Tallahassee Ear, Nose & Throat-Head & Neck Surgery, P.A.

TODAY'S DATE: _____ **FOR TODAY'S VISIT YOU WILL BE PAYING:** ___**Cash** ___**Check** ___**Credit Card**

PATIENT INFORMATION:

Primary Care Physician:_____ Referring Physician: _____

Last Name: _____First Name: _____ Middle Initial: ___ Age: _____

Social Security #: _____ Birthdate: ____/____/_____Gender: M F X Marital Status: ___

Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Race: _____ Ethnicity: Hispanic / Non-Hispanic Language: _____
(Please circle one above)

Primary #: (_____) _____ Cell #: (____) _____

Work #: (____) _____ Home #: (____) _____

Email: _____

CONFIRMATION PREFERENCE:

☐ **TEXT**

☐ **CALL**

☐ **EMAIL**

PRIMARY INSURANCE CARRIER:

Insured's Name: _____

Insured's Address: _____

City: _____ State: ____ Zip: _____

Insured's DOB: _____/_____/_____

SECONDARY INSURANCE CARRIER:

Insured's Name: _____

Insured's Address: _____

City: _____ State: ____ Zip: _____

Insured's DOB: _____/_____/_____

Please submit insurance card for scanning. If no insurance card is available, please complete the following information:

Insurance Co: _____

Policy Number: _____

Insurance Co: _____

Policy Number: _____

PARENT/LEGAL GUARDIAN INFORMATION

If the patient is under the age of 18 or insurance is maintained by someone else; please complete the following:

If you are the grandparent or step-parent do you have legal guardianship of the patient? Yes No

****You must have court ordered paperwork on hand in order for the patient to be seen. Please submit paperwork so it may be filed in the chart and complete the information below:**

Name: _____ DOB: ___/____/____ SSN: _____

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

Employer: _____ Work Phone: (_____)_____Ext_____

Relationship: (please circle one) Mother Father Grandparent Step-Parent Legal Guardian Other _____

AUTHORIZATIONS

I authorize the release of any medical information necessary to process the insurance claim form for services and/or quality assurance activity required by your plan or entity rendered by Tallahassee Ear, Nose & Throat-Head & Neck Surgery, P.A. I also request payment of government benefits to the party who accepts assignment. I do authorize payment of medical benefits to Tallahassee Ear, Nose & Throat Physicians/Providers.

FINANCIAL RESPONSIBILITY:

Patient/Responsible party shall pay to Tallahassee Ear, Nose and Throat such sums as are now or may become due for services rendered to the patient and for which the patient's health maintenance organization or insurer is not liable for payment for fees to TENT. Guarantor must sign for all minors or dependents. An administrative fee will be assessed should the account require collection efforts. The guarantee of the account hereby assumes full financial responsibility for payment for all medical services by the named patient in accordance with the terms as set forth in the Authorization above.

Please be aware that collections made by our office staff at the time of check-out are only an estimate for services rendered. Our policy is to bill and collect any balances due for services rendered by Tallahassee Ear, Nose and Throat.

SIGNATURE: _____ DATE: _____

RECEIPT OF PATIENT PRIVACY NOTICE:

A copy of the Patient Privacy Notice from Tallahassee Ear, Nose & Throat-Head & Neck Surgery, P.A has been made available to me as printed and/or posted in the office or available on the website for my review. My Protected Health Information may be used for treatment, payment and general practice operation.

USE AND DISCLOSURE:

Patient/Provider relationship only begins at the time of the visit. No notes are reviewed prior to this visit. If you are scheduled with an Advanced Practice Registered Nurse in our office, you understand that they are not a physician and work with the support of the physicians in our practice. I understand that as part of my health care, Tallahassee Ear, Nose and Throat originates and maintains a paper and/or electronic record describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. The use and disclosure of Protected Health Information for treatment, payment or operations is described in the Patient Privacy Notice. Your records may be shared with your other providers electronically or via phone, fax, or health information exchange.

