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. We are not responsible for providing estimates for services outside our office, such as cytology, pathology or labs.

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 printed and/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 Provider (APRN/PA) 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 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: _____

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: _____

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

1405 Centerville Rd. Suite 5400 2625 Mitcham Drive
(850) 877-0101

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 receive 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)
Have you noticed behaviors that concern you for autism? NO YES
(poor eye contact, no smiling at people, loss of skills, doesn't play with toys appropriately)
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:** _____

TALLAHASSEE EAR, NOSE & THROAT - HEAD & NECK SURGERY, P.A.
www.TallyENT.com www.TallahasseeHearingHelp.com

1405 Centerville Road, Suite 5400, Tallahassee, FL 32308
Phone: (850) 877-0101

Auditory Brainstem Response (ABR) Test Instructions

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.**

The ABR procedure is painless and will be carried out while the patient rests. The ABR requires approximately one hour to complete for adults and two hours for children. During the test, "clicks" will be presented to each ear individually through small earphones inserted into the ear canal. Recording electrodes will be taped on the patient's forehead and earlobes to pick up small electrical signals from the brain, which are a natural response to the clicks presented in each ear. These electrical signals are sent to a computer for storage where they can be analyzed and interpreted by the audiologist.

For reliable data to be obtained, the electrodes must be in good contact with the skin. Lotions, oils, or make-up may interfere with the contact of the electrodes to the skin thereby preventing accurate recordings. Small areas on the patient's forehead and earlobes will be scrubbed to ensure good contact. After the electrodes and earphones are in place, testing will begin while the patient is at rest.

Pediatric Instructions

It is most important that your child sleep throughout the ABR testing. Small movements can interfere with recording the necessary information. In order to ensure your child sleeps during the scheduled appointment time ***we ask that you sleep deprive your child.*** If your appointment time is in the morning hours please be sure to keep your child up late the night before, wake him/her earlier than normal in the morning, and have them remain awake until the appointment time. If your appointment is in the afternoon, do not allow any naps. ***It is very important the child is NOT allowed to sleep in the car on the way to the test***. You may bring any items that will help your child fall asleep once in the office (example: blanket or toy). ***We ask you NOT feed your child until you have been called into the office for your appointment.*** It is most helpful if your baby is hungry and sleepy when the appointment begins, this helps to ensure he/she will sleep throughout the testing time. We also ask you bring extra diapers and bottles with you to the appointment. Only the child and parent(s) will be allowed in the test room. Any alterations in these instructions may cause a delay in your child falling asleep, which may lead to the necessity of rescheduling the appointment for another day.

We look forward to seeing you in the near future. If you have any questions, please do not hesitate to contact us at 850-877-0101 ext. 243. Thank You.

_____ _____

(Patient Signature) (Date)