ENT CENTER OF THE OZARKS

☐ **6823 Isaac's Orchard Rd.**
Springdale, AR. 72762

☐ **3344 N. Futrall Drive (2nd floor)**
Fayetteville, AR. 72701

☐ **3730 S. Pinnacle Hills Parkway, Suite 1**
Rogers, AR. 72758

☐ **1101 Progress Ave Suite 3**
Siloam Springs, AR. 72761

PHONE: 479-750-2080
FAX: 479-750-2082

Thank you for choosing the Ear, Nose and Throat Center of the Ozarks to provide your health care. Enclosed are the forms for you to review & complete prior to your appointment. **Please complete and bring with you to your appointment along with your insurance cards and complete list of medications.**

The staff at the Ear, Nose and Throat Center of the Ozarks is committed to providing thorough examinations, comprehensive diagnoses, treatments and detailed answers to your questions. Please assist your doctor by completing the questionnaire(s) enclosed in the packet. **Please fill out every item**. It is important for your doctor to know that you have reviewed every area of this form.

Thank you for your time and assistance. If you have any questions when completing the accompanying forms, please do not hesitate to ask for our assistance.

Patient Name:_____

Appt. Date:_____ Arrival Time: _____

Seeing _____

Patient Information

Acct #_____

Last Name_____First_____Middle Initial_____

Nickname_____Social Security #_____

Sex M F (circle) Marital Status S M W D Date of Birth_____(mm/dd/yyyy) Age_____ Weight_____Height_____

Address_____ City_____ State_____Zip_____

Primary Phone Number( )_____-_____ Work Phone ( )_____-_____

EMERGENCY Phone Number ( )_____-_____ Email_____

Please circle your preferred method of contact: Phone Text Email

Race/Ethnicity_____ Language Preference_____

Employer_____Occupation_____

Name of Insurance Company_____ Group Number_____

Name of Primary Insured_____ I.D. Number_____

Do you have secondary insurance? YES NO Name of Secondary Insurance Company _____

Spouse's Name_____ S.S.#_____ Date of Birth_____

Spouse's Employer_____ Work Phone Number ( )_____-_____

If the patient is a minor, please fill in the following information:

Mother's/Guardian's Name_____ S.S.#_____ Date of Birth_____

Employer_____ Work Phone Number( )_____-_____

Father's Name_____ S.S.#_____ Date of Birth_____

Employer_____ Work Phone Number( )_____-_____

Name of Referring Physician or Self-Referred _____

Name of General/Family Doctor_____Reason for Today's Visit_____

Primary Pharmacy (please include location/city)_____

I understand that the payment is expected when services are provided. Payment in full will be required if insurance cannot be verified.
Method of payment for today's visit: CASH CHECK CREDIT CARD

I authorize Ear, Nose and Throat Center of the Ozarks to provide medical care. I authorize the release of any medical information necessary to provide medical care process insurance claims and payments of medical benefits to physician and supplier.

I agree that I will not obtain any photos and recordings of any kind without written permission from the attending physician.

Signature_____ Date_____

Name_____

Medical Allergies

Medication	Reaction	Are you allergic to any of the following?
		LATEX
		TAPE
		IODINE or CONTRAST DYE

Medical History	**Surgical History**

Medications- If you have a list, please provide it when you turn in paperwork.

Medication	Reason for Taking	Medication	Reason for Taking

Do you have any *family history* of bleeding disorders or complications with anesthesia? YES NO

If yes, please list them _____

Do you have any *family history* of head or neck cancer? YES NO

If yes, please list them _____

Is there a history of other medical conditions in your family? YES NO

If yes, please list them _____

Have you ever used tobacco? NEVER PAST USE CURRENTLY

If yes, what type and how much? _____ If yes, how long? _____

Have you ever used alcohol? NEVER PAST USE CURRENTLY

If yes, how often? _____

Are you or have you been exposed to second hand smoke? NEVER IN THE PAST CURRENTLY

