Florida Gulf Coast
EAR, NOSE & THROAT LLC

Medical Information Sheet

Patient's Name _____ **Age** _____ **DOB** ____/_____/_____

Primary Reason for Today's Visit _____

Who referred you to our office? _____ **Primary Care Physician** _____

Pharmacy Name, Location & Phone Number _____

Family History (***this information pertains to immediate family members***)

☐Hearing loss ☐Heart problems ☐Cancer ☐Diabetes ☐Thyroid Disease ☐Bleeding disorder ☐Sleep Apnea

☐Sinus / Allergy Problems ☐Anesthesia problems ☐Asthma

Other (specify)_____

Social History: (***this information pertains to the patient only***)

Tobacco use: ☐Never___ ☐Quit x ___ years ☐Smoke ___ppd x ___ years ☐Dip/Chew ____cans/day

If child – Does anyone who lives with child smoke? _____No _____ Yes

Alcohol use: No____ ☐Yes – List type, amount & frequency _____

Drug use: No_____ ☐Yes – List type, amount & frequency_____

Full-time Florida Resident_____ Snowbird_____ If child do they attend daycare? ___ No ___ Yes

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Past Medical History (***this information pertains to the patient only***)

Medication Allergies? _____ **no** _____ **yes** - please list _____

Food or Latex Allergy? _____ **no** _____ **yes** - please list _____

List previous operations, give date of procedure or age when performed _____

Have you ever had any problems associated with receiving general anesthesia during an operation?___No __Yes

If yes, provide details_____

Do you have any bleeding problems or have you had heavy bleeding during or after any procedure/operation?
Yes_____ No_____

Immunizations: (Please include dates) Hepatitis A_____ Hepatitis B_____ Measles_____ Tetanus_____
Pneumonia_____Varicella_____Influenza_____ Rubella_____

REVIEW OF SYSTEMS (*this information pertains to patient only; circle all that apply*):

EARS: Hearing Loss □Tinnitus (noise in ears) □ □Balance problems □Dizzy(Vertigo) □ Wax Impaction
NOSE: Difficulty breathing □Stuffiness Recurrent infection □Post Nasal Drip Bleeding Snoring
THROAT: Difficulty Swallowing Voice changes Sensation of lump in throat Tonsilliths / Tonsil stones □
MOUTH: Mouth breathing □Bad breath/ Foul Odor □Bad taste □Oral lesion Tongue Tied
NECK: Mass/lump □Swollen glands □Pain □Injuries □Thyroid nodules □
HEAD/ FACE: Persistent headaches □Facial pain/pressure □Injuries □
Eyes: Loss/Change in Vision Burning/Itching Discharge
Constitution: Fever Weight Loss Weight Gain Night Sweats
Heart/Vascular: High Blood Pressure Heart Disease Varicose Veins
Breathing/Respiratory: Shortness of Breath Coughing Wheezing
Stomach/Intestinal: Nausea/Vomiting Diarrhea Abdominal Pain
Urinary/Kidneys: Incontinence Pain with Urination Kidney Stones
Muscles / Bones: Arthritis Pain/Swelling
Skin: Rash Excessive Dryness Discoloration
Neurological: Stroke Headache Loss of Balance Weakness
Mental Health/Psychiatric: Depression Anxiety Difficulty Sleeping
Blood/Lymph System: Non-Healing Wounds Excessive Bleeding
Endocrine System: Increased Urination or Thirst Palpitations Anxiety

_____

Is there anything else about your medical history or current condition that might be helpful for the doctor to know? (please specify) _____

List any medical conditions you are currently being treated for: _____

_____

List current medications and dosage (Include over the counter medications):

If you have a written list of medications please give to medical assistant when called back to see physician.

