Northeast Texas Ear, Nose & Throat Center
Northeast Texas Hearing Services
New Patient Information Sheet

Patient's Name ______________________ S.S.# ______________________

Marital Status: S M W D Sex: M F Race __________ Birthdate __________ Age ________

Patient's Address ______________________ City __________ State ______ Zip ________

Employer ______________________ Occupation ______________________

Home Phone # ______________________ Cell Phone# ______________________

Work Phone # ______________________ Email Address: ______________________

How should we contact you? (please circle) Home Phone Cell Phone Work Phone Email

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Release of Information: Please specify persons that confidential medical information may be released to for the above named patient. This release will be made VERBALLY only and does not give the following any rights to the patient's written or electronic medical records without written consent from the patient or guardian.

Spouse's Name ______________________ Birthdate __________ Phone# __________

Name ______________________ Relationship __________ Phone# __________

Name ______________________ Relationship __________ Phone# __________

Name ______________________ Relationship __________ Phone# __________

Have you had any of the following vaccines?

Flu ______ Pneumonia ______ Flu and Pneumonia ______ None/Neither ______

Family Doctor ______________________ Did He/She refer you? (please circle) YES NO

Drug Allergies ______________________ Regular Pharmacy ______________________

How did you find out about us? (please circle) Physician Referral Phone Directory Newspaper Health Plan Family/Friends Past Experience Other

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** IF PATIENT IS UNDER **25** PLEASE FILL IN THIS INFORMATION **

Parent's Marital Status: M S D W Custodial Parent: Mother Father Insured: Mother Father

Mother's Name ______________________ Father's Name ______________________

S.S. # __________ D.O.B. __________ S.S. # __________ D.O.B. __________

Address ______________________ Address ______________________

Home # __________ Work # __________ Home # __________ Work # __________

Employer ______________________ Employer ______________________

Consent to Treatment: The services provided by NE Texas ENT Center are by a licensed physician to treat medical problems. The services provided by NE Texas Hearing Services are by a licensed audiologist, who is not a doctor, to assist in the diagnosis of hearing, ear and/or balance problems. I have read the above statements and hereby consent to the treatment for myself or the minor named above.

Assignment of Benefits: I authorize benefits including Medicare, Medicaid, private insurance and other health plans to Northeast Texas ENT Center and/or Northeast Texas Hearing Services. This authorization will remain in effect until revoked by me in writing. A photocopy of this authorization is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize Northeast Texas ENT Center and/or Northeast Texas Hearing Services to release all information necessary to secure payment.

Acknowledgement of Privacy Policies: I acknowledge that I have received a copy of the Privacy Policies for Northeast Texas Ear, Nose & Throat Center and/or Northeast Texas Hearing Services.

Signature ______________________ Relation to Patient __________ Date __________
(Responsible Party)

NEW PATIENT HISTORY FORM

Name: ______________________________ Age: ________ Date: __________

What Medical Problem are you having?: ______________________________

____

____

List All Medication Allergies: ______________________________

List Present Medications: ______________________________

____

Family History:

Your Father: Living _____ Deceased _____ Cause of Death ______________

Your Mother: Living _____ Deceased _____ Cause of Death ______________

Your Brothers & Sisters: Total No. ________ No. Living ________ No. Deceased __________

Cause of Death(s) ______________________________

Do you have a Family History of:

Heart Disease _____ High Blood Pressure _____ Diabetes _____ Stroke _____ Cancer ________

Location of Cancer ______________ Thyroid Disease _____ Other Disease __________

Review of Your Body Systems: Do you have now or have you ever had any of the following?

