The Center for ENT
Otolaryngology – Head & Neck Surgery

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Patient Registration Form

Today's Date: ____________________ **If referred by a doctor give name & phone no.:** ______________________________________

PATIENT INFORMATION

Last name:			**First name:**		**M.I.:**
DOB:	**Age:**	**Sex:** M: ☐ F: ☐	**Marital Status:**		**Drivers Lic. #:**
Address:			**City:**	**State:**	**Zip Code:**
Home phone no.:			**Cell phone no.:**		
Contact Email:					
Employer:			**P:**	**F:**	
Address:			**City:**	**State:**	**Zip Code:**
Emergency Contact Name:			**P:**	**Relationship:**	
Primary Care Physician:			**P:**	**F:**	
Preferred Pharmacy:			**P:**	**F:**	
Address:			**City:**	**State:**	**Zip Code:**

PRIMARY INSURANCE INFORMATION		**SECONDARY INSURANCE INFORMATION**	
Subscriber Name:		**Subscriber Name:**	
DOB:		**DOB:**	
Primary Insurance:		**Primary Insurance:**	
Policy #:	**Group #:**	**Policy #:**	**Group #:**
Employer:		**Employer:**	

In order to track Meaningful Use of our Electronic Medical Record, we are required to maintain the information below as part of your personal medical record. As with all of your medical information, this will be maintained CONFIDENTIALLY.

**** We will grant you access to our patient portal for electronic messaging and access to portions of your health records. ****

*** We will NOT share your email address with any other parties. ***

PRIMARY LANGUAGE: (CHECK ONE)
☐ English
☐ Spanish
☐ Indian (Includes Hindi & Tamil)
☐ Russian
☐ Other: ________________

RACE: (CHECK ONE)
☐ American Indian or Alaska Native Asian
☐ Native Hawaiian or Other Pacific Islander
☐ Black or African American
☐ White
☐ Hispanic
☐ Other: ________________
☐ Unreported I Prefer Not to Answer

ETHNICITY: (CHECK ONE)
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Prefer Not to Answer

Notice of Privacy Practices Acknowledgment

You have been given the Notice of Privacy Practices for The Center for ENT and its Physicians. This notice describes your legal rights regarding your health information and will inform you of the legal duties and privacy practices The Center for ENT with respect to health information created for services generated by The Center for ENT. If you receive services by your physician or other health care providers at a different location, you may want to ask about that office or clinic's health information privacy policies and notices because they could different.

Your name and signature below indicates that you have been provided with a copy of this Notice of Privacy Practices.
If you have a question regarding any of the information set forth in this Notice of Privacy Practices, please do not hesitate to call our Practice Administrator at 713-795-5343

Patient Name: ______________________________ Signature of Patient or Responsible Party: ______________________________

CONTACTS: Please list other persons that we may inform about your health information

______________________________ ______________________________

PHONE NUBMER: At which phone numbers would like you to receive calls about appointment, financial, or medical conditions information? [check all that apply] We may leave a voice mail? ___ Yes ___ No

___Home Phone ___Cell Phone ___Work Phone: ___ Other Phone: ________________

Patient Signature: ____

Patient Consent for Use of Email Communication

To better serve our patients, The Center for ENT allows patients to communicate with our staff via Email. Prior to doing this, you must read through and sign this Email policy. 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 2 business days. If a response is not received within the expected timeframe, please call our office for immediate assistance.

All Email communications related to your health and treatment may be filed in your medical record. The Center for ENT is not liable for improper disclosure of information, breaches of confidentiality caused by the patient (i.e. printing or forwarding Emails), third parties, or technical factors beyond the Practice's control. In addition, The Center for ENT has no control over security or management of third-party Email systems, if used. The patient understands and agrees that The Center for ENT will make its best effort to minimize the risk of confidentiality breaches for factors within its control, but cannot guarantee that unencrypted information will not be intercepted, altered, or read by an unintended patient.

