PATIENT INFORMATION FORM

Patient Name _____ Birth date _____ Age _____

Address _____ Patient SSN _____

City _____ State _____ Zip _____ Sex ☐ M ☐ F

Home Phone _____ Cell Phone _____

☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Employer _____ Occupation _____

Employer Address _____ Work Phone # _____

Spouse Name _____ Birth date _____ SSN # _____

Spouse Employed by _____ Occupation _____

Employer Address _____ Work Phone # _____

Health Insurance Information

Primary Insurance Company Name _____ Policy/ID # _____

Policy Holder Name _____ Group # _____ Copay Amount _____

Relationship to patient _____

Are you covered by any additional health insurance policy's? ☐ Yes ☐ No

Secondary Insurance Name _____ Policy/ID # _____
(if applicable)

Policy Holder Name _____ Group # _____ Relationship to patient _____

Please list 2 emergency contacts (not at your address):

_____

Who may we thank for referring you (Name, Phone #) : _____

Primary Care Physician (Name, Phone #) : _____

Pharmacy Name and Phone #: _____ I will be paying by: ☐ CASH ☐ CHECK ☐ CREDIT

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to the Ear, Nose & Throat Institute of MI, PLLC. I also understand I am fully responsible for any charges regardless of my insurance status.

Signature of Patient : _____ Date: _____

Medical History

Name _____ Date _____ Age _____ Height _____ Weight _____

What is the main reason for your visit today? _____

Medication Allergies (please list) _____ ☐ No Known Allergies

List Present Medication and Dosage (or provide list) _____

_____

Please list over the counter medications, vitamins or supplements you take _____

Do you take Aspirin/Motrin/Coumadin/Plavix on a regular basis? ☐ Yes ☐ No Have you ever had any bleeding problems? ☐ Yes ☐ No

Ear, Nose & Throat History

Please check all that apply.

☐ Hearing Aids R L Both
☐ Hearing Loss
☐ Ear Pain
☐ Frequent Ear Infections
☐ Ringing in Ear R L Both

☐ Nose Bleeds
☐ Chronic Sinus Infections
☐ Sinus Headaches
☐ Snoring
☐ Decreased Sense of Smell/Taste

☐ Change in Voice
☐ Heartburn
☐ Frequent Sore Throats
☐ Hoarseness
☐ Balance Disturbance (Vertigo/Spinning)

Have you had previous Ear, Nose or Throat Surgery or Injuries? ☐ Yes ☐ No
If yes please list operations, injuries and dates: _____

_____

Please list any other procedures or operations you've had and dates _____

_____

Medical History

Have you ever had, or do you have (check all that apply) .....

☐ AIDS
☐ Anemia
☐ Arthritis
☐ Anxiety
☐ Cancer

☐ Chemical Dependency
☐ Diabetes
☐ Depression
☐ Emphysema
☐ Epilepsy/Seizures

☐ Eye Disease
☐ Heart Disease
☐ Hepatitis
☐ Herpes
☐ HIV

☐ High Cholesterol
☐ Hypertension
☐ Kidney Disease
☐ Liver Disease
☐ Pacemaker

☐ Panic Attacks
☐ Stroke
☐ Stent (heart)
☐ Thyroid Disorder
☐ Venereal Disease

Family History

Please check all that apply.

	Yes	No	Family member(s) relation to patient
Asthma	☐	☐	_____
Cancer	☐	☐	_____
Bleeding Disorder	☐	☐	_____
Heart Disease	☐	☐	_____
Hearing Loss	☐	☐	_____

Has any member of your family been seen in this practice? ☐ Yes ☐ No

Names _____

Have you ever had any difficulty with anesthesia? ☐ Yes ☐ No
If yes, please describe reaction:

_____

Social History

Please check all that apply.

Smoke Tobacco: ☐ Yes ☐ No If yes, pack per day? _____ for _____ years. If quit, when _____

Alcohol: ☐ Yes ☐ No Drinks per day? _____ Caffeine: ☐ Yes ☐ No Cups per day? _____

Smokeless Tobacco: ☐ Yes ☐ No Cocaine: ☐ Yes ☐ No Marijuana: ☐ Yes ☐ No

I certify this information is true and correct to best of my knowledge. I will notify you of any changes in the above information.

Patient Signature _____

Ear, Nose & Throat Institute of Michigan, PLLC

Notice of Health Information Practices

The Ear, Nose, & Throat Institute of Michigan, PLLC may use and disclose personal health information for treatment, payment, and healthcare operations. Examples of treatment include, but are not limited to, information sent to other physicians treating you, or to labs, x-ray facilities, hospitals, or to agencies providing therapy services. Examples for payment include insurance companies, coordination of benefits between payers, and collection agencies. Examples of healthcare operations include quality control audits. You are not required to consent to these uses of personal health information. However, if you refuse, we are not required to accept you as our patient.

