PATIENT AND INSURANCE INFORMATION

(PLEASE COMPLETE ALL SECTIONS OF THIS FORM)

Today's date: _____ Pharmacy and Location: _____

Name of Patient: _____ Age: _____ Birth date: _____ Race: _____

Sex: M __ F __ Single ___ Married ___ Widowed ___ Divorced ___ Social Security # of patient: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____ Email Address: _____

1st Phone: ( ) _____ **2nd** Phone: ( ) _____ **3rd** Phone: ( ) _____

Patient's Employer: _____ Work Phone: _____

Spouse's Name: _____ Spouse's Employer: _____

Spouse's Work Number: _____

IF PATIENT IS A MINOR OR A STUDENT PLEASE COMPLETE THE FOLLOWING:

Mother's name: _____ Social Security #: _____

Birth date: _____ Employer: _____ Work Phone: ( ) _____

Father's name: _____ Social Security #: _____

Birth date: _____ Employer: _____ Work Phone: ( ) _____

INSURANCE INFORMATION:

Primary Insurance

Name of Insurance: _____

ID, Contract, or Member #: _____

Group Number: _____

Name as on Card: _____

Date of Birth: _____

Patient's relationship to insured: _____

Secondary Insurance (if applicable)

Name of Insurance: _____

ID, Contract, or Member #: _____

Group Number: _____

Name as on Card: _____

Date of Birth: _____

Patient's relationship to insured: _____

Tertiary Insurance (if applicable)

Name of Insurance: _____

ID, Contract, or Member#: _____

Group Number: _____

Name as on Card: _____

Date of Birth: _____

Patient's relationship to insured: _____

Please present your insurance cards, driver's license, and co-pay when returning this form

EMERGENCY CONTACT INFORMATION:
(OUTSIDE YOUR HOUSEHOLD)

Name: _____

Home phone: _____

Address: _____

_____

Relationship to patient: _____

I hereby authorize Anniston Ear, Nose, and Throat, P.C. to furnish any information concerning my medical condition, treatment, prognosis, test results, and appointment dates and times to the following family members:

Name_____ Phone #_____ Relationship_____

Name_____ Phone #_____ Relationship_____

Name_____ Phone #_____ Relationship _____

____ **I do not want my information released to anyone.**

TO RELEASE INFORMATION: I hereby authorize Anniston, Ear, Nose and Throat to release information related to all treatments and care.

ASSIGNMENT OF BENEFITS: I hereby instruct and direct my insurance company to pay benefits directly to Anniston Ear, Nose, and Throat, P.C. that would otherwise be payable to me. I further understand that I am financially responsible for payment of charges not covered by this authorization.

LEGAL/COLLECTION FEE: I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court costs, if such be necessary. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other State.

CONSENT TO CONTACT YOU BY CELL PHONE: Anniston Ear, Nose, and Throat, P.C. and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

NON-COVERED SERVICES: I understand that I will be billed directly by Anniston, Ear, Nose, and Throat, P.C. for services rendered that my insurance carrier deems not medically necessary or non-covered services. These services may not be covered by third-party payors and I will be directly responsible for their payment. This includes co-pays and annual deductible.

_____ _____

Date **Patient or Guardian Signature**

Revised: 03/29/2016

PATIENT MEDICAL HISTORY

(Please complete all sections of this form)

Date_____ **Name:**_____ **Age:**_____

Birthdate:_____ Male____ Female_____ Primary care physician:_____

Why are you here today?_____

_____

If you are here for an accident or injury, please indicate date of accident or injury:_____
How long have you had these symptoms?_____Have you received prior treatment and/or medications for this current problem? No___Yes___ (if yes please explain.)_____

_____

Have you had the flu vaccine Yes___ or No ____ **Have you had the pneumonia vaccine Yes___ or No____**

Did another doctor refer you to us? Yes___ No____ If yes, name of physician: _____

_____

LIST THE MEDICATIONS AND STRENGTH THAT YOU ARE CURRENTLY TAKING: (Indicate *None* if you are taking none.)