I understand that The Center for ENT is not responsible for information loss or delay, or for breaches of confidentiality, due to technical factors beyond the Practice's control. By signing below, I am agreeing that The Center for ENT may send medical related correspondence to me via Email, and may respond to my Emails via Email.

Patient Signature: ______________________________ Date: ____________________

Patient Authorization for Greater Houston Healthconnect

The Center for ENT participates in HealthConnect, a non-profit organization that provides a secured electronic network for Healthconnect participants, including doctors' offices, hospitals, labs, pharmacies, radiology centers and payers of health claims such as health insurers to share your protected health information. ("PHI") A list of current Healthconnect participants is available at www.ghhconnect.org. When you join Healthconnect, your doctors can electronically search all Healthconnect participants for your PHI and use it while treating you. Healthconnect does not change who gets to see your information—it allows your information to be shared in a new way. All Healthconnect participants must protect your privacy in accordance with state and federal laws.

Your treatment and eligibility for benefits will not be affected in any way should you choose not to join Healthconnect. By signing this Authorization, you agree that Healthconnect and its current and future participants may use and disclose your protected health information electronically through Healthconnect **for the limited purposes of treatment, payment and health care operations**. You understand that Healthconnect may connect to other health information exchanges in Texas and across the country that also must protect your privacy in accordance with state and federal laws, and you authorize Healthconnect to share your information with those exchanges for the same limited purposes.

Your health information that may be shared through Healthconnect includes:

- Diagnosis (disease or problem)
- Clinical summaries of treatment and copies of documents in your medical record
- Results of lab tests, x-rays and other test
- Medication (current and in the past)
- Personal information such as name, address, telephone number, gender, ethnicity and age
- Names of providers and dates of services
- Alcohol, drug abuse, mental and behavioral health treatment
- HIV/Acquired Immune Deficiency Syndrome (AIDS) test results and treatment
- Hepatitis B or C test results and treatment
- Genetic test results and treatment
- Genome information, if provided
- Family medical history, if provided

This authorization remains in effect unless and until you revoke it. You can revoke this authorization at any time by giving written notice to any healthcare provider who participates in Healthconnect. Your revocation will be effective within three (3) days. You understand that revoking this authorization does not impact PHI previously shared when your authorization was in effect.

You understand that when your PHI is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by state or federal privacy regulations.

Patient Name: ______________________________

Date: ____________________ ☐ Check to Opt-In Healthconnect

D.O.B: ____________________ ☐ Check to Opt-Out Healthconnect

Signature of Patient or Responsible Party:

____

Physician Disclosure of Financial Interest

The Center for ENT and individual physicians, have a financial interest in several medical entities. Therefore, the Center for ENT physicians stand to benefit financially if you have services performed at these facilities or pharmacy. Below is a list of the area medical entities that I or The Center for ENT have financial interest in:

Dr. Sam Weber Apnix Sleep Diagnostic 4003 Bellaire Blvd, Houston, Tx 77025 P: (713) 349-9767 | F: (713) 349-9634	**Dr. Ron Moses & Dr. Eric Powitzky** First Street Surgical Hospital 411 N. First Street, Bellaire, Tx 77401 P: (713) 665-1111 | F: (713) 665-4146	**Dr. Eric Powitzky & Dr. Richard Hung** MH Surgery Center Kirby, LLC 2459 S. Braeswood Blvd, Houston, Tx 77030 P: (713) 590-8600 | F: (713) 590-8603
Sigma Pharmaceutical Consulting Group, LLC- Webster Pharmacy 15610 Hwy 3, Webster, Tx 77598 P: (281) 886-7164 | F: (281) 652-5345	The Center for Allergy and Sinus 6624 Fannin St. Ste 1460, Houston, Tx 77030 P: (713) 790-1272 | F: (713) 512-8383	Premier Audiology & Hearing Aid Center 6624 Fannin St. Ste 1482, Houston, Tx 77030 P: (713) 328-0828 | F: (713) 328-0830

Dr. Kristin Marcum & Dr. Samuel Patton
OakBend Surgery Center - River Oaks
4120 Southwest Fwy #100, Houston, Tx 77027
P: (713) 626-8500

Financial Policy

Welcome to The Center for ENT! We are committed to providing you with quality medical care and we 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 responsibility.