	No	Yes	Please Explain
1. Ulcers	____	____	______________________
2. Colitis	____	____	______________________
3. Rectal Bleeding	____	____	______________________
4. Change in Bowel Habits	____	____	______________________
5. Heart Disease	____	____	______________________
6. High Blood Pressure	____	____	______________________
7. Chest Pain	____	____	______________________
8. Cough Blood	____	____	______________________
9. Shortness of Breath	____	____	______________________
10. Thyroid Disease	____	____	______________________
11. Lung Disease	____	____	______________________
12. Cancer (location)	____	____	______________________
13. Asthma or Emphysema	____	____	______________________
14. Hepatitis (jaundice)	____	____	______________________
15. Venereal Disease	____	____	______________________
16. Kidney Stone(s)	____	____	______________________
17. Blood in Urine	____	____	______________________
18. Epilepsy	____	____	______________________
19. Swollen or Painful Joints	____	____	______________________
20. Depression	____	____	______________________
21. Diabetes	____	____	______________________
22. Stroke	____	____	______________________
23. Blood Disease or Anemia	____	____	______________________

NEW PATIENT HISTORY FORM

Name: ______________________________ Date: ____________

Your Personal History:

Hospitalizations:		Year	Hospital
Illnesses (kind)	____________	______	____________
	____________	______	____________
	____________	______	____________
Surgery (kind)	____________	______	____________
	____________	______	____________
	____________	______	____________

Your Children:

Number Living _____ List any serious diseases in children: ____________

Number deceased children: _____ Cause: ____________

Your Personal Habits:

	No	Yes	Please Explain
Regularly exercise (3 or 4 times/wk)	_____	_____	____________
Wear auto seat belts	_____	_____	____________
Take diet pills, including herbal	_____	_____	____________
Use illegal drugs	_____	_____	____________
Use alcohol	_____	_____	____________
Were you ever a heavy drinker	_____	_____	____________
Do you Smoke?	_____	_____	____________
If ever, when did you stop? ________			

Tests and Immunizations: (Give date last done)

	Yes	Year Performed	Not Sure	Never	Comments
Pap smear (Women)	_____	_____	_____	_____	_____
Breast Mammography	_____	_____	_____	_____	_____
Chest X-Ray	_____	_____	_____	_____	_____
EKG	_____	_____	_____	_____	_____
Fasting Blood Sugar	_____	_____	_____	_____	_____
Thyroid Profile	_____	_____	_____	_____	_____
Tetanus (DPT)	_____	_____	_____	_____	_____
Flu Shot	_____	_____	_____	_____	_____
Pneumonia Vaccine	_____	_____	_____	_____	_____

Northeast Texas Ear, Nose & Throat Center, PLLC
Northeast Texas Hearing Services

NOTICE OF PRIVACY PRACTICES
Original Effective Date: April 14, 2003

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

I. OUR COMMITMENT TO PROTECTING HEALTH INFORMATION ABOUT YOU.
The "HIPPA Privacy Rule", a federal regulation, requires that we provide this notice to you. This regulation also requires that we protect the privacy of your health information that identifies you, our patient. This information is called "protected health information" or "PHI".

II. HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU.
For treatment, payment and health care operations, Northeast Texas Ear, Nose & Throat Center and/or Northeast Texas Hearing Services participate in an organized health care arrangement with respect to sharing PHI with each other. We may also use and/or disclose your PHI for these purposes as follows:

Treatment: We may use or disclose your PHI when consulting with other health care providers regarding your treatment for coordination and management of your health care. These health care providers may be those that referred you to our office or they may be those we referred you to from our office. The coordination and management of your health care may include scheduling you an appointment in our office, scheduling you for surgery at another facility, making you an appointment with another healthcare provider for further evaluation, ordering tests to be performed by other health care providers at other facilities, requesting information from your referring health care provider, calling in prescriptions, and sending medical information to other health care providers especially those that asked us to consult with you.

Payment: We may use or disclose your PHI when contacting your insurance company to determine their coverage for services that you are scheduled to receive or have already received. We may disclose PHI to your insurance company for billing, claims management, and/or determination of benefits for claims that have been submitted for payment. We may contact your primary care physician to obtain a referral for your visit so that your insurance benefits will be applied at the highest level of payment. We will use your PHI to send bills and/or letters to you in the mail for any balances that you may owe. We may disclose PHI to consumer credit reporting agencies relating to collection of payments owed to us.

