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

**TODAY'S DATE:** _____

**PATIENT INFORMATION:**

Primary Care Physician: _____ Referring Physician: _____

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

Social Security #: _____ Birthdate: ____/____/_____ Gender: M F X

Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Marital Status (circle one): Single Married Separated Divorced Widowed

Race (circle one): Other American Indian or Alaska Native Asian Black or African American

Native Hawaiian or Pacific Islander White

Ethnicity: Hispanic / Non-Hispanic Language: _____

Day/Best #: (_____) _____ Cell #: (____) _____

ALT #: (____) _____ Home #: (____) _____

Email: _____

**CONFIRMATION PREFERENCE:**

☐ **TEXT**

☐ **CALL**

☐ **EMAIL**

*Chose one option*

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

**PRIMARY INSURANCE CARRIER:**

Insurance: _____

Policy Number: _____

Insurance Phone Number: _____

**SECONDARY INSURANCE CARRIER:**

Insurance: _____

Policy Number: _____

Insurance Phone Number: _____

**PATIENT GUARANTOR/LEGAL GUARDIAN INFORMATION**

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

**Please complete if the patient is under the age of 18 or patient has a legal guardian:**

****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. A $30 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 and CT services offered on-site by Tallahassee Ear, Nose & Throat - Head & Neck Surgery, P.A.: 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 the availability of both physicians and doctors of audiology in our group is advantageous to our patients, **but should you wish to have an alternative provider for these services, we will provide a list upon request.** In addition, these same physicians have ownership in the Red Hills Surgical Center. **Upon your request, you may select any facility for surgical services where we are credentialed. 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: _____

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/Disclose Information for Treatment, Payment of Healthcare Operations, and Behavior Policy**

_____ _____

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.

We expect our patients to respect the privacy of other patients. If you obtain information about another patient, you are to notify us immediately so that we can take corrective action. **We expect our staff and physicians to treat you in a respectful manner. We ask that you conduct yourself in a manner that is respectful as well. If at any time your behavior is demeaning or disrespectful we reserve the right to discharge you from the practice.**

**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: _____

**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**

*Processed by*: _____ Date: _____ H001-18– Nov 2023

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

**www.TallyENT.com**

**Patient Name: _____ DOB: _____**

Please be advised there are times when our providers need to perform an in-office procedure to correctly diagnose and treat problems. **Procedures performed in our office are not included in the standard visit but are in the best interest of patient care.** Procedures will be billed separately and will be in addition to a regular office visit charge.

Insurance carriers classify these procedures as "surgery" and apply the charges to your surgical deductible, copayment, and/or co-insurance amount.

**We are providing this information to notify you in advance so you are not surprised when you receive your explanation of benefits from your insurance and it states a "surgical procedure" was performed.**

There may be a difference in the estimated amount collected at check-out after your visit and the amount your insurance determines is patient responsibility.

**Amounts collected at the time of service are simply an estimate**. The final balance will not be known until after review by your insurance company.

**Examples of procedures include, but are not limited to, the following:**

**Fiberoptic laryngoscopy (Scope of Throat):** A long, thin, fiberoptic scope (either rigid or flexible) will be passed through the nasal cavity or into the throat. The fiberoptic scope enables the physician to visualize areas of the throat not readily seen using any other means.

**Nasal endoscopy (Scope of Nose):** A scope attached to a light source will be used to view areas of the nasal cavities that cannot be viewed by the physician using the standard nasal speculum or visual inspection.

**Tympanogram:** This is an examination used to test the condition of the middle ear and mobility of the eardrum (tympanic membrane) and the conduction bones by creating variations of the air pressure in the ear canal.

**Other procedures: Ear cleanings, hearing tests, CT scans and ultrasounds**

**When recommended, the above procedures are necessary to properly diagnose and treat your medical condition, and if not performed, may limit our ability to provide an appropriate treatment or surgical solution.**

If you have additional questions, please feel free to speak to our staff and/or contact your insurance carrier for more information.

By signing below, I acknowledge that in-office procedures are separate from the office visit and understand that I am responsible for any balance that my insurance company applies to the deductible/copay/coinsurance according to my individual policy.