ANY CHANGES IN INSURANCE COVERAGE, ADDRESS, AND TELEPHONE OR OTHER DEMOGRAPHICS MUST BE GIVEN TO THE RECEPTIONIST WHEN YOU SIGNIN FOR YOUR APPOINTMENT.

SELFPAY/ CASH PAY POLICY
For patients who are not using insurance for their office visit, a **$200 deposit will be due at CHECK-IN.** This deposit will be applied to the actual charges at check-out. If the visit charges exceed $200, the remaining balance will be due at check-out. In the event the actual charges are less than $200; the difference will be refunded at check-out.

INSURANCE
Insurance is a contract between you and your insurance company. We are not a party to your contract though we may have a contractual fee schedule agreement with the insurance company. We will not become involved in disputes with your insurance company regarding deductibles, non-covered/covered expenses, co-insurance or "reasonable and customary" charges other than to supply factual information as necessary. **You are responsible for timely payment of your account and office visit claim follow-up with your insurance company.** If applicable, our office will submit insurance claims. You agree to allow our practice to "accept assignment" of benefits and receive payment directly from your insurance company. In the event your insurer sends payment for a claim from our office to you directly, you agree to endorse the payment to our practice in fulfillment of any amounts due within 10 days of postmark.

Medicare: We are participating providers with Medicare. We will also file with your secondary or supplementary policy.

Contracted Managed Health Care: (HMO's, PPO's, EPO's) **It is your responsibility to make sure that the Physician(s) you will see is currently enrolled with your plan. All necessary referrals must be obtained prior to each visit.** If a referral is not completed or obtained prior to your appointment, it may result in a delay or possibly rescheduled.

Worker's Compensation: We **DO NOT ACCEPT** Worker's Compensation patients as of 07-01-2002.

Minors/Unaccompanied Minors: The parent accompanying a child of a divorced family will be responsible for payment of charges incurred for the date of service regardless of insurance or divorce decree status.

ADDITIONAL POLICIES

Initials	Policy
______	**Scheduling Fees:** A $**100 scheduling fee** is required to reserve an **in- office procedure/surgery or outpatient surgery time**. If an in-office procedure/surgery or outpatient surgery is cancelled with less than a one week's notice for a non-medical reason, the scheduling fee is non-refundable. If the in-office procedure/surgery or outpatient surgery is performed as scheduled, the fee will be applied to your final remaining balance. A $**25 scheduling fee** is required to reserve your time for **allergy testing**. If your allergy test is cancelled with less than a 72 hour notice for a non-medical reason, the scheduling fee is non-refundable. If the allergy test is performed as scheduled, the fee will be applied to your final remaining balance. **No Show/Missed Appointments or Late Appointments:** If it is necessary for you to cancel your appointment, we ask that you contact the office 24 hours in advance. If you are a no show or missed appointment you will be charged a $25.00 no show/missed appointment fee. If you arrive more than 15 minutes late for an appointment, we reserve the right to reschedule your appointment.
______	**Form Fees:** Our practice charges for additional paperwork outside of the completion of the medical record. The following fees apply and are subject to change without notice: FMLA, Immigration, and disability forms $**25**. Copies of your pertinent medical information will be provided to you for a fee of $**25** Medical record copies forwarded to other physicians involved in your healthcare are provided free of charge.
______	**Collection Fees, Bank Fees, and Credit Reporting:** Accounts more than 90 days old are subject to a $25 collection fee and report to the credit bureau. In addition, banks charge for checks that do not clear or cannot be cashed. You agree to be liable for all such fees with a minimum charge of $25.

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.

☐ Check to Acknowledge

Patient Name: ____

Date: ___________________

Signature of Patient or Responsible Party: _________________________________

Patient Medical History

Please provide the following confidential information regarding your medical history. Thank you.
This information should be updated **ANNUALLY** or with any changes to your medical history.