NAME _____

Systems Review:

In the past few months, have you had:	-fever within the last month	-night sweats	-excessive bruising
	-enlarged lymph nodes or glands	-change in skin or in a mole	-weight loss of more than 10 lbs
	-double or blurred vision	-seizures	-headache
	-tick or insect bite(s)	-animal bite or scratch	-recurrent infections
	-diminished hearing	-dizziness or vertigo	-ringing in the ears
	-ear fullness	-drainage from the ears	-ear injury
	-sinus problems	-significant headaches	-seasonal allergies
	-post nasal drainage	-sneezing/itchy nose	-loss of sense of smell
	-runny nose	-nosebleeds	-face pain or pressure
	-sinus infection requiring antibiotics	-difficulty breathing through your nose	
	-NONE		
Are you bothered by:	-wheezing	-coughing	-swallowing difficulty
	-hoarseness	-speech difficulty or changes	-chronic halitosis/"bad breath"
	-snoring	-throat pain	
	-NONE		
Have you:	-had "heartburn" or reflux	-coughed up sputum	-been exposed to TB
	-been diagnosed with asthma	-coughed up blood	-shortness of breath
	-"blacked out" (lost consciousness)	-had weakness or tingling	-had neurological changes
	-had abnormal pain or swelling of the legs or feet		
	-had heart valve problems	-had chest pain or pressure	-had rapid heart beats
	-NONE		
Do you have:	-stomach trouble	-significant constipation	-significant diarrhea
	-blood in your bowel movements	-nausea or vomiting	-pain in your abdomen
	-depression	-anxiety	-fatigue
	-decreased appetite	-heat or cold intolerance (that is different from others around you)	
	-excessive urination	-burning with urination	-pain with urination
	-difficulty completely emptying your bladder	-difficulty with leaking urine from your bladder	
	-joint pain, stiffness, or swelling	-muscle pain or stiffness	-back pain or stiffness
	-NONE		

Signature

_____**Date**_____

Thank you very much for your time. These forms will help us serve you better.

Authorization to Send Electronic Messages

By signing this form, I authorize **Ear, Nose and Throat Center of the Ozarks** to send electronic messages to my cell phone or email in lieu of phone calls in order to convey information. I understand that text messaging rates may apply to any messages received. I also understand that I may revoke this permission in writing at any time. I agree not to hold **Ear, Nose and Throat Center of the Ozarks** liable for any electronic messaging charges or fees generated by this service.

_____ _____
Patient Name Date of Birth

_____ _____
Cell Phone # Email address

Does your cell phone have internet services?

☐ YES

☐ NO

_____
Signature

_____
Printed Name, if signed by Patient Representative

_____
Date

I decline to receive text messages or emails at this time.

_____ _____
Signature Date

Authorization for Verbal Communications

I permit, Ear, Nose and Throat Center of the Ozarks, their physicians, nurses and other personnel to discuss health information, in person or by telephone, with the following family members or friends involved in my medical care:

	Name	Phone Number	Relationship
1.	_____	_____	_____
2.	_____	_____	_____

(List the family member/friend name and contact number, and state that person's relationship to the patient)

This authorization is limited to discussions regarding the following medical condition(s):

_____

(If no limitations are listed, discussions will be permitted regarding any medical condition.)

This authorization is limited to the following timeframe from _____(date) to _____(date)
(If no dates are indicated, this form will remain in effect for an unlimited amount of time.)

Release of information under this document is limited to verbal discussions with my Health Care Providers.

This document does not permit release of any written health information to the individuals named above.

If, at any time, I do not want verbal discussions to be permitted between Ear, Nose and Throat Center of the Ozarks & any of the individuals named above, I understand that I must notify Ear, Nose and Throat Center of the Ozarks by updating this written authorization.

