Jacksonville ENT Surgery

www.jacksonvilleENTsurgery.com

MAIN OFFICE	SATELLITE OFFICE	SATELLITE OFFICE	SATELLITE OFFICE	SATELLITE OFFICE
11512 Lake Mead Ave Ste #536	4131 University Blvd S #18	3890 Dunn Ave Ste #202	1444 Beach Blvd, #28	789 W. Duval St
Jacksonville, FL 32256	Jacksonville, FL 32216	Jacksonville, FL 32218	Jacksonville, FL 32250	Lake City, FL 32055
(904) 419-2054 (Ph)	(904) 419-2054 (Ph)	(904) 419-2054 (Ph)	(904) 419-2054 (Ph)	(904) 419-2054 (Ph)
(904) 419-2057 (Fax)	(904) 419-2057 (Fax)	(904) 419-2057 (Fax)	(904) 419-2057 (Fax)	(904) 419-2057 (Fax)

Patient Registration

Patient Information

Name: _____ Today's Date: _____

Sex: _____ Age: _____ Birthdate: _____ Social Security #: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone #: _____Work Phone #: _____ Mobile Phone #: _____

Marital Status (Check One): ○ Married ○ Single ○ Divorced ○ Widowed ○ Separated ○ Common Law ○ Living Together

○ Domestic Partner ○ Registered Domestic Partner ○ Legally Separated ○ Annulled ○ Interlocutory

Email address: _____

Emergency Contact

Name: _____ Phone: _____ Relationship to Patient: _____

For minors:

Guardian/Responsible Party: _____ Relationship to Patient: _____

Birthdate: _____ Social Sec #: _____ Tel#: _____

Address (if different from patient's): _____

Pharmacy and Referrals

Name, Location & Telephone #:_____

Primary Care Physician's Name, Location & Telephone #: _____

Referring Physician's Name, Location & Telephone #: _____

If you are under the care of any specialists, please provide their Names, Locations, & Telephone #s:

_____

Medical History

Please check off any of the following medical conditions that you currently have:

- ☐ NONE
- ☐ Cancer: Bone
- ☐ Cancer: Brain
- ☐ Cancer: Breast
- ☐ Cancer: Cervical
- ☐ Cancer: Chronic lymphocytic leukemia
- ☐ Cancer: Colon
- ☐ Cancer: Endometrial
- ☐ Cancer: Esophageal
- ☐ Cancer: Head and Neck
- ☐ Cancer: Leukemia
- ☐ Cancer: Liver
- ☐ Cancer: Lung
- ☐ Cancer: Lymphoma
- ☐ Cancer: Myeloma
- ☐ Cancer: Ovarian
- ☐ Cancer: Prostate
- ☐ Cancer: Pancreas
- ☐ Cancer: Sarcoma (soft tissue)
- ☐ Cancer: Skin - Basal cell carcinoma
- ☐ Cancer: Skin - Melanoma
- ☐ Cancer: Skin - Merkel cell carcinoma
- ☐ Cancer: Skin - Squamous cell carcinoma
- ☐ Cancer: Other
- ☐ Cardio: Arrhythmia
- ☐ Cardio: Atrial fibrillation
- ☐ Cardio: Cardiomyopathy
- ☐ Cardio: Congestive heart failure
- ☐ Cardio: Coronary artery disease
- ☐ Cardio: Hyperlipidemia/High Cholesterol
- ☐ Cardio: Hypertension/High blood pressure
- ☐ Cardio: Myocardial infarction/Heart attack
- ☐ Cardio: Valve disease; valve prolapse, stenosis, or "leaky" valve
- ☐ Cardio: Other
- ☐ Endocrine: Diabetes
- ☐ Endocrine: Diabetes, Type 1
- ☐ Endocrine: Diabetes, Type 2
- ☐ Endocrine: Pituitary adenoma or other pituitary problem
- ☐ Endocrine: Thyroid disease
- ☐ Endocrine: Other
- ☐ General: Eating disorder
- ☐ General: Obesity
- ☐ General: Sexually transmitted infection
- ☐ GI: Barrett's Esophagus
- ☐ GI: Cholecystitis (gallbladder disease) or gallstones
- ☐ GI: Cirrhosis
- ☐ GI: Diverticulitis
- ☐ GI: Diverticulosis
- ☐ GI: Hemorrhoids
- ☐ GI: Incontinence
- ☐ GI: Inflammatory bowel disease
- ☐ GI: Irritable bowel syndrome
- ☐ GI: Liver Disease: Auto-Immune Hepatitis
- ☐ GI: Liver Disease - Hepatitis
- ☐ GI: Liver Disease - Hepatitis A
- ☐ GI: Liver Disease - Hepatitis B
- ☐ GI: Liver Disease - Hepatitis C
- ☐ GI: Liver Disease - Cirrhosis
- ☐ GI: Liver Disease: Sclerosing Cholangitis
- ☐ GI: Reflux/GERD
- ☐ GI: Other
- ☐ Uro: Benign prostatic hypertrophy (large prostate)
- ☐ Uro: End stage renal disease (kidney failure)
- ☐ Uro: Incontinence
- ☐ Uro: Kidney Stones
- ☐ Uro: Recurrent urinary tract infections
- ☐ Uro: Urinary/kidney reflux
- ☐ Uro: Other
- ☐ Ob/Gyn: Endometriosis
- ☐ Ob/Gyn: Fibroids
- ☐ Ob/Gyn: HPV (Papilloma virus/warts)
- ☐ Ob/Gyn: Polycystic ovary disease
- ☐ Ob/Gyn: Pregnancy history
- ☐ Ob/Gyn: Other
- ☐ Immuno: HIV
- ☐ Immuno: Immunodeficiency
- ☐ Immuno: Other
- ☐ Lymph: Anemia
- ☐ Lymph: Bleeding disorder/Hemophilia
- ☐ Lymph: Blood clotting disorder
- ☐ Lymph: Neutropenia (low white blood count)
- ☐ Lymph: Sickle cell anemia
- ☐ Lymph: Thrombocytopenia (low platelets)
- ☐ Lymph: Other
- ☐ Ortho: Arthritis
- ☐ Ortho: Degenerative joint disease
- ☐ Ortho: Osteoporosis
- ☐ Ortho: Spinal stenosis
- ☐ Ortho: Other
- ☐ Neuro: ALS
- ☐ Neuro: Alzheimer's
- ☐ Neuro: Autism
- ☐ Neuro: Cerebral (brain) aneurysm
- ☐ Neuro: Cerebral palsy
- ☐ Neuro: CVA/Stroke
- ☐ Neuro: Dementia
- ☐ Neuro: Developmental delay
- ☐ Neuro: Headaches Cluster
- ☐ Neuro: Headaches Migraine
- ☐ Neuro: Headaches Muscular Tension
- ☐ Neuro: Headaches (specify type)
- ☐ Neuro: MS (Multiple sclerosis)
- ☐ Neuro: Parkinson's
- ☐ Neuro: Seizures
- ☐ Neuro: Other
- ☐ Ophth/Opt: Blindness
- ☐ Ophth/Opt: Macular degeneration
- ☐ Ophth/Opt: Cataracts
- ☐ Ophth/Opt: Glaucoma
- ☐ Ophth/Opt: Detached retina
- ☐ Ophth/Opt: Other
- ☐ Psych: Anxiety
- ☐ Psych: Bipolar disorder
- ☐ Psych: Depression
- ☐ Psych: Personality Disorder
- ☐ Psych: Psychosis
- ☐ Psych: Schizophrenia
- ☐ Psych: Other
- ☐ Pulm: Asthma
- ☐ Pulm: Bronchiectasis
- ☐ Pulm: COPD
- ☐ Pulm: Cystic Fibrosis

- ☐ Pulm: Emphysema
- ☐ Pulm: Obstructive sleep apnea (OSA)
- ☐ Pulm: Pulmonary Embolism
- ☐ Pulm: Pulmonary Fibrosis
- ☐ Pulm: Pulmonary Hypertension
- ☐ Pulm: Other
- ☐ Rheum: Autoimmune disorder (specify type)
- ☐ Rheum: Fibromyalgia
- ☐ Rheum: Gout
- ☐ Rheum: Lupus
- ☐ Rheum: Rheumatoid Arthritis
- ☐ Rheum: Scleroderma
- ☐ Rheum: Sjorgren's syndrome
- ☐ Rheum: Other
- ☐ Vasc: Peripheral artery disease
- ☐ Vasc: Carotid stenosis
- ☐ Vasc: Abdominal aortic aneurysm
- ☐ Vasc: Thoracic aortic aneurysm
- ☐ Vasc: Other
- ☐ Other

Surgical History

Please tell us about your surgical history. Check all that apply.