Patient/Guardian Signature: _____ Date: _____

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

# DIZZY QUESTIONNAIRE

**NAME: _____ DOB: _____**

**DATE: _____**

Please answer to the best of your ability. All questions may not apply to your symptoms. The audiologist performing your test will discuss your answers in greater detail.

YES NO Have you consumed alcohol in the last 48 hours?

YES NO Have you taken Medication in the last 48 hours (including drugs like medical marijuana, Delta 8, and other THC products)

YES NO Have you consumed caffeine in the last 24 hours?

**When you are dizzy, do you experience any of the following sensations?**

YES NO Lightheadedness

YES NO Spinning sensation

YES NO Loss of balance when walking

YES NO Loss of balance to the point of falling

YES NO Nausea or vomiting

YES NO Headache/Migraine

How would you describe your symptoms without using the word "dizzy"?

_____

_____

**My dizziness is:**

YES NO Constant

YES NO In attacks

When did the dizziness first occur? _____

How long does the dizziness last (circle one)? Seconds Minutes Hours Days

When was the last attack? _____

YES NO Have you recently had a cold or viral episode

YES NO Are you completely free of dizziness between attacks

YES NO Do changes in position make you dizzy

YES NO Do you have trouble walking in the dark

YES NO Do objects seem to bounce up and down when you walk

Do you know of any possible cause for your dizziness? _____

_____

**Do you know of anything that will:**

YES NO Make your dizziness better

If yes, what? _____

YES NO Make your dizziness worse

If yes, what? _____

YES NO Do your symptoms seem to be helped by medication?

If yes, what medication? _____

List the medications you are taking and any health issues you may have: _____

_____

_____

_____

_____

_____

**Do you have any of the following symptoms?**

YES NO Difficulty hearing Both ears RIGHT LEFT

YES NO Noise in your ears Both ears RIGHT LEFT

If yes, does the noise change with your dizziness? Yes No

YES NO Fullness in your ears Both ears RIGHT LEFT

If yes, does it change with your dizziness? Yes No

**Have you experienced any of the following?**

YES NO Pain in the back or shoulders

YES NO Difficulty with speech or swallowing

YES NO Double vision, blurred vision, or blindness

**TALLAHASSEE EAR, NOSE & THROAT - HEAD & NECK SURGERY, P.A.**
**AUDIOLOGY ASSOCIATES OF NORTH FLORIDA**
www.TallyENT.com www.TallahasseeHearingHelp.com
**1405 Centerville Rd., Suite 5400, Tallahassee, FL 32308 (850) 877-0101 Ext. 243**

# Videonystagmography (VNG) Instruction Sheet

You are required to call the office three (3) days prior to the scheduled procedure to complete pre-admission instructions. (850) 877-0101 ext. 243.
**Failure to call and complete pre-admission will result in a cancellation of your appointment.**

This procedure is typically performed on individuals experiencing dizziness or unsteadiness. A computer is used to monitor your eye movements while performing various visual tasks. Contact lenses can be worn during procedure. Cool and warm air will be blown into the ear canals which may cause some mild dizziness. The dizziness should only last for a few minutes.

Please follow these instructions for the VNG Evaluation:

1. Do not eat two hours prior to procedure. (NOTE: if you are diabetic or hypoglycemic please maintain your regular eating schedule.)
2. Please wear only minimal makeup or facial moisturizers – **NO mascara or eyeliner**.
3. Do not consume any alcohol at least 48 hours prior to your appointment.
4. Please let the audiologist know if you have any history of neck or back surgery problems.
5. Medications – Some medications may interfere with test results. The following is a list of medications to avoid for **48 hours prior to procedure**. If you have any questions concerning other medications that could affect the VNG, please call the Audiology Department at (850) 877-0101, Extension 243.

| **Anti-nausea** | | **Anti-Vertigo** | | |
|---|---|---|---|---|
| Vontrol | Bonine | Antivert | Meclizine | Valium |
| Phenergan | Compazine | Diazepam | Ativan | Xanax |
| Dramamine | Tigan | Transderm Scop Patch | | |

**Other**
Cannabis (medical marijuana, recreational marijuana, edibles, Delta 8, vapes, etc)

**Please bring a list of all medications you are currently taking.**

**Discontinue any medications you have been prescribed (including over the counter) to control dizziness or nausea.**

NOTE: Please **TAKE** your insulin, blood pressure, cardiac-related medications or any other life-supporting medicine.