We are permitted or required to disclose information without the patient's consent in certain circumstances. Examples include court orders and public health requirements.

The Ear, Nose & Throat Institute of Michigan, PLLC will not make any other use or disclosure of your health information without your written consent. You may revoke this consent at any time, but this must be in writing.

We may at times contact you to remind you of appointments or to give you information about treatment alternatives or other health-related benefits and services that may be of interest to you.

The Ear, Nose & Throat Institute of Michigan, PLLC will abide by the terms of this notice or the updated notice effect at the time of any information disclosure. We reserve the right to update the terms of this notice and to make new notice provisions effective for all the personal health information that we maintain. We will provide each patient with a copy of any revisions of our Notice of Information Practices at the time of their next visit. We may send a copy of the revised Notice via mail if we need to release information in a way covered by revisions to the Notice. Copies may also be obtained at any time at our office.

Any person or patient may file a complaint about these practices to the Secretary of Health and Human services if they believe their privacy rights have been violated. They may also file a complaint with our Privacy Officer at Ear, Nose & Throat Institute of Michigan, PLLC, 14555 Levan Road, Suite 206, Livonia, MI 48154. All complaints will be addressed and results will be reported to the President of the practice and to the Compliance Committee. It is our policy that no retaliatory action will be taken against someone submitting a complaint.

Acknowledgment and Consent

I acknowledge that I have been made aware of the Notice of Privacy Practices for the Ear, Nose and Throat Institute of Michigan, PLLC. I hereby consent to the release of confidential information maintained about me by the Ear, Nose & Throat Institute of MI, PLLC to third parties for the purposes of treatment, obtaining payment, or for healthcare operations. I also consent to release of personal health information for other purposes specified by the Health Insurance Portability and Accountability Act of 1966 (HIPPA). I also understand that I may request to read the Ear, Nose & Throat Institute of MI, PLLC Notice of Information Practices in it's entirety.

_____ _____

Signature of Patient (or patient's personal representative) Date

Personal representative information (if applicable):

_____ _____ _____

Name of personal representative Date Relationship to patient

_____

Signature of staff

Ear, Nose & Throat Institute of Michigan, PLLC

FINANCIAL AGREEMENT

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any 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.

PATIENTS MUST FILL OUR PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. WE WILL REQUEST TO PHOTOCOPY YOUR INSURANCE CARD(S) AND ID FOR YOUR FILE.

- APPOINTMENTS — 24 hours notice must be provided in the event you cannot keep an appointment. Should you not provide this notice, a cancellation of $25 may then be added to your account.

- 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 . If you do not have your referral, YOU WILL BE REQUIRED TO SIGN A FINANCIAL WAIVER. It is then your responsibility to provide us with the referral within 48 hours or you will be personally responsible for that day's services.

- CO-PAYMENTS — By law we MUST collect your carrier designated co-pay. This payment is expected at time of service. Please be prepared to pay that co-pay at each visit. Should you not pay at the time of service and we subsequently send you a statement, an administrative fee of $20 may be added to your account.

- OUT OF NETWORK PLANS — You will be responsible for any balance your plan indicates as due on their explanation of benefits form. We will adjust the charges to coincide with your plans 'reasonable and customary charges. All patients will be responsible for their co-insurance and deductible. Should you receive payment from your insurance company, please forward it to the physician's office.

- SELF-PAY PATIENTS — Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.

- MEDICARE — We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one.

  Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits be made on behalf to ENT Institute of Michigan 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.

  Private Insurance Authorization for Assignment of Benefits/Information Release: I, the undersigned, authorize payment of medical benefits to the ENT Institute of Michigan for any services furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize any holder of medical information about me to release to my insurance company information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

- DIVORCED/SEPERATED PARENTS OF MINOR PATIENTS — The parent who consents to the treatment of a minor child is responsible for payment of services rendered. We will not be involved with separation or divorce disputes.

You are responsible for the timely payment of your account. Should it be necessary for us to use an outside agency to collect payment from you, you will be responsible for whatever charges we incur as a result of this.

WE ACCEPT CASH OR CHECKS ~~CREDIT~~

THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share concerns with us.

Patient's Name (print): _____ Date: _____

Responsible Party Signature: _____ Relationship: _____

** You may request a copy of this agreement for your personal records.*