Name: ______________________________ Age: _________ Referring Physician: ______________________________
Reason for appointment: ____

- **Current Medications:** ☐ No ☐ Yes; Please list:

1	**Name of medication:**	**Dosage & milligrams?**	**How often & frequency?**
2	**Name of medication:**	**Dosage & milligrams?**	**How often & frequency?**
3	**Name of medication:**	**Dosage & milligrams?**	**How often & frequency?**
4	**Name of medication:**	**Dosage & milligrams?**	**How often & frequency?**

- **Height:** ________ft. ________in. **Weight:** _________
- **Are you pregnant?** ☐ No ☐ Yes; How many months? _________
- **Medical History.** Which medical conditions apply to you? Please provide a brief explanation.

	NO	YES	EXPLANATION
Arthritis	☐	☐	
Asthma	☐	☐	
Bleeding / Blood Disease	☐	☐	
Cancer	☐	☐	
Diabetes	☐	☐	
Heart Disease / Murmur	☐	☐	
High Blood Pressure	☐	☐	
High Cholesterol	☐	☐	
Kidney / Urinary	☐	☐	
Liver problems / Hepatitis	☐	☐	
Nervous Disorders	☐	☐	
Seizures or Epilepsy	☐	☐	
Stomach problems	☐	☐	
Thyroid Disorders	☐	☐	
Other	☐	☐	

- **Allergies** to medicine: ☐ No ☐ Yes; Please list:

1	**Name of medication:**
2	**Name of medication:**
3	**Name of medication:**
4	**Name of medication:**

- **Previous surgeries?** ☐ No ☐ Yes; Please list:

1	
2	
3	
4	

- **Family History.** Which medical conditions apply to you? Please provide a brief explanation.

	DAD	MOM	SIBLING	CHILD	OTHER	EXPLANATION
Arthritis	☐	☐	☐	☐	☐	
Asthma	☐	☐	☐	☐	☐	
Bleeding / Blood Disease	☐	☐	☐	☐	☐	
Cancer	☐	☐	☐	☐	☐	
Diabetes	☐	☐	☐	☐	☐	
Heart Disease / Murmur	☐	☐	☐	☐	☐	
High Blood Pressure	☐	☐	☐	☐	☐	
High Cholesterol	☐	☐	☐	☐	☐	
Kidney / Urinary	☐	☐	☐	☐	☐	
Liver problems / Hepatitis	☐	☐	☐	☐	☐	
Nervous Disorders	☐	☐	☐	☐	☐	
Seizures or Epilepsy	☐	☐	☐	☐	☐	
Stomach problems	☐	☐	☐	☐	☐	
Thyroid Disorders	☐	☐	☐	☐	☐	
Other	☐	☐	☐	☐	☐	

- **Occupation:** ________________________
- **Do you use tobacco?** ☐ No ☐ Yes ☐ Former Smoker
  No. of packs per day? _________ No. of years? ______
- **Do you drink alcohol?** ☐ No ☐ Yes
  How many drinks a week? _________

- **Currently,** do you have any of the following symptoms? (Please mark those that apply)

☐ Seasonal allergies	☐ Rash on skin	☐ Ringing in ears	☐ Nasal drainage	☐ Nosebleed	☐ Muscle or joint pain
☐ Cough	☐ Temperature intolerance	☐ Hearing loss	☐ Sore throat	☐ Problems swallowing	☐ Headache
☐ Shortness of breath	☐ Ear pain	☐ Dizziness	☐ Hoarseness	☐ Heartburn or indigestion	☐ Numbness/Weakness
☐ Fever	☐ Ear drainage	☐ Facial pain	☐ Lumps & nodules	☐ Swollen glands	☐ Visual disturbances
☐ Weight loss	☐ Ear blockage	☐ Nasal congestion	☐ Snoring	☐ Bruise or bleed easily	

Patient Signature: ____ Date: ______________________