ERIC J. FURST MD

5504 BACKLICK RD
SPRINGFIELD,VA 22151
PHONE (703) 941-9552 / (703) 642-1422 (FAX)
EMAIL: ejfurstmd1@gmail.com

OFFICE HOURS: Our office hours are **Monday through Thursday from 8:30 am to 4:00 pm** and **Friday from 8:30 am to 12:00 pm.** Phones are off between **12 noon to 1:30 pm Monday through Friday.**

OFFICE FEES : Courtesy calls are performed by a member of our staff to remind patients of their appointment the day before. Should the patient, **No Show** the appointment or **give less than a 24 hour notice of cancellation,** the patient will be billed a **$50.00 fee.**

Returned check fee is **$35.00**

Fee for personal copies of your medical records will be determined by the physician.

PATIENT INFORMATION: Please inform our office of any change of address, telephone or insurance information. Bring a list of all **current medications** to your appointments.

INSURANCE POLICY: All claims are submitted to your insurance by **ERIC J FURST, MD.** If you need a referral to be seen by our office, it is your responsibility to bring the referral with you or a $50 fee will be applied to your account for late cancelation of your appointment. If you have any concerns or questions regarding a billing statement you have received, please contact **Tammy** at **410-686-4128**. Payment will be collected on the day of service in full by self -pay patients that have an insurance policy that reflects our office as a non participating or non in-network provider.

Dr Eric J Furst is a non-network provider for Medicaid and its affiliates. This means, if you have any Medicaid or Medicaid affiliate policy as primary or secondary, **you will be responsible for payment**. If Medicare is primary and Medicaid or its affiliates are secondary, we will collect your 20% Medicare coinsurance up front. If you have Medicaid policy and wish to still be seen by Dr Eric Furst, you will have to do so and be considered as a self-pay patient. Since we are non-participating with Medicaid we are unable to submit any claims whether it be primary or secondary to Medicaid.

AUTHORIZATION AND INSURANCE ASSIGNMENT: I hereby authorize this office to apply for benefits on my behalf for covered services rendered. I request payment from my insurance company to be made to the above named provider. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any information to my insurance company in order to determine insurance benefits to which I may be entitled. I also authorize the release of my medical information to any physician or facility to which I am referred for diagnostic testing or other services necessary to my treatment. I may revoke this authorization at any time in writing.

FINANACIAL AGREEMENT: By signing this form I understand and agree that I am responsible for my account. In the event my account is forwarded to collections, I agree to reimburse you the fees of collections agency which may be based on a percentage at a maximum of 30% of the debt and all cost and expenses including reasonable attorney's fees. We incur in such collection efforts.

_____ _____

Patient Signature Or Personal Representative **Date**

_____

Name Printed

Eric J Furst, MD
5504 Backlick Rd Springfield VA 22151
(703) 941-9552 / (703) 642-1422 (Fax)

PATIENT REGISTRATION FORM

Date:_____

First Name:_____ **Mi:**____ **Last Name:**_____

Birth Date:_____ **Age:**____ **Male:**___ **Female:**___ **Soc. Sec. #:**_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Marital Status: M S D W **Occupation:**_____

Home #:_____ **Work #:**_____ **Cell #:**_____

E-mail address: _____

Drug Allergies and Reaction:_____

Pharmacy Name: _____ **Phone #:** _____

Referring Or Primary Physician :_____

Referring Or Primary Physician Phone #:_____

INSURANCE SUBSCRIBER INFORMATION:

Primary Ins:_____ **Policy Holder:**_____ **DOB:**_____ **Relationship:**_____

Secondary Ins:_____ **Policy Holder:**_____ **DOB:**_____ **Relationship:**_____

Insured SS. # (if not patient):_____ **Employer:**_____

CONTACT INFORMATION AND AUTHORIZATION

I give permission for Eric J. Furst MD or staff to contact me by phone or letter and leave a message. I give permission for my personal health information (PHI) to be discussed with the following people:

Name	Relationship	Phone #	Restriction If Any

I understand I may revoke this consent at any time. I also understand that my PHI will not be released without consent except as stated in the Privacy Notice. I have been offered or given a copy of the Notice of Privacy Practices for: Eric J. Furst, MD PC.

_____ _____

Patient Signature **Date**

_____

Signature of Patient Representative

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PRIVACY NOTICE

The Department of Health and Human Services. Office of Civil Rights, under the Public Law 104-191 **(The Health Insurance Portability and Accountability Act of 1996 or "HIPAA"),** mandates that we issue this new revised **Privacy Notice** to our patients. This notice to our patients meets all current requirements as it relates to **Standards for Privacy of Individually Identifiable Health Information or "IIHI"**; affecting our patients. You are urged to read this notice. As part of the Privacy Standard, implemented on April 14, 2001, you are required to provide this office with a new, signed and dated **Consent Agreement**. Every patient must receive our new Privacy Notice and execute a new Consent Agreement before this office may use your information for treatment, payment, or other health care operations. Our Privacy Notice informs you of our use and disclosure of your **Protected Health Information or PHI**, as defined as: "any information, whether oral or recorded in any medium, that is created or received by a health care provider, health plan, public health authority, employer, life insurance company, school or university or clearing house and that relates to the past, present or future physical or mental health or a condition of an individual, the provision of health care to an individual, or the past, present or future payment for the provision of health care to an individual".