SIGNATURE: _____ DATE: _____

DISCLOSURE OF OWNERSHIP:

Audiology Associates of North Florida, a division of Tallahassee Ear, Nose & Throat, is the only local audiology group able to coordinate your hearing services with physicians on-site. Please be advised that the following physicians own an interest in the audiology, allergy, and plastic services offered on site by Tallahassee Ear, Nose & Throat - Head & Neck Surgery, P.A.: Duncan S. Postma, M.D., Spencer E. Gilleon, M.D., Adrian P. Roberts, M.D., Marie O. Becker, M.D., Joseph C. Soto, M.D and Graham T. Whitaker, M.D. We feel that the cooperation of the physicians and audiologists in our group is advantageous to our patients, but should you wish to have an alternative provider for these services, we will provide them upon request. In addition, these same physicians have ownership in the Red Hills Surgical Center and the CT scanner in the office. You may select any facility for your diagnostic study or where we are credentialed for surgical services upon your request.

I acknowledge this disclosure of ownership and my freedom to request any facility.

SIGNATURE: _____ DATE: _____

MEDICARE ASSIGNMENT:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act U.S.C. 3801-3812 provides penalties for withholding information). Regulations pertaining to Medicare assignment of benefits also apply.

SIGNATURE: _____ DATE: _____

MEDICATION REPOSITORY:

Any pharmacy that participates with a central repository will have an updated list of your medications. In order to provide you with the best possible care, the providers would like your permission to access this repository.

SIGNATURE: _____ DATE: _____

TALLAHASSEE EAR, NOSE & THROAT - HEAD & NECK SURGERY, P.A.
AUDIOLOGY ASSOCIATES OF NORTH FLORIDA
www.tallyent.com

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Tallahassee, FL 32308
(850) 671-5172

2625 Mitcham Drive
Tallahassee, FL 32308
(850) 877-4094

PEDIATRIC HEARING HISTORY: BIRTH TO 3 YEARS

Child's Name:_____ **Birthdate:** _____

Parent's Name: _____ **Today's Date:** _____

Do you have legal guardianship? NO YES

What is the primary reason for today's visit?

_____

_____

BIRTH/MEDICAL HISTORY

Were there any complications during pregnancy or delivery? NO YES
If yes, please list: _____
Did the birth mother have rubella (measles), cytomegalovirus (CMV), herpes, toxoplasmosis or syphilis during pregnancy? NO YES
Birth Weight: _____ lbs _____ oz
Was your baby premature (less than 37 weeks)? NO YES
If yes, delivered at how many weeks? _____
Did your baby pass the newborn hearing screening? NO YES UNKNOWN
If no, which ear? ☐ Right ☐ Left ☐ Both
Birth Hospital: _____
Did your baby receive oxygen or mechanical ventilation after delivery? NO YES
If yes, how long? _____
Was your baby cared for in a special care nursery (NICU)? NO YES
If yes, how long? _____
Was your baby diagnosed with jaundice (hyperbilirubinemia)? NO YES
Was a blood transfusion required? ☐ Yes ☐ No
Did your baby received ECMO (forced oxygen into tissues)? NO YES

Is there a family history of hearing loss: One or more blood relatives of the child had permanent hearing loss in early childhood? NO YES
If yes, Who? ☐ parent, ☐ grandparent, ☐ aunt, ☐ uncle, ☐ child's first cousin, ☐ brother, ☐ sister.
Baby's Mother's or Father's family? _____
Has your child been hospitalized since birth? NO YES
If yes, when? _____why? _____
Has your child required IV antibiotics or chemotherapy? NO YES

Has your child had an infection such as meningitis, mumps, measles, MRSA, or RSV? NO YES
Has your child experienced head trauma? NO YES
(i.e. a serious fall causing a concussion or skull fracture)
Has your child been diagnosed with a specific syndrome or disorder? NO YES
(i.e. Down Syndrome, cleft palate) Specify: _____
Has your child had more than 4 ear infections in the past 12 months? NO YES
Date of the last ear infection? _____
Has your child had tubes? If yes, when? _____ NO YES

