ENT SURGICAL ASSOCIATES

Today's Date _____

PATIENT DEMOGRAPHICS

First Name _____ Middle _____ Last _____

Sex _____ Date of Birth _____ Martial Status _____ Race _____ Ethnicity _____

Address _____ Zip_____ City _____State _____

Email Address _____ (unless minor)

Home Ph _____ Mobile _____ Wk _____ Pref Ph _____

Referring Provider _____ Phone _____

INSURANCE AND SUBSCRIBER INFORMATION

Primary Insurance Name _____

Group #_____ Subscriber ID _____

Subscriber Name _____ Middle _____Last _____DOB _____

Address _____Zip_____City _____ State _____

Home Ph _____ Mobile _____ Wk _____

Email Address _____ Pt Relation to Subscriber _____

Other Insurance _____

Group # _____ Subscriber ID _____

Subscriber Name _____ Middle _____ Last _____

DOB _____ Ph _____ Pt Relation to Subscriber _____

Is patient a Medicare Beneficiary? Yes No Primary or Secondary?

Is patient a Medicaid Beneficiary? Yes No Primary or Secondary?

EMERGENCY CONTACT

Pt Relation to Contact _____

Name _____Middle _____ Last_____

Hm Ph _____ Mobile _____ Wk _____

PHARMACY

Pharmacy Name/Location _____Phone_____

Patient/Responsible Party_____ Relation to Pt _____

Signature Phone _____

As the responsible party, I agree that all charges that are not directly paid by insurance will be my responsibility.

ENT SURGICAL ASSOCIATES
MEDICAL HISTORY

TODAY'S DATE _____

First Name_____ Middle _____Last _____

Date of Birth _____ Age _____ Gender _____

REASON FOR VISIT _____

DRUG ALLERGIES_____

MEDICATIONS that you are presently taking _____

_____

_____

PAST SURGERIES _____

_____

PAST MEDICAL HISTORY: Please check any of the medical conditions that you have had:

____ High Blood Pressure	____ Anemia	____ Thyroid Disease	____ Asthma
____ Bleeding Disorder	____ COPD	____ Liver Disease	____ Heart Disease
____ Kidney Disease	____ Stroke	____ Stomach Ulcer	____ Cancer
____ Arthritis	____ Glaucoma	____ Diabetes	____ AIDS or HIV+
____ Tuberculosis	____ Seizure	____ Other _____	

SOCIAL HISTORY: Smoking YES NO If yes, Years: _____ Amount:_____
Alcohol None Occasional Moderate Excessive
Smokeless Tobacco YES NO
Street Drugs YES NO

ALLERGY HISTORY: Allergy Tested: YES NO If yes, when: _____

Pets owned: Dogs Cats Other: _____

FAMILY HISTORY: Please check any of the medical conditions below that a blood relative has had:

____ High Blood Pressure	____ Heart Disease	____ Thyroid Disease	____ Adopted
____ Asthma	____ Diabetes	____ Liver Disease	
____ Stroke	____ Seizure	____ Cancer	

REVIEW OF SYSTEMS: Please check any of the following that you have now or have had in the past year:

____ Weight Change	____ Dry Eyes	____ Chronic Cough	____ Chest Pain
____ Chronic Diarrhea	____ Depression	____ Change in Voice	____ Difficulty Swallowing
____ Rapid Heart Beat	____ Heartburn	____ Blood in Stools	____ Joint or Muscle Pain
____ Easy Bruising	____ Migraines	____ Shortness of Breath	____ Swollen Feet/Ankles
____ Ringing in Ears	____ New or Changing Moles		

ENT SURGICAL ASSOCIATES
THOMAS C. FRANK, M.D.
Head and Neck Surgery Pediatric and Adult Ear Nose and Throat Allergy

SUITE 210
2821 E. PRESIDENT GEORGE BUSH HIGHWAY
PHONE (972)231-9361 RICHARDSON, TX 75082 FAX (972)231-3123

GENERAL CONSENT FOR TREATMENT

***The following is a general consent for treatment for any services rendered here in the office. If your plan of treatment requires further procedures, you will be consulted on those specific procedures.*

*The consent you are about to read was written by the Texas Medical Association and requires that all physicians have patient consent for general treatment. ***

"I, knowing that I am suffering from a condition requiring diagnostic, medical or surgical treatment, do hereby voluntarily consent to such procedures and care and to such medical, surgical or other services under the general and specific instructions of the Physician of ENT Surgical Associates, their assistants, or their designee as is necessary in their judgement."

I also acknowledge that the practice of medicine is not an exact science and no guarantees have been made to me as to the result of treatments or examination by ENT Surgical Associates.

--Texas Medical Association.

****

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment of surgical/medical benefits to ENT Surgical Associates for services rendered by them in person or under their supervision. I understand that I am financially responsible for all of the fees or any balance not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize ENT Surgical Associates to release any medical or incidental information that may be necessary for either medical care or in processing claims or applications for financial benefits.

A photocopy of these assignments shall be as valid as the original.

Print Patient Name Here: _____ Date of Birth: _____

Print Parent or Guardian Name Here: _____

Signature: _____ Date: _____

ENT SURGICAL ASSOCIATES

NOTICE OF PRIVACY PRACTICE

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED

AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 4/14/03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclosure your health information for any reason except those described in this Notice.

To your Family and Friends: We must disclose your health information to you, as described in the patient rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonable believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security

activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters)

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may do this by registering for the patient portal where you have access to your records. YOU MAY DOWNLOAD A COPY OF YOUR MEDICAL RECORD FROM THE PATIENT PORTAL AT NO COST. If you request that we provide you with a copy, the fee for obtaining your medical record is $25.00, plus mailing costs (if applicable). Patients who want a copy of their medical record must complete an Authorization for the Release of Medical Records. You may obtain the form by calling the phone number listed at the bottom of this page.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of the Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: *Officer Manager* Telephone: 972-231-9361 Fax: 972-231-3123

_____ _____

Patient or Guardian Signature Date