Patient's Signature:_____ Date:_____
If signed by the Patient's Representative:
Printed Name of Representative: _____
Relationship to Patient: _____

EAR, NOSE & THROAT CENTER OF THE OZARKS

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. This notice describes the types of uses and disclosures or my protected health information (PHI) that might occur in my treatment, payment of my bills, or in the performance of healthcare operations. This form will be filed in the patient's medical record.

_____	_____	_____
Printed Name	Date	Signature
_____	_____	_____
Legal Representative	Date	Description of Authority

_____

OFFICE USE ONLY

An attempt was made to obtain the patient's or legal representative's signature on this Acknowledgement but did not because:

It was emergency treatment _____
Inability to communicate with patient _____
Patient refused to sign _____
Patient was unable to sign _____ Reason _____

Other _____

_____ _____
Signature of Privacy Officer Date

NOTICE OF PRIVACY PRACTICES

EAR, NOSE & THROAT CENTER OF THE OZARKS

6823 ISAAC'S ORCHARD RD, SPRINGDALE, AR 72762
2900 MEDICAL CENTER PKWY, SUITE 110, BENTONVILLE, AR 72712
1101 N PROGRESS, SUITE 3, SILOAM SPRINGS, AR 72761

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS CAREFULLY.

Our privacy commitment

Thank you for giving us the opportunity to serve you. In the normal course of business-providing medical care to you- Ear, Nose & Throat Center of the Ozarks creates records about you and the treatment and services we provide to you. The information we collect is called Protected Health Information (PHI). We take our obligation to keep your PHI secure and confidential very seriously.

We are required by federal and state law to protect the privacy of your PHI in your healthcare records and any other identifiable patient health information used or disclosed by us in any form and to provide you with this Notice about how we safeguard and use it. We are also required by law to notify you following a breach of your unsecured PHI.

When our office, its employees, Business Associates and other involved parties use or disclose your PHI, we are bound by the terms of this Notice that is currently in effect. This Notice applies to all electronic or paper records we create, obtain and/or maintain that contain your PHI, including clinical notes, lab results, x-rays, and medication history.

After reading this Notice, we will need your signature on a written, dated Consent or Acknowledgement Form before we will use or disclose your PHI for certain purposes. You may request and receive a copy of this Notice. You may take back or revoke your consent or authorization at any time (unless we have already acted based on it) by submitting to us in writing a revocation. Your revocation will take effect when we receive it. It will not affect what we have already used or disclosed in our reliance on your consent.

If you do not sign our Authorization/Acknowledgement Form or if you revoke it in the future, your PHI may be used or disclosed as permitted or required by law.

This Notice of Privacy Practices is NOT an authorization.

How We Protect Your Privacy

We restrict access to your PHI to authorized workforce members (employees, volunteers, trainees and business associates) who need that information for your treatment, for payment purposes, and/or for healthcare operations. We maintain technical, physical and administrative safeguards to ensure the privacy of your PHI.

To protect your privacy, only authorized and trained workforce members are given access to our paper and electronic records and to non-public areas where this information is stored. Our workforce members are trained on HIPAA and the privacy data protection required for PHI as well as maintaining technical, physical and administrative safeguards in place to maintain the privacy and security of your PHI. Should you have any questions, please ask to speak to our office manager.

How We Use and Disclose Your PHI

Uses/Disclosures of your PHI without your authorization

Treatment

- -To coordinate your healthcare and services with a different healthcare facility or professional
- -To share with nurses, doctors, pharmacies, health educators and other healthcare professionals so they can determine a plan of care
- -To consult with your family or others so they may assist you with home care
- -To arrange appointments with other healthcare providers, schedule lab work, etc

Payment

-To verify insurance coverage and/or receive authorization for a procedure
-To submit claims to your health plan or third party for payment
-To bill or collect payment from you
-You may restrict disclosure to your insurance carrier for services if you pay "out of pocket" in full for the services
-To coordinate benefits with other coverage you may have

Healthcare Operations

-To provide customer service such as appointment reminders, calling you by name in the waiting room, placing name on a sign-in sheet, recommending or informing you of health-related products and complementary or alternative treatments that may interest you. If you prefer we not contact you with appointment reminders or information about treatment alternatives or health-related products and services, you may notify us of this in writing and we will not use or disclose your PHI for these purposes.
-To support and/or improve the programs or services we offer you.