- ☐ NONE
- ☐ Abdominal/GI: Abdominoperineal resections (APR)
- ☐ Abdominal/GI: Appendectomy
- ☐ Abdominal/GI: Bariatric surgery (specify type)
- ☐ Abdominal/GI: Bowel resection
- ☐ Abdominal/GI: Cholecystectomy (gallbladder)
- ☐ Abdominal/GI: Colectomy - Colon resection
- ☐ Abdominal/GI: Colectomy - Diverticulitis
- ☐ Abdominal/GI: Colectomy - Inflammatory bowel disease
- ☐ Abdominal/GI: Colostomy
- ☐ Abdominal/GI: Esophagectomy
- ☐ Abdominal/GI: Exploratory bowel surgery
- ☐ Abdominal/GI: Gastrectomy (stomach resection)
- ☐ Abdominal/GI: Hepatectomy (liver resection)
- ☐ Abdominal/GI: Hemorrhoidectomy
- ☐ Abdominal/GI: Hernia repair
- ☐ Abdominal/GI: Liver Shunt
- ☐ Abdominal/GI: Liver transplant
- ☐ Abdominal/GI: Low anterior resection
- ☐ Abdominal/GI: Pancreas resection
- ☐ Abdominal/GI: Splenectomy
- ☐ Abdominal/GI: Other
- ☐ Breast: Lumpectomy (Both Breasts)
- ☐ Breast: Lumpectomy (Left Breast)
- ☐ Breast: Lumpectomy (Right Breast)
- ☐ Breast: Mastectomy (Both Breasts)
- ☐ Breast: Mastectomy (Left Breast)
- ☐ Breast: Mastectomy (Right Breast)
- ☐ Breast: Other
- ☐ Cosmetic: Breast augmentation
- ☐ Cosmetic: Breast reduction
- ☐ Cosmetic: Eyelid (blepharoplasty)
- ☐ Cosmetic: Facelift
- ☐ Cosmetic: Liposuction
- ☐ Cosmetic: Rhinoplasty
- ☐ Cosmetic: Tummy tuck
- ☐ Cosmetic: Other
- ☐ Heart: Biological Valve Replacement
- ☐ Heart: Coronary artery bypass surgery (CABG)
- ☐ Heart: Heart transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: Pacemaker
- ☐ Heart: PTCA (Percutaneous transluminal coronary angioplasty)
- ☐ Heart: Thoracic aortic aneurysm repair
- ☐ Heart: Other
- ☐ Lymph: Lymph node biopsy (specify location)
- ☐ Lymph: Other
- ☐ Neurosurgery: Craniotomy
- ☐ Neurosurgery: Pituitary
- ☐ Neurosurgery: Spine - Discectomy
- ☐ Neurosurgery: Spine - Fusion
- ☐ Neurosurgery: Spine - Hardware
- ☐ Neurosurgery: Spine - Laminectomy
- ☐ Neurosurgery: Tumor removal
- ☐ Neurosurgery: VP shunt
- ☐ Neurosurgery: Other
- ☐ Ob/Gyn: Bilateral tube ligation (tube tie)
- ☐ Ob/Gyn: Caesarean section
- ☐ Ob/Gyn: Dilation and curettage (D&C of uterus)
- ☐ Ob/Gyn: Hysterectomy - Caesarean section
- ☐ Ob/Gyn: Hysterectomy - Cervical cancer
- ☐ OB/Gyn: Hysterectomy - Uterine cancer
- ☐ Ob/Gyn: Oophorectomy (ovary resection)
- ☐ Ob/Gyn: Tubal Ligation
- ☐ Ob/Gyn: Other
- ☐ Ophth/Opt: Cataract surgery
- ☐ Ophth/Opt: Corneal surgery
- ☐ Ophth/Opt: Glaucoma surgery
- ☐ Ophth/Opt: Injections
- ☐ Ophth/Opt: Lasik
- ☐ Ophth/Opt: Lid
- ☐ Ophth/Opt: Macular hole
- ☐ Ophth/Opt: Retinal detachment repair
- ☐ Ophth/Opt: Laser retinal surgery

