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.

SIGNATURE: _____ (if patient is a minor or dependent, the Guarantor must sign here)

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. Beyond this, I may provide in writing a list of people who are authorized to have information medical or financial account information about me.

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: _____

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?

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

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

I understand that Tallahassee, Ear, Nose & Throat-Head & Neck Surgery, P.A. may send letters, emails, text messages, voicemails, billing statements, or communication through the secure patient portal. I acknowledge that email, voicemail and cell phones are not secure. 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.

I understand that medical and financial information may be used by Tallahassee, Ear, Nose & Throat-Head & Neck Surgery, P.A. for treatment, payment and normal operation of business. <u>Beyond this, I give permission for the contacts listed below to be given information regarding my medical treatment/care, financial account, and emergency information to be discussed with the people I list on this form.</u>

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

****

•Name: ______________________________DOB: ___/___/___ Phone: _________________

Relationship: (please circle one)
Spouse Mother Father Adult Child Step-Parent Legal Guardian Grandparent Sibling Other __________

•Name: ______________________________DOB: ___/___/___ Phone: _________________

Relationship: (please circle one)
Spouse Mother Father Adult Child Step-Parent Legal Guardian Grandparent Sibling Other __________

•Name: ______________________________DOB: ___/___/___ Phone: _________________

Relationship: (please circle one)
Spouse Mother Father Adult Child Step-Parent Legal Guardian Grandparent Sibling Other __________

•Name: ______________________________DOB: ___/___/___ Phone: _________________

Relationship: (please circle one)
Spouse Mother Father Adult Child Step-Parent Legal Guardian Grandparent Sibling Other __________

I accept the terms of the Patient Privacy Notice. I consent to the Use or Disclosure of Protected Health Information (PHI) described above for treatment, payment or healthcare operations. I understand that if I need to change my contacts it is my responsibility to request it in writing to the Privacy Officer.

____

Patient Signature or Guardian Signature Required

INTERNAL USE ONLY: ________________________ ________________

Employee Signature Date Names Entered