Austin ENT ASSOCIATES

WELCOME TO OUR PRACTICE
New Patient Form
Adults 18 and older

Today's date: _____ MR#: _____

PATIENT INFORMATION

Last name _____ First Name _____ MI _____ Sex: ❑ M ❑ F

Age _____ Birth Date _____ Social Security # _____ Driver's Lic # _____

Home Address _____

City _____ State _____ Zip _____

Primary Phone _____ Secondary Phone _____ Work Phone _____

E-mail address to reach you: _____

May we share your e-mail address with the hospital or surgery center if you schedule surgery with one of our physicians? ❑ Yes ❑ No

Are you employed? Yes _____ No _____ Retired _____ Student _____

If yes, name of Employer _____

Occupation _____

Employer Address _____ Phone _____

Are you married? ❑ Yes ❑ No Name of spouse/partner _____ Phone _____

Spouse/Partner Employer's name & address _____

The Pharmacy you normally use _____ Phone _____

Name of nearest relative not living with you _____ Relationship _____

Address _____ Phone _____

Who do you authorize us to speak to regarding your medical care? Please list their name and relationship. _____

_____

PRIMARY INSURANCE INFORMATION

❑ Medicare ❑ Medicaid ❑ PPO ❑ HMO ❑ POS ❑ Private Pay

Insurance Company name & address _____

Policy holder's name _____ Birth date _____

Relationship to patient _____ Social Security # _____

Phone # _____ Identification # _____ Group # _____

SECONDARY INSURANCE INFORMATION

Insurance Company name & address _____

Policy holder's name _____ Birth date _____

Relationship to patient _____ Social Security # _____

Phone # _____ Identification # _____ Group # _____

REFERRED BY: ❑ Primary Care Physician ❑ Dentist ❑ Other Physician ❑ Friend ❑ Internet ❑ Other

Have you or any of your family members been seen as patients in this Practice? ❑ Yes ❑ No

If yes, name of patient _____ When? _____

Primary Care Physician _____ Phone _____

Dentist _____ Phone _____

Physician who referred you to our Practice? _____ Phone _____

***Please be sure to include first and last name of your physicians**

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Patient: _____ DOB: _____ Date: _____

Your current medication(s), medication allergies, and past health problems are an important part of your diagnosis and treatment plan. Please try to answer all questions fully.

What problem are you being seen for today? _____

_____

_____

What medications are you currently taking? Include any blood thinning over the counter agents such as aspirin, Motrin, Orudis, Aleve, Relafen, Lodine, ibuprofen, or naproxen. If you have a list, please let us make a copy of your list.

_____ _____

_____ _____

_____ _____

_____ _____

What medication allergies do you have? Please include the type of reaction you experienced:

_____

_____

Please list medical problems that are currently being treated by another physician (i.e. Hypertension, Heart Attack, Emphysema, etc.):

_____ _____

_____ _____

_____ _____

Do you have a history of cancer? If so, what type? _____

Please list any surgeries you have had in the past and the approximate dates:

_____ _____

_____ _____

Have you or any family member had any adverse reactions to general anesthesia? If yes, please explain: _____

_____

Have you received radiation in the past? Yes _____ No _____ Why? _____ When? _____

Do you or have you ever smoked? Yes _____ No _____ If so, for how long? _____ How much? _____ Currently Smoking? _____

Have you ever chewed tobacco? Yes _____ No _____ If yes, for how long? _____ Currently chewing? _____

Do you drink alcohol on a regular basis? Yes _____ No _____ If yes, how many drinks per day? _____ OR per week _____

Do you use any other "recreational drugs"? Yes _____ No _____

Please list any other information you think your physician should know about your health:

_____

_____

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Patient _____ DOB _____ Date _____

The following list reviews a number of health problems. Please place a check mark if you or your family has experienced any of these health problems.

	Problem	Patient	Family	Please explain
General	Fever/chills Fatigue Weight change			
Eye	Change in vision Glasses Cataracts or glaucoma			
Ear, Nose, & Throat	Nosebleeds Sore throat or tonsillitis Hoarseness Swallowing problems Hearing problems Dizziness or Vertigo Sinus or nose problems Tinnitus (ears ringing)			
Allergy	Seasonal Hayfever Food reactions Allergy shots Latex reactions			
Lung	Asthma Chronic cough Bronchitis or pneumonia			
Heart	Chest pain or palpitations Congestive heart failure Heart disease or surgery High blood pressure Coronary artery disease High cholesterol/triglycerides			
GI	Acid reflux / heartburn Abdominal pain Peptic ulcer disease Hepatitis / jaundice			
GU	Prostate problems GYN problems			
MS	Arthritis problems Back or neck problems Muscle weakness Gout			
Skin	Hives or rashes Eczema Breast disease			
Neurologic	Stroke Seizures Headaches or Migraines Neurologic problems			
Endocrine	Diabetes Thyroid problems Pituitary or adrenal problems Perimenopausal symptoms			
Psyche	Depression Anxiety			
Immune	Bleeding disorders Anemia problems Enlarged lymph nodes HIV / AIDS			

Austin ENT ASSOCIATES

AUSTIN ENT CONSENT PAGE

CONSENT FOR TREATMENT. I hereby authorize evaluation and treatment by the physician(s) at Austin ENT Associates.