Disclosure to Other Individuals in Your Healthcare

-To family members but only if you are present and verbally give permission
-If you are in an emergency situation and are not present or are incapacitated, we will use our professional judgment and the surrounding circumstances to decide whether disclosing your PHI to others is in your best interest. If we do disclose your PHI in a situation where you are unavailable, we will only disclose information that is directly relevant to your treatment or for a payment related to your treatment. We may also disclose your PHI in order to notify or assist in notifying such persons of your locations, your general medical condition, or your death.
-We may disclose your child's PHI to your child's other parent
-If you do not want us to disclose your PHI or your child's PHI to others, please let us know.
-You may name another individual to act as your personal representative. Your representative will be allowed access to your PHI, to communicate with the healthcare professionals and facilities providing your care and to exercise all other HIPAA rights on your behalf. Depending on the authority you grant your representative, this person may also have authority to make healthcare decisions for you.

Special situations when your PHI will be disclosed/used without your authorization:
-As required by law
- e.g. child and elder abuse, domestic violence

-To avert a serious threat to health or safety of the public or another person
-Business Associates
- We may disclose PHI to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services

-Organ and tissue donation
- If you are an organ donor, we may use or disclose PHI to organizations that handle organ procurement

-Military and Veterans
- If you are a member of the armed forces, we may disclose PHI as required by military command authorities

-Worker's Compensation
- We may disclose PHI for worker's compensation or similar programs

-Federal or state government healthcare oversight activities
- i.e. civil rights laws, fraud and abuse investigations, audits, investigations, etc

-Lawsuits and disputes
- If you are involved in a lawsuit or dispute, we may disclose PHI in response to a court order or administrative order, subpoena, discovery request or other lawful process. We will make every effort to tell you of the request

-Law Enforcement
- In response to a court order, subpoena, warrant, or summons or similar process
- Limited information to identify or locate a suspect, fugitive, material witness or missing person
- About the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement
- About a death we believe may be the result of criminal conduct

- About criminal conduct on our premises and
- In an emergency to report a crime, the location of the crime or victims, or the identity, Description or location of the person who committed the crime

-Correctional Institution

- If you are or become an inmate of a correctional institution, we may disclose PHI to the institution or its agents when necessary for your health or the health and safety of others

-National Security and Intelligence Activities

- We may release PHI about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law

-Coroners, Medical Examiners and Funeral Directors

- This may be necessary, for example, to identify a deceased person or determine the cause of death
- We also may release PHI to funeral directors as necessary for their duties

-For Research

- Those projects approved by a review board to ensure confidentiality; you will be asked to sign an authorization

Uses of PHI that require your authorization

Other uses and disclosures as set forth below will be made only with your consent, authorization or opportunity to object unless required by law. The following categories of information that are marked with an * are considered sensitive and require enhanced privacy protection:

-Psychotherapy notes*
-Alcohol and drug abuse prevention, treatment and referral notes*
-HIV/AIDS testing, diagnosis or treatment*
-Any PHI that contains genetic information that will be used for underwriting purposes*
-PHI that is used for marketing purposes
-Disclosures that constitute a sale of your PHI

YOUR INDIVIDUAL RIGHTS

You have the following rights regarding the PHI that we create, obtain, and/or maintain for you.

1. Obtain a paper copy of the Notice upon request. At your request, we will provide you with a copy of this Notice. We are required to follow terms of this Notice currently in effect but reserve the right to change the terms of our Notice at any time.