Medication Name	**Strength (mg)**	**How many & times per day**
_____	_____	
_____	_____	
_____	_____	
_____	_____	

Florida Gulf Coast EAR, NOSE & THROAT LLC

PATIENT INFORMATION

Patient Name:Last_____**First**_____**MI**_____

Date of Birth: _____/_____/_____ **Age:**_____ **Gender: Male**_____**Female**_____ **Marital Status:** ___**S** ___**M** ___**D** ___**W**

Street Address_____

City _____ **State** _____ **Zip Code** _____

Preferred method of communication (Circle): Cell phone Home Phone Email

Home Phone _____**Cell Phone** _____**Work Phone** _____

Email Address_____**Social Security #**_____

By providing your email address you agree that our office staff may contact you via email for non-urgent matters such as appointment reminders, office updates, etc. We respect your privacy and will not share your information with third parties.

How Did You Hear About Us?

Please be specific and include the name of radio station, website or print publication if applicable.

Name of Physician Referred_____Radio_____

Internet Search_____ Print Publication_____ Other_____

Mailer_____ Insurance_____

Name of Insured: Last _____ **First** _____ **MI** ____ **SSN**_____

Date of Birth __/__/____ **Male**__ **Female**__ **Home Phone**_____**Work** _____

Street Address _____

City _____ **State**_____ **Zip Code** _____

Insurance Plan Name and Policy Number_____

Responsible Party, if different from above_____

Race (Circle): Native American/Alaskan, Asian/Pacific Islander, Black/African American, White, Decline to State

Ethnicity(Circle): Hispanic/Latino, Not Hispanic/Not Latino, Decline to State

Language(Circle): English, Spanish, Other_____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Florida Gulf Coast Ear, Nose and Throat LLC. to diagnose and treat me. I also authorize Florida Gulf Coast Ear, Nose and Throat LLC. to release medical and/or any other information to my insurance carrier, and/or Centers for Medicare and Medicaid Services or its intermediaries or carriers, any information needed for payment on Medicare/Insurance Company Claims for services rendered by Florida Gulf Coast Ear, Nose and Throat LLC and/or its physicians. I permit a copy of this authorization to be used in place of the original, and request assignment of payment of medical insurance benefits either to Florida Gulf Coast Ear, Nose and Throat LLC. and/or its physicians. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for treatment. (Section 1128B of the SS Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information). I have also been informed of my rights to privacy via posters and handouts contained within this office as mandated under the current federal HIPAA laws. I also acknowledge receipt and understanding of the Florida Gulf Coast Ear, Nose and Throat LLC. Financial Policy and Patient Notification for Payer Payment Policies for Certain In-Office Procedures.

_____ _____

Patient or Legal Guardian Signature (If patient under 18 years old) **Date**

FINANCIAL POLICY

Patient Name: _____

As our office strives to hold down the cost of patient care, it is important for you to understand your financial responsibility for your medical care. **Our office performs "in office" procedures in which your insurance company may consider a surgical procedure.** In some cases **they will apply** "outpatient benefits" in which you may have to meet a deductible or pay an additional co-insurance amount. ***Please check your insurance benefits book for coverage information.***

It is important for you to understand what your insurance policy covers and does not cover. Each patient's insurance policy is different and because of this, it is impossible for our staff to know the details of each insurance policy. ***It is your responsibility to understand your coverage, benefits and financial responsibilities. If you have questions regarding your insurance, please call the member services department listed on your insurance card.***

MANAGED CARE PATIENTS: It is your responsibility to obtain all necessary referrals and/or authorization from your Primary Care Physician. You will be responsible for all services if insurance denies due to no authorization.
All co-payments are due at the time of service

COMMERCIAL INSURANCE PATIENTS: We will file your medical services to your insurance company for you. As a courtesy, we will also file any secondary insurance policies that you may have. However, you are fully responsible for all charges incurred especially any charges denied as non-covered by your insurance company. Your insurance may have its own "Usual, Customary, and Reasonable (UCR)" fee schedule.

SELF-PAY PATIENTS: You are responsible for payment of services on the day you are seen. A $500 deposit will be collected at time of check-in.

MEDICARE PATIENTS: We are participating with Medicare. We will bill Medicare for you. Please note Federal Law requires us to collect your yearly deductible and co-insurance amounts. If you have a secondary insurance we will bill your secondary insurance after Medicare pays. We do not set Medicare rates.