_____ Date_____

SIGNATURE OF PATIENT/RESPONSIBLE PARTY

RELEASE OF INFORMATION. I hereby authorize Austin ENT Associates to furnish medical information for my current illness or injury, including hepatitis and HIV information, to my family physician(s), referring physician(s), and my insurance companies. I further authorize my family physician, referring physician, and other healthcare providers to furnish all medical information regarding my present illness or injury to Austin ENT Associates.

_____ Date_____

SIGNATURE OF PATIENT/RESPONSIBLE PARTY

ASSIGNMENT OF BENEFITS. I request payment of the medical and/or surgical benefits, otherwise payable to me, directly to Austin ENT Associates for services provided to me by them. I understand that I am financially responsible to Austin ENT for charges not covered by this assignment of benefits.

_____ Date_____

SIGNATURE OF PATIENT/RESPONSIBLE PARTY

RECORDINGS, VIDEOS, PHOTOS. At Austin ENT we have complete respect for your privacy. We would never make an audio, photographic or video recording of you without your specific permission. We ask that you likewise agree that neither you nor anyone with you will make any audio, photographic or video recording of anyone in this clinic without their express and specific permission. Please indicate your agreement by signing below:

_____ Date_____

SIGNATURE OF PATIENT/RESPONSIBLE PARTY

PATIENT APPOINTMENT REMINDERS. I authorize Austin ENT to send appointment reminders as indicated below- **PLEASE CHOOSE ONLY ONE**

____Send text to cell phone (_____) _____-_____

____Voicemail to cell phone (_____) _____-_____

____Voicemail to home phone (landline) (_____) _____-_____

_____Date _____

SIGNATURE OF PATIENT/RESPONSIBLE PARTY

***IF SIGNING AS RESPONSIBLE PARTY ABOVE, RELATIONSHIP TO PATIENT:**

_____

AUSTIN ENT PAYMENT POLICIES

INSURANCE. There have been many changes in recent years in the way health insurance pays for your services. More and more financial responsibility is being shifted to patient responsibility. It is your responsibility to understand your insurance benefits. Please contact your insurance company with any questions you may have regarding your coverage, We will assist as best we can, but we do not have the staff time available nor is it our responsibility to educate patients on their individual plans as plans vary so much. Please understand that if you have a deductible plan, you basically have no insurance until that deductible has been met annually.

If your insurance card has a copay listed on it, we will collect the specialist copay and file your claim for services rendered. Deductible may apply if you are out of network. If you have any procedures with your office visit and your insurance applies those services to your deductible or coinsurance, you will receive a statement for the balance due. **Payment will be due upon receipt, or prior to any follow-up appointments, whichever comes first.**

If the insurance card does not show a copay, then that indicates it is a deductible plan. You will be charged the insurance allowable for any services rendered at the time of the visit. We will promptly file your claim and issue a refund if any overpayment has occurred. **If you owe an additional balance, a statement will be sent to you payable upon receipt, or prior to any follow-up appointments, whichever comes first.**

If you are private pay, the charge for the first consultation with the physician is $200 and will be collected at check-in prior to seeing the physician. Any additional procedures such as scopes, biopsies, hearing tests, etc. will be in addition to that and will be collected at check-out.

If you are private pay and you are an established patient, the charge for the office visit is $150 and will be collected at check-in prior to seeing your physician. Any additional procedures will be in addition to that and will be collected at check-out.

If you are scheduled for surgery, our office will verify your insurance benefits and eligibility for those services. ***An estimate of your financial responsibility will be given to you prior to your procedure***. You will be expected to pay your estimated amount. A refund will be issued to you promptly once the claim processes should any overpayment occur. **If you owe an additional balance, a statement will be sent to you payable upon receipt, or prior to any follow-up appointments, whichever comes first.**

Proof of Insurance. We must obtain a copy of your current insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information, you will be responsible for the balance of the claim. We also require a photo ID be presented at check-in. **You will be asked for these items each time you see the physician. If you cannot provide your insurance card, you will be considered private pay. WE CANNOT ACCEPT YOUR INSURANCE CARD FROM YOUR PHONE.**

Referrals and authorizations. Patients are responsible for obtaining necessary referrals and authorizations prior to your visit. You will be asked to reschedule your appointment or sign a waiver stating you will be responsible for the balance if the referral or authorization is not received by our office in a timely manner. It is the patient's responsibility to track the expiration date and number of referrals remaining.