Medication	Strength/Frequency	Medication	Strength/Frequency

ARE YOU ALLERGIC TO ANY MEDICATIONS?_____ If yes please list below and the allergic reaction. If you are not allergic to any medications please list *None*.

Medication	Allergic reactions	Medication	Allergic reactions

MEDICAL HISTORY

Please check if you are currently receiving treatment or have received treatment in the past for the following conditions?

__ Anemia	__Arthritis	__Currently Pregnant	__Stroke
__Bleeding Disorders	__Cancer	__High Blood Pressure	__Diabetes
__Heart Disease	__Hepatitis **B or C**	__Recurrent Infections	__Asthma
__Kidney Disease	__Sexually Trans Disease	__Thyroid Disease	__Ulcers
__Scarlet Fever	__Mitral Valve Prolapse	__Birth Defects	__Head Injury
__Intestinal Disorders	__Family history of hearing loss	__HIV/AIDS	__Seizures
__Glaucoma	__Meniere's Disease		

Other (please specify):_____

Please continue on reverse ----

Please complete all sections of this form

Please list all surgeries and their approximate date: (if you have not had any surgery please state *None.*)

SURGERY	DATE	SURGERY	DATE
_____	_____	_____	_____
_____	_____	_____	_____

Have you had any problems or complications from surgery or being put to sleep? No__ Yes__(if yes please explain)_____

_____

SOCIAL HISTORY

Do you smoke or chew tobacco? _____ If yes, how much? _____

Have you ever smoked? _____ If so, how long has it been since you stopped?_____

Do you drink alcoholic beverages? _____If yes, how much? (i.e. 3 drinks a month)_____

FAMILY MEDICAL HISTORY

Has any member of your family **(Parents, Grandparents, Siblings)** ever had: (If *yes*, please explain)

Thyroid trouble: No__ Yes_____

Diabetes: No__ Yes_____

Glaucoma: No__ Yes_____

Epilepsy: No__ Yes_____

Blood disorders or "free bleeding". No__ Yes_____

REVIEW OF SYSTEMS

Are you currently having any of the following symptoms? **(please circle)**

Neuro:	**Headache**	**Tremors**	**Numbness**	**Weakness**
Eyes:	**Visual changes**	**Flashes**	**Pain**	
ENT:	**Ear pain**	**Seasonal allergies**	**Sinus infections**	**Sore throats**
Resp:	**Wheezing**	**Cough**	**Shortness of breath**	
CV:	**Chest pain**	**High Blood Press**	**Swelling:ankles**	
GI:	**Abdominal pain**	**Nausea**	**Vomiting**	**Heartburn**
GU:	**Urinary retention**	**Urinary Frequency**	**Urinary Infections**	
Endocrine:	**Excessive thirst**	**Hot/Cold Flashes**		
Heme:	**Anemia**	**Swollen glands**	**Easy Bruising**	
Musculoskeletal:	**Joint pain**	**Back pain**	**Neck pain**	**Osteoporosis**
Skin:	**Rashes**	**Itching**		
Psychologic:	**Depression**	**Suicidal**	**Anxiety**	

Patient Signature:_____

I have reviewed the above information with the patient to verify its accuracy.

Physician Signature:_____ **Date:**_____

EFFECTIVE DATE APRIL 1, 2003

NOTICE OF PRIVACY PRACTICES

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.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the practice may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the practice or the hospital. For example, we may disclose medical information about you to people outside the practice who may be involved in your medical care, such as family members, clergy or other persons that are part of your care.

For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts.

WHO WILL FOLLOW THIS NOTICE. This notice describes our practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the practice, whether made by practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; inmates; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; protective services for the President and others; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances.

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.

CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in the practice's waiting room.

COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the practice, contact Paula Angle (256)236-4426. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.

I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights.

_____ _____

Patient or Patient's Personal Representative **Date**