walking _____ Learning _____ Talking _____
Does child live with: Mother _____ Father _____ Both Parents _____
Other: _____
Are immunizations current? Yes _____ No _____

FEMALES ONLY

Chance of pregnancy? Yes _____ No _____
Currently breastfeeding? Yes _____ No _____

HIPAA Notice of Privacy Practices
CENTURY EAR, NOSE, AND THROAT, HEAD AND NECK SURGERY

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment:
We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment:
Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations:
We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and abide by the same HIPAA Privacy standards as outlined in this Notice of Privacy Practice.

Other Permitted Uses and Disclosures Requiring Your Written Authorization

Unless noted above in our Use and Disclosures, all other permitted uses and disclosures of your protected health information will be made only with your consent, authorization or opportunity to object unless required by law. This includes:

- Most uses and disclosure of psychotherapy notes
- Uses and disclosure for marketing purposes
- Disclosures that constitute a sale of your protected health information.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form.

We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to receive a Breach Notification. You have the right to receive a notification upon a breach of any of your unsecured Protected Health Information.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT
CENTURY EAR, NOSE & THROAT – HEAD AND NECK SURGERY

I understand that under the Health Information Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____
PATIENT NAME OR LEGAL GUARDIAN (PRINT) DATE OF BIRTH

_____ _____
SIGNATURE DATE

_____ _____
I DECLINE TO SIGN DATE

_____
REASON FOR DECLINING TO SIGN

	Circle One
Test results may be left on my answering machine.	YES NO
Appointment information may be left on my answering machine.	YES NO

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, will allow my health information, test
PATIENT NAME
results, and billing questions to be discussed with the following people (such as spouse, children, friend):

Person	**Relationship**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____
PATIENT/PARENT/GUARDIAN SIGNATURE DATE

FINANCIAL POLICY

Thank you for choosing **CENTURY EAR, NOSE AND THROAT** as your specialist provider. We are committed to providing you with affordable quality healthcare. Please read the following information regarding your responsibilities related to payment of services.

Insurance: CENTURY EAR, NOSE AND THROAT participates in most insurance plans, including Medicare. If you are not insured by a plan we are contracted with, payment in full is expected at each visit. If you are insured by a plan we are contracted with, but do not have an up-to-date insurance card, payment in full is required for each visit until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Co-payments: All co-payments are due at the time of service. This arrangement is part of your contract with your insurance company.

Non-covered services: Please be aware that some and perhaps all of the services you receive may not be covered and considered not reasonable or necessary by Medicare or other insurers.

Proof of Insurance: All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license, a valid insurance card, and a credit card for payment.

Payment Responsibility: You will receive an explanation of benefits (EOB) from your insurance company designating the amount paid and/or the patient responsibility amount. If payment is not made within 60 days, your credit card or debit card will be charged for the balance due, unless prior arrangements have been made. **CENTURY EAR, NOSE AND THROAT** will maintain your Visa, MasterCard, Discover or American Express card on file to satisfy any patient responsibilities such as deductibles, co-insurance or other balances at the time of initial appointment. If you present a debit card, funds will be drawn directly from your bank account.

Your credit card or debit card is encrypted and not visible to **CENTURY EAR, NOSE AND THROAT**. The information is stored in a high level security system that goes well beyond HIPPA and Payment Card Industry (PCI) compliance.

If we cannot collect payment after 60 days past due, we may refer your account to a **COLLECTION AGENCY** and future services may not be provided to the patient until payment has been made.

I have read and agree with the FINANCIAL POLICY outlined above. I authorize CENTURY EAR, NOSE AND THROAT to securely maintain my credit card or debit card account information and to charge my account in full for any outstanding balances 60 days after my insurance carrier has processed my claim, if payment has not been received.

_____ _____

PATIENT'S NAME (Please Print) **PATIENT'S DATE OF BIRTH**

_____

Name on Credit Card

_____ _____

Billing Address for Credit Card **Zip Code**

_____ _____

Cardholder's Signature **Date**