- ☐ Ophth/Opt: Other
- ☐ Ortho: Carpal tunnel
- ☐ Ortho: Hip arthroscopic surgery
- ☐ Ortho: Hip replacement
- ☐ Ortho: Knee arthroscopic surgery
- ☐ Ortho: Knee replacement
- ☐ Ortho: Shoulder arthroscopic surgery
- ☐ Ortho: Shoulder replacement
- ☐ Ortho: Surgical fracture repair (ORIF - specify bone)
- ☐ Ortho: Tumor resection
- ☐ Ortho: Other
- ☐ Pulm: Lung transplant
- ☐ Pulm: Pleurodesis
- ☐ Pulm: Pneumonectomy (lung resection)
- ☐ Pulm: Other
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: MOHs resection
- ☐ Skin: Skin Biopsy
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Skin: Wide local resection
- ☐ Skin: Other
- ☐ Uro: Cystectomy
- ☐ Uro: Implant
- ☐ Uro: Kidney stone removal
- ☐ Uro: Kidney transplant
- ☐ Uro: Nephrectomy (kidney resection)
- ☐ Uro: Orchiectomy (testicle resection)
- ☐ Uro: Prostatectomy - Prostate Cancer
- ☐ Uro: Prostatectomy - TURP
- ☐ Uro: Other
- ☐ Vascular: Abdominal aortic aneurysm repair
- ☐ Vascular: AV shunt (for dialysis access)
- ☐ Vascular: Carotid endarterectomy
- ☐ Vascular: Vascular bypass (leg vessels)
- ☐ Vascular: Other
- ☐ Breast: Lumpectomy (Both Breast)
- ☐ Breast: Lumpectomy (Left Breast)
- ☐ Breast: Lumpectomy (Right Breast)
- ☐ Breast: Mastectomy (Both Breast)
- ☐ Breast: Mastectomy (Left Breast)
- ☐ Breast: Mastectomy (Right Breast)
- ☐ Ortho: Carpal tunnel
- ☐ Colon (Colectomy) : Colon Cancer Resection
- ☐ Colon (Colectomy) : Diverticulitis
- ☐ Colon (Colectomy) : Inflammatory Bowel Disease
- ☐ Colon: Colostomy
- ☐ Esophagectomy
- ☐ Eye: Cataract
- ☐ Eye: Glaucoma Surgery
- ☐ Eye: Laser Surgery
- ☐ Gallbladder (Cholecystectomy)
- ☐ Gastrectomy
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Kidney: Kidney Stone Removal
- ☐ Kidney: Kidney Transplant
- ☐ Kidney: Neprectomy
- ☐ Liver: Hepatectomy
- ☐ Liver: Liver Transplant
- ☐ Liver: Shunt
- ☐ Lymph Node Excision
- ☐ Neuro: Crani
- ☐ ORIF
- ☐ Ovaries (Oophorectomy) : Ovarian Cancer
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate (Prostatectomy): Prostate Cancer
- ☐ Prostate (Prostatectomy): TURP
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Spine: Discectomy
- ☐ Spine: Fusion
- ☐ Spine: Hardware
- ☐ Spine: Laminectomy
- ☐ Uterus (Hysterectomy): Cesearean Section
- ☐ Uterus (Hysterectomy): Uterine Cancer
- ☐ Uterus (Hysterectomy): Cervical Cancer
- ☐ Other

Female Patients Only

Please complete the following: Last menstrual period: _____

Last mammogram: _____

Last pelvic exam: _____

Last Pap smear: _____

Pediatric History

Gestational Age at Birth: _____ (in weeks)

Birth Weight: _____lbs. _____oz.

Maternal Illness during Pregnancy: _____

Forceps Delivery: ◯Yes ◯No

ENT History

Please check off any of the following procedure you have had and provide date of procedure:

ENT Disease History

- ☐ None
- ☐ Cancer: Head and neck Cancer - specify location
- ☐ Cancer: Lymphoma, neck nodes
- ☐ Cancer: Sinus or nasal cavity
- ☐ Cancer: Skin - basal cell carcinoma
- ☐ Cancer: Skin - Melanoma
- ☐ Cancer: Skin - other type - specify
- ☐ Cancer: Skin - squamous cell carcinoma
- ☐ Ear: Acoustic neuroma
- ☐ Ear: Cholesteatoma
- ☐ Ear: Hearing loss
- ☐ Ear: Mastoiditis
- ☐ Ear: Other
- ☐ Ear: Otitis externa (swimmer's ear)
- ☐ Ear: Otitis media (middle ear infection)
- ☐ Ear: Otosclerosis
- ☐ Ear: Tinnitus (ringing or other noise of the ear)
- ☐ Ear: Vertigo
- ☐ General: Facial fractures
- ☐ General: Other
- ☐ General: reflux
- ☐ Larynx/trachea: Papillomas
- ☐ Larynx/trachea: Subglottic stenosis
- ☐ Larynx/trachea: Tracheal stenosis
- ☐ Larynx/trachea: Vocal cord nodules
- ☐ Larynx/trachea: Vocal cord paralysis
- ☐ Larynx/trachea: Vocal cord polyps
- ☐
- ☐ Larynx: Other
- ☐ Nasal: Deviated septum
- ☐ Nasal: Epistaxis (nose bleeds)
- ☐ Nasal: Loss of smell
- ☐ Nasal: Nasal fracture
- ☐ Nasal: Nasal obstruction
- ☐ Nasal: Other
- ☐ Nasal: Polyps
- ☐ Nasal: Rhinitis (allergies)
- ☐ Nasal: Septal perforation
- ☐ Nasal: Sinusitis
- ☐ Nasal: Turbinate hypertrophy
- ☐ Neck: Branchial cleft cyst
- ☐ Neck: Hyperparathyroidism
- ☐ Neck: Neck mass
- ☐ Neck: Other
- ☐ Neck: Parotid tumor
- ☐ Neck: Sialoadenitis (infected or inflamed salivary gland)
- ☐ Neck: Sialolithiasis (stone of the salivary gland)
- ☐ Neck: Thyroglossal duct cyst
- ☐ Neck: Thyroid nodules
- ☐ Oral: other
- ☐ Oral: Sleep apnea
- ☐ Oral: Tonsillitis
- ☐ Oral: Ulcers
- ☐ Other

  _____

ENT Surgical History

- ☐ None
- ☐ Ear: Acoustic neuroma resection
- ☐ Ear: Mastoidectomy
- ☐ Ear: Myringotomy and tubes (specify ear)
- ☐ Ear: Myringotomy (specify ear)
- ☐ Ear: Other - specify
- ☐ Ear: Otoplasty
- ☐ Ear: Stapedectomy
- ☐ Ear: Tympanoplasty (repair ear drum)
- ☐ Head and neck: Lymph node biopsy
- ☐ Head and neck: Neck dissection
- ☐ Head and neck: Other - specify
- ☐ Head and neck: Parathyroidectomy
- ☐ Head and neck: Parotidectomy
- ☐ Head and neck: Resection in mouth or throat - specify
- ☐ Head and neck: Skin graft
- ☐ Head and neck: Skin resection
- ☐ Head and neck: Submandibular gland excision
- ☐ Head and neck: Thyroglossal duct cyst excision
- ☐ Head and neck: Thyroidectomy
- ☐ Head and neck: Tracheotomy
- ☐ Nose: Balloon sinuplasty
- ☐ Nose: Endoscopic sinus surgery
- ☐ Nose: Nasal fracture repair
- ☐ Nose: Other - specify
- ☐ Nose: Rhinoplasty
- ☐ Nose: Septoplasty
- ☐ Nose: Turbinate reduction

- ☐ Throat: Adenoidectomy
- ☐ Throat: Other - specify
- ☐ Throat: Sleep apnea surgery - uvulopalatopharyngoplasty (UPPP)
- ☐ Throat: Tonsillectomy
- ☐ Other _____

ENT Family History

- ☐ None
- ☐ Otitis Media
- ☐ Sinusitis
- ☐ Smoking
- ☐ Thyroid Cancer
- ☐ Thyroid Disease
- ☐ Other _____

ENT Pediatric History

- ☐ None
- ☐ Cleft Lip
- ☐
- ☐ Cleft Palate
- ☐ Otitis Media
- ☐
- ☐ Other _____

Medications

Please list all medications you are currently taking:

Drug: _____ Dosage: _____ Frequency: ____

Drug: _____ Dosage: _____ Frequency: ____

Drug: _____ Dosage: _____ Frequency: ____

Drug: _____ Dosage: _____ Frequency: ____

Drug: _____ Dosage: _____ Frequency: ____

Drug: _____ Dosage: _____ Frequency: ____

Allergies

Please list all known allergies (environment, drug, food), as well as the type of reaction and level of severity:

Allergy: _____ Reaction: _____ Severity: _____

Allergy: _____ Reaction: _____ Severity: _____

Allergy: _____ Reaction: _____ Severity: _____

Allergy: _____ Reaction: _____ Severity: _____

Social History

Smoking Status:

- ☐ NEVER
- ☐ Former Smoker
- ☐ Light Tobacco Smoker
- ☐ Heavy Tobacco Smoker
- ☐ Current Some Day smoker
- ☐ Current Everyday Smoker
- ☐ Cigar Smoker
- ☐ Chewing Tobacco User

If applicable:

When did you start smoking? _____

When did you quit smoking? _____

Number of packs per day: _____

Total number of years smoking: _____

Alcohol Consumption:

- ☐ None
- ☐ Less than 1 Drink per Day
- ☐ 1-2 Drinks per Day
- ☐ 3+ Drinks per Day
- ☐ Other: _____

Other details:

- ☐ Not Sexually Active
- ☐ Sexually Active with One Partner
- ☐ Sexually Active with Multiple Partners
- ☐ Drug Use
- ☐ IV Drug Use
- ☐ Patient Feels Safe at Home
- ☐ Patient Drives During the Day
- ☐ Patient Drives at Night
- ☐ Patient Exercises (Frequency: _____)
- ☐ Patient Consumes Caffeine (Frequency: _____)

Driving Status:

- ☐ Drives in the Daytime
- ☐ Drives at Night

Employer & Occupation: _____

Place of Residence: _____

Family History

Please list any family history of illness or disease:

Disease/Illness: _____ Relation: _____ Deceased? ◯ Yes ◯ No

Disease/Illness: _____ Relation: _____ Deceased? ◯ Yes ◯ No

Disease/Illness: _____ Relation: _____ Deceased? ◯ Yes ◯ No

Disease/Illness: _____ Relation: _____ Deceased? ◯ Yes ◯ No

Let us know if there is anything else you would like to disclose:

_____

_____

Authorization to Release Medical Information

I, _____authorize my information to be given to:
Patient Name

Name:_____Relation:_____Phone_____

Name:_____Relation:_____Phone_____

Name:_____Relation:_____Phone_____

Name:_____Relation:_____Phone_____

Regarding the initialed items below: I understand that by signing this form, only the person(s) designated above is/are allowed to obtain my information and they are only allowed to obtain information regarding the items that I have designated below. By initialing next to "ALL INFORMATION", I understand that the person(s) listed above will have availability to all of my medical and personal information that Jacksonville ENT Surgery has on file. I understand that this written authorization will remain in my permanent record and will not change at any time unless I issue a written consent to discontinue and/or change this authorization.

Initial information you authorize to release:

_____Appointment Dates/Times
_____Test Results
_____Office notes
_____Surgery Information
_____ALL INFORMATION
_____Other_____

☐ NO INFORMATION IS TO BE RELEASED

_____ _____
(Patient Signature) ***(Date)***

_____ _____
(Staff Witness) ***(Date)***

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APPOINTMENT CANCELLATION & NO SHOW POLICY

Missing an appointment or cancelling an appointment (this includes clinic appointments, in office tests/procedures, and/or operative procedure appointments) within so many hours of your scheduled appointment time will result in a cancellation fee that will be assessed to your account:

We require **24 business hours** or the following fees will be assessed for:

$50.00 **Office visit**

$100.00 **in-office tests/procedures**

We require **72 business hours** or the following fee will be assessed for:

$200.00 **Surgery (in-office surgery/Outside Facility)**

Please be advised that this fee is **NOT** covered by insurance.

*** Please be advised that if you are a **"No Show"** for **3** appointments, you are subject to **dismissal** from the practice. ***

I acknowledge that I have read and understand the above statement.

Signature _____ Witness _____

Date _____

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PATIENT PRIVACY PRACTICE ACKNOWLEDGEMENT AND CONSENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I have reviewed and I consent to the above statements.

Patient Name:_____ Phone: _____

Patient/Guardian Signature:_____ Date:_____

****

PATIENT CONTACT

All calls regarding your appointments, diagnostic or surgical scheduling will be made to your home phone number. If you would like us to contact you on an alternate phone number, please indicate that number here:_____ Location:_____

_____ (initial here) I hereby authorize this medical practice to contact me by telephone and if I am not present, they may leave a message on my answering machine/voicemail or with (name of individual):_____

~OR~

_____ (initial here) If you prefer that we do **NOT** leave messages on your answering machine.

****

OFFICE USE ONLY

Signed form received by *(print):*_____ Initials: _____

Acknowledgement refused:_____
Reason for refusal:_____