STATE ASSISTED PATIENTS: We participate with the Florida State Medicaid program and will bill Medicaid. Medicaid benefits are valid month to month; therefore, it will be necessary to present your Medicaid certificate to us each month. We will collect all co-payments at the time of service. Please note, if there is a lapse in your monthly Medicaid coverage (i.e. you are not eligible for Medicaid benefits) you will be considered a Self-Pay patient.

NO SHOW FEE: Cancellations must be received 48 hours prior to your scheduled appointment or a $25.00 no show fee will be charged. If you should fail to show for your hearing test and office visit there will be a charge of $50.00. Failure to show for allergy testing, dizziness evaluations and office procedures will result in a $100.00 fee. Thank you for your consideration.

PAYMENT POLICY
All co-payments, coinsurance amounts, deductibles and/or other patient due balances must be paid in full at the time of your visit. Failure to make payment on your account **will result in your dismissal** from the practice and your account will be turned over to an outside collection agency for payment**.** You will be responsible for any additional collection or legal fees incurred. **We report unpaid accounts to the credit bureau.** Please note that we have a $30.00 returned check fee on all checks returned to us from our bank for non-sufficient funds which will be charged to your patient account and responsible to pay.

Medical Records
Your medical records are property of FGCENT. You are entitled to copies of your medical record. A fee of $1.00 per page os charged for the cost of processing. If you need your records trasfered to another provier a release of medical records needs to be completed and filed with the practice.

Date _____ **Patient/Guardian Signature** _____

PATIENT CONFIDENTIALITY

Florida Gulf Coast Ear, Nose and Throat LLC. Follows HIPAA guidelines to ensure integrity of your privacy. We need your help in ensuring your privacy by providing us with the following information:
May we leave a detailed message regarding your healthcare on your voice mail: ____ **Yes** ____**No**

In the event that I, _____ cannot be reached personally, Florida Gulf Coast Ear, Nose and Throat LLC. May leave any test result, lab result, appointment information, or other confidential medical or financial information to the following designated individuals:

Name	Relationship to Patient	Date of Birth (mm/dd)	Contact Phone

Release of your protected health information (PHI) to anyone other than the patient or partent/legal guardian will be restricted to those individuals listed above or individuals otherwise listed on the Notice of Privacy Practices.

Patient Signature: _____ Date: _____

E-PRESCRIBING CONSENT

ePrecribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These include:

Formulary and benefit transactions — Gives the prescriber information about which drugs are covered by the drug benefit plan.

Medication history transactions - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

Fill status notification - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent you are agreeing that Florida Gulf Coast Ear, Nose & Throat can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Florida Gulf Coast Ear, Nose & Throat to enroll me in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Patient Name_____Signature of patient or legal guardian:_____

AUTHORIZATION TO PERFORM PROCEDURE

_____

Patient name

A patient presenting to our office with any ear, nose or throat complaint requires a thorough examination. In many cases, this can only be accomplished through the use of a diagnostic procedure or office procedure. These are essentially painless and usually can be accomplished quickly. A procedural fee will be submitted to your insurance carrier for this procedure. In most cases we will accept your insurance company's allowance for this procedure. You will be obligated to pay any deductible and or co-payments/coinsurance that are applied to this claim. Please be advised that some insurance companies may list these diagnostic procedures as "surgery" on the insurance remittance form you receive.

These procedures ensure that you have the most complete evaluation and, if recommended, have been deemed medically necessary by your physician to fully evaluate or potentially treat your current complaint. By refusing any diagnostic test, procedure, or evaluation recommended by your physician, you acknowledge that you are putting yourself at risk of missing a potentially serious medical condition. Any refusal will be noted in your permanent medical record. Please sign below to acknowledge that you have read the above and agree to undergo the procedure ***if*** deemed necessary by your physician upon any visit.

The most common office procedures include, but are not limited to, these listed below:

- Nasal Endoscopy 31231
- Flexible Laryngoscopy 31575
- Nasopharyngoscopy 92511
- Nasal Debridment 31237
- Binocular Microscopy 92504
- Cerumen Removal 69210

_____ _____ _____

Date **Patient/Guardian Signature** **Witness**