Health Care Operations: We may use and disclose PHI in performing business activities which are called Health Care Operations. We may use or disclose your PHI when taking phone messages in our office to relay to our health care providers. We will use your PHI to contact you by phone to remind you of your appointment with our office and to provide you with information about your medical condition and any other information we deem pertinent to your medical care. We will compile the entire PHI that we have in our office about you into a chart, either physical or electronic, and in various files in our computer system. Your PHI may be seen by doctors reviewing the services provided to you, and by accountants, lawyers, and others who assist us in complying with the law and managing our business for planning, development and cost management analysis. Your PHI may be disclosed in the event that we sell our practice to another health care provider or entity or combine our practice with another practice. We may disclose PHI when providing training to students, health care providers and non-healthcare providers. We may also disclose PHI for the health care operations of an "organized health care arrangement" in which we participate with hospitals and healthcare providers that see patients in the hospital.

USES AND DISCLOSURES WE MAY MAKE WITHOUT YOUR WRITTEN AUTHORIZATION FOR WHICH YOU HAVE THE OPPORTUNITY TO AGREE OR TO OBJECT:
If you do not object, we may disclose PHI about you to your family members if that information is directly relevant to the family member's involvement in your care or payment for your care. If you are present and able to consent or object (or if you are available in advance), this is your opportunity to object to this disclosure. If you are not present or you are unable to consent or object, we may exercise

professional judgment to determine whether the use or disclosure of PHI is in your best interests. We also may use professional judgment and our experience with common practice to make reasonable decisions about your best interests in allowing a person to act on your behalf to pick up prescriptions, free samples of prescription medicines, medical supplies, x-rays, or other things that contain PHI about you.

OTHER USES AND DISCLOSURES WE CAN MAKE WITHOUT YOUR WRITTEN AUTHORIZATION OR OPPORTUNITY TO AGREE OR OBJECT

We may use and disclose PHI about you as required by or to:

- Federal, State or Local Law.
- Public Health Authorities
- Law Enforcement officials
- Coroners, Medical Examiners, Funeral Directors
- Prevent a threat to the health or safety of a person or to the public.
- Government Entities to determine eligibility for benefits, for national security or for the health or safety of employees and inmates of correctional institutions.
- Secretary of the US Department of Health and Human Services when requested.
- Workers' Compensation representatives that provide benefits for work-related injuries or illness.
- Proper Government authorities if domestic violence, abuse or neglect is suspected for patients of all ages.

NOTE: ALL OTHER USES AND DISCLOSURES OF PHI NOT OUTLINED ABOVE WILL ONLY BE MADE WITH YOUR WRITTEN AUTHORIZATION. IF YOU HAVE AUTHORIZED US TO USE OR DISCLOSE PHI ABOUT YOU, YOU MAY REVOKE YOUR AUTHORIZATION AT ANY TIME, EXCEPT TO THE EXTENT WE HAVE TAKEN ACTION BASED ON THE AUTHORIZATION.

III. FEDERAL LAW GIVES YOU THE FOLLOWING RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU.

- To restrict our disclosure of your PHI to certain individuals involved in your care. This request will need to include the information that you want to restrict; how you want to restrict the information; and to whom you want those restrictions to apply.
- To receive confidential communications regarding your PHI in a certain manner or at a certain location.
- To inspect and receive a copy of PHI about you in certain records that we maintain.
- To request that we amend PHI about you as long as such information is kept by or for our office.
- To request an "accounting" of certain disclosures that we have made of PHI about you. This is a list of disclosures made by us during a specified period of up to six years other than disclosures made for treatment, payment, and health care operations; to you directly; to family members involved in your care; or pursuant to a written authorization from you. This accounting will be of disclosures made after April 14, 2003.
- To received a paper copy of this Notice at any time.

To take advantage of these rights as stated above, a written request must be submitted to our Privacy Official with a reason for the request. Requests received that are not in writing or without a stated reason, may be denied. We are not *obligated* to restrict our disclosure of your PHI to certain individuals but may reach an agreement with you. If we do agree to your request, we are required to comply with our agreement except in the case where the information is needed to treat you in the case of an emergency. The first copy of PHI and/or an accounting of PHI disclosures furnished to you will be free. Copying fees as allowed by Texas law will apply for all subsequent copies.

IV. COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us. To file a complaint with our office, submit your complaint in writing to our Privacy Official at the address and number listed below. We will not retaliate or take action against you for filing a complaint. If you are not satisfied with our resolution of your complaint, you may contact the Secretary of the US Department of Health and Human Services.

V. QUESTIONS

You may contact our Privacy Official at the following address and phone