2. To inspect and copy your PHI. You may request in writing to review or receive a copy of your PHI that is included in certain paper or electronic records we maintain. Under limited circumstances, we may deny you access to a portion of your records. All original records will remain on the premises and will only be available for inspection during regular business hours. You will have the right to request a copy in electronic format if your health record is maintained electronically. If your PHI is maintained in electronic format but is not readily producible in such format, we will produce it in a readable electronic format upon which we agree. We have the right to charge a reasonable fee for paper or electronic copies.

3. Right to request restrictions. You may ask to restrict the way we use and disclose your PHI for treatment, payment and healthcare operations as explained in this Notice. We are not required to agree to the restrictions. If we agree to the restrictions, we will follow them except in an emergency where we will not have time to check for limitations, in which case we will ask the receiving person not to further use or disclose your PHI. We will honor your request to restrict information to your health plan or insurer about a visit, service or prescription for which you have paid in full provided that disclosure is not otherwise required by law. You may exercise this right at the time of service. If you do so, no claim or communication with your health plan or insurer will occur.

4. Right to receive notice of a breach. You have the right to be notified upon a breach of any of your unsecured PHI.

5. Right to amend your records. You may ask us to correct or amend your PHI contained in our electronic or paper records if you believe it is inaccurate or something is missing. We will act on your request within 30 days from receipt of a written request. If we determine the information is inaccurate, we will notify you in writing and make the changes by noting (not deleting) what is incorrect or incomplete and adding the changed language. We may deny your request under certain circumstances. If we deny your request, we will notify you in writing and you may file a complaint with us if you disagree. If you are not satisfied with our decision, you may complain to the U.S.

Department of Health and Human Services. If a different healthcare facility or professional created the information that you want changed, you should ask them to amend the information.

6. Right to receive confidential communications. You may ask us in writing to communicate with you in a different way or at a different place. We will accommodate all reasonable requests whenever feasible.

7. Right to receive an accounting of disclosures. Upon your written request, we will provide a list of the disclosures we have made of your PHI for a specified period of time. However, the list will exclude:
    a. Disclosures you have authorized
    b. Disclosures made earlier than six (6) years before the date of your request or three (3) years in the case of disclosures made from an electronic health record
    c. Disclosures made for treatment, payment and healthcare operations purposes.
    d. Disclosures as expected by law
    e. Disclosures to you or to your personal representative
    f. Disclosures incidental to a use or disclosure that is otherwise permitted or required by law

    Your request must state in what form you want the list (paper or electronically) and the time period you want us to cover. If you request an accounting more than once during any 12 month period, we will charge you a reasonable fee for each accounting report after the first one.

ACTIONS WE MAY TAKE

Contact us. If you have any questions about your privacy rights, believe that we may have violated your privacy rights or disagree with a decision that we made about access to your PHI, you may contact us at the following address or telephone number.

Brenda Bayless
Ear, Nose & Throat Center of the Ozarks
6823 Isaacs Orchard Rd, Springdale, AR 72762
(479) 750-2080
brenda@entozarks.com

Contact a government agency. If you believe that we may have violated your privacy rights, you may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services (HHS). Your complaint can be sent by email, fax or mail to the HHS Office for Civil Rights (OCR). You will not be retaliated against for filing a complaint. For more information, go to the OCR website www.hhs.gov/ocr/privacy/hipaa/complaints Mailed complaints may be direct to:

Office of Civil Rights
Region IV
U.S. Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, Texas 75202
Fax: (214) 767-0432

NOTICE AVAILABILITY AND DURATION

Notice Availability. A copy of this Notice is available from our office (s) and is posted in prominent locations in our office at all times.

Right to change terms of this Notice. We may change the terms of this Notice at any time, and we may, at our discretion, make the new terms effective for all of your PHI in our possession, including any PHI we created or received before we issued the new Notice.

If we change this Notice, we will give you a new Notice when you receive treatment. In addition, we will post any new Notice in a prominent location in our office(s).

Effective Date. These privacy practices are in effect as of September 23, 2013, and will remain in effect until we revise them as permitted or required by law.