Our office will use or disclose your PHI for purposes of treatment, payment and other healthcare purposes as required to provide you the best quality healthcare services that we offer to the extent permitted by your Consent Agreement or in such specific situations, by your signed and dated Authorization. It is our policy to control access to your PHI: and even in cases where access is permitted, we exercise a "minimum necessary information" restriction to that access. We define the minimum necessary information as the minimum necessary to accomplish the intent of the request. An Authorization differs from a Consent Agreement in that it is very specific with regard to the information allowed to be disclosed or used, the individual or entity to which the information may be disclosed, and the date that it was initiated which may include the duration of the authorization. This is a form, separate from the Consent Agreement, and usually used for only one specific request for information. In the event of a non-healthcare related request for PHI, this office will request you to complete an Authorization Form. You, as our patient may revoke any Consent Agreement or Authorization at any time and all use and disclosure and administration of related healthcare services will be revised accordingly, with the exception of matters already in process as a result of prior use of your PHI.

To revoke either the Consent Agreement or the Authorization, you will have to provide this office with a written request with your signature and date and your specific instructions regarding an existing Authorization or Consent Agreement. Any revocation will not apply to information already used or disclosed. If you had a "personal representative" initiate an Authorization, you may revoke that authorization at any time. You, the patient, have access to your health care information and may request to examine your information, may request copies of your information, and under the law you may request amendments to your information. The physician or principal will exercise professional judgment with regard to requests for amendments and is not bound by law to make any changes to the information. If the physician or professional agrees with the request to amend the information, we are bound by law to abide by the changes. In limited circumstances, the Privacy Standard permits, but does not require, covered entities to continue certain existing disclosures of health information without individual authorization for specific public responsibilities. These permitted disclosures include: emergency circumstances like identification of the body of a deceased person, or to assist in determining the cause of death. Public health needs; research, generally limited to when a waiver of authorization is independently approved by a privacy board or Institutional Review Board; oversight of healthcare system; judicial and administrative proceedings; limited law enforcement meetings; and activities related to national defense and security.

There are specific state laws that required the disclosure of health care information related to Hepatitis C and HIV/AIDS. Where the state laws are more stringent than HIPAA Privacy Standard, the state laws will prevail. All these disclosures could occur previously under former laws and regulations however, the Privacy Standard establishes new safeguards and limits. If there is no other law requiring your information be disclosed, we will use our professional judgments to decide whether to disclose any information, reflecting our own policies and ethical principles. On some occasions we may furnish your PHI to a third party. This could be an insurance company for the purpose of payment or another health care provider for further treatment or additional services. Although we will institute a "chain of trust" contract and monitor our business associates contracts with us, we cannot absolutely guarantee that they will not use or disclose your PHI in such a way as to violate the Privacy Standard. It is our practice to retain information about non-healthcare related requests for your health care information for a period of seven years. In complying with the Privacy Standard, we have appointed a Privacy Officer, trained our Privacy Officer and the staff in the law, and implemented policies to protect your PHI. We have instituted privacy and security processes to guard and protect your IIHI. This office is taking and continues to monitor and improve steps for the protection of your information and to remain in compliance with the law.

Please sign below and date the form indicating that you have received this Privacy Notice. Thank you

_____ _____

Patient Signature or Patient Personal Representative Date

Initials: _____ Initials: _____ Initials: _____ Initials: _____ Initials: _____ Initials: _____ Initials: _____ Initials: _____

Dr. Eric J. Furst
5504 Backlick Road,
Springfield VA 22151
Tel: 703-941-9552 Fax 703-642-1422

PATIENT INFORMATION

Patient Name:	Date:
Date of Birth:	Marital Status:

PATIENT MEDICAL HISTORY

ENT Surgical History:

Tobacco Use: Y N	Alcohol Use: Y N	Drug Use: Y N	Weight:	Height:

Self or Family Medical History (father, mother, brother, sister)	YES	NO
Abdominal Pain / Cramps		
Acid Reflux (GERD) / Heartburn		
Anemia		
Asthma or Lung Disease		
Cancer (type)		
Constipation / Diarrhea		
Diabetes		
Digestive Disease		
Gastrointestinal Bleeding		
Headache / Migraine		
Hearing Problems		
Heart Disease		
Hepatitis		
High Blood Pressure		
High Cholesterol		
Kidney Problems		
Nausea / Vomiting		
Osteoporosis		
Polyps		
Sleep Apnea		
Thyroid		
Ulcers		
Vertigo		
Other		

List of Current Medications, Dose and Frequency:

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AUDIOLOGY CASE HISTORY QUESTIONNAIRE

(DR. FURST REQUIRES ALL NEW PATIENTS TO COMPLETE THIS SECITON, THANK YOU)

Name: _____ **DOB:** _____ **Date:** _____

Please answer the following questions:

YES NO Any active drainage from the ear within the last 90 days?

YES NO Any history of sudden or rapidly progressive hearing loss within the last 90 days?

YES NO Have you experienced any acute (recent) or chronic long term dizziness?

YES NO Is there a sudden or recent onset of unilateral (one ear) hearing loss within the last 90 days?

YES NO Do you have any ringing, noises, or sounds in your ears?

YES NO Do any of your family members have hearing loss?

YES NO Have you ever been exposed to excessive noise?

YES NO Have you had any ear surgery? If so, when? _____

YES NO Have you received any medical or surgical treatment for hearing loss?

YES NO Have you experienced any pain or discomfort in the ear?

YES NO Have you seen a physician regarding your ears? If so, who? _____

YES NO Do you take a blood thinner?

YES NO Have you ever had a stroke or heart attack?

YES NO Have you ever had a trauma or blow to your head?

YES NO Have you ever worn a hearing aid before? When? _____

Which is your best ear? RIGHT LEFT Both are the same.

Please described your hearing loss

_____

_____