List any medical conditions your child has been diagnosed with: _____

List any medicine your child is currently taking: _____

List any allergies your child has: _____

SURGICAL HISTORY

List any previous surgeries your child has undergone: _____

SPEECH, LANGUAGE AND AUDITORY DEVELOPMENT

Do you have any concern regarding your child's speech and language development? NO YES
If yes, what is your primary concern? _____
_____

Does your child speak more than one language? NO YES

Is your child currently or has your child ever received speech and language therapy? NO YES
Where? _____
For how Long? _____
How Often? _____

Do you have any concerns about how your child talks or expresses his/her wants and needs? NO YES

Do you have any concerns about your child's ability to follow directions or understand what is being said to him/her? NO YES

How many words (approximately) does your child have in his/her vocabulary? NONE 1-5 6-10 11-20 21-50 50+

Does your child put two words together (i.e. mommy more, daddy bye-bye)? NO YES

Does your child speak in phrases or short sentences? NO YES

Does your child seem to respond to sounds in the environment that are easy to hear, unusual, or otherwise alerting (i.e. dog bark, door bell)? NO YES

Does your child seem to respond to his/her name or noise when you would have expected him/her to respond? NO YES

Has your child been diagnosed with developmental delay? NO YES

Is your child receiving any other type of therapy or services? NO YES
If yes, please list: _____

Please list anything else you believe would be helpful for us to know when assessing your child?

_____

_____

How Did You Hear About Our Center? FRIEND / DOCTOR REFERRAL / NEWSPAPER / TV AD / RADIO / SEMINAR / TELEPHONE BOOK / OTHER: _____

I have completed this form and to the best of my knowledge it is accurate. I understand that this document will be used for medical decision making.

Parent/Legal Guardian Signature: _____ **Date:** _____

Audiology Associates of North Florida
a Division of Tallahassee Ear, Nose and Throat

TALLAHASSEE EAR, NOSE & THROAT - HEAD & NECK SURGERY, P.A.

Consent to Use or Disclose Information for Treatment, Payment of Healthcare Operations

_____ _____

Patient's Name Patient's Date of Birth

I, the patient (or authorized representative), understand and consent to the terms of the Patient Privacy Notice from Tallahassee Ear, Nose & Throat-Head & Neck Surgery, P.A. made available to me as printed, posted in the lobby, and/or available on the website for my review. I understand that my Protected Health Information may be used for treatment, payment and general practice operation.

I have the right to revoke this consent. Such revocation must be submitted to the Privacy Officer in writing. The revocation shall be effective except in the extent that Tallahassee Ear, Nose & Throat has already acted in reliance within the guidelines of the consent. If the consent is not signed or is terminated after signature, Tallahassee Ear, Nose & Throat may refuse to treat me or continue to treat me (except as required by law to treat individuals) as consent is required for general practice operation.

I understand that Tallahassee, Ear, Nose & Throat-Head & Neck Surgery, P.A. may send letters, emails, texts, voicemails, billing statements, or communication through the secure patient portal to the guarantor on my account. I acknowledge that email, voicemail, and cell phones are not secure forms of communication. It is my responsibility, as the patient, to provide accurate and current demographic information including mailing address, phone numbers, and private personal email address for communication through the portal.

For patients under the age of 18, a parent or legal guardian must be listed on this form for subsequent appointments in our office.

I give permission for the contacts listed below to be given information regarding my medical conditions and diagnoses (including treatments, financial account, and healthcare options) with:

If no one, please check here: ☐

- Name: _____ DOB: ___/___/___ Phone: (___)-_____ Relationship: _____
- Name: _____ DOB: ___/___/___ Phone: (___)-_____ Relationship: _____
- Name: _____ DOB: ___/___/___ Phone: (___)-_____ Relationship: _____
- Name: _____ DOB: ___/___/___ Phone: (___)-_____ Relationship: _____
- Name: _____ DOB: ___/___/___ Phone: (___)-_____ Relationship: _____

I understand that if I need to change my contacts it is my responsibility to request it in writing to the Privacy Officer. A copy of this form can be provided upon request.

_____

Patient Signature or Guardian Signature Required

INTERNAL USE ONLY: _____ _____

Employee Signature Date Names Entered