Third party Insurance. We do not file third-party insurance under any circumstances, including motor vehicle accidents or other liability claims. You will be considered private pay and payment is expected at the time services are rendered.

Tertiary Insurance. We will assist in filing secondary claims, but we will no longer file tertiary insurance claims.

Nonpayment. Our office makes multiple efforts to inform patients of balances due. If your account is delinquent and you have not responded to statements and phone calls regarding your balance, you account will be forwarded to an outside collection agency. Once your account is referred to an outside agency, we cannot accept payment from you, you will have to deal with the collection agency directly.

I have read and understand the payment policy of Austin ENT Associates. I agree to abide by their guidelines above.

Signature of patient or responsible party_____Date_____

Relationship of responsible party_____

Rev 06/08/2021

AUSTIN ENT ASSOCIATES NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.
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.**

Your Rights
You have the right to:
- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices
You have some choices in the way that we use and share information as we:
- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures
We may use and share your information as we:
- Treat you
- Manage our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights
When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record
You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record
You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can notify us if you feel we have violated your rights by contacting us using the information on the last page.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes (However, we will not disclose psychotherapy notes to health care providers who are not the originators of those notes unless we have your written authorization to do so.)

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Manage our organization

We can use and share your health information to manage our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?
We are allowed or required to share your information in other ways - usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: *www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.*

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if requested, to insure that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will notify you promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: *www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html*

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Instructions for Notice

- **Effective date of this Notice is 10/01/2020**

- If you have questions or if you believe your privacy rights have been violated, you may contact Austin ENT Associates:

  Attn: Office Administrator
  7200 Wyoming Springs Dr., Suite 1400, Round Rock, TX 78681
  Ph: (512) 380-4050 Fax: (512) 580-0097

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name (Please print)_____ Date of birth _____

I understand that I have rights regarding my protected health information. These rights are governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I have been informed of, and given the opportunity to review and to receive a copy of the Austin ENT Associates Notice of Privacy Practices, which contains a complete description of the uses and disclosure of my protected health information. (You may refuse to sign this acknowledgement, if you wish)

_____ _____

Signature of Patient or Legal Representative **Date**

Detailed messages regarding test results can be left on answering machine or voicemail:
❑ Yes ❑ No Do not disclose medical information

At which of the following number(s) do we have permission to contact or leave messages for you regarding your appointments, medication, medical information, financial information or promotional events.

❑ Home: _____ ❑ Cell: _____

❑ Work: _____ ❑ Other: _____

Other than your insurance carrier, whom may we talk to about your healthcare information?

Name_____ Relationship _____ Ph# _____

Name_____ Relationship _____ Ph# _____

Name_____ Relationship _____ Ph# _____

Name_____ Relationship _____ Ph# _____

FOR OFFICE USE ONLY
We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign
- Physically unable to sign
- Other (Please provide details) _____

_____

_____ _____

Employee Signature Date

Austin ENT ASSOCIATES

Jeffrey S. Zapalac, M.D., F.A.C.S.
Daniel J. Ratcliff, M.D., F.A.C.S.
Lauren Opperman, Au.D., CCC-A
Rebecca L. Dixon, Au.D., CCC-A
Brook V. Johnson, M.A., CCC-A

NOTIFICATION OF NO-SHOW POLICY

Austin ENT strives to accommodate our patients when scheduling their appointments. Appointments are scheduled to allow our day to flow efficiently for each patient and family and to accommodate new protocol standards since the pandemic. ***We request our patients give us at least a 24-hour notice of cancellation or to reschedule.***

Should you fail to come to an appointment and give proper notice, your visit will be counted as a "NO SHOW". No shows are costly to the practice and prevent other patients from utilizing appointment times.

- A $50 No Show fee will be charged to your account (not the insurance company) in the event you fail to properly notify our office that you will not be able to make your appointment.
- After two (2) no show visits, you may receive a warning letter.
- After three (3) no show visits, our office reserves the right to decline to reschedule the patient. At this point, we will give you names of alternate providers where you may establish care and will forward your records to the provider of your choice.

Please be aware that as a courtesy Austin ENT sends out text/phone patient reminders. If you do not receive a reminder, this policy remains in effect regardless.

Also be aware that any no-show appointments occurring prior to the signature of this document may count towards your limit.

Messages can be left over the weekend with our answering service.

I, the undersigned, understand and agree to the policy set forth above.

Signature of patient/guardian: _____

Patient Name (Printed) _____ Date: _____

Wyoming Springs Medical Center
7200 Wyoming Springs Dr., Ste. 1400
Round Rock, Texas 78681
Tel: 512.458.6391
Fax: 512.580.0097
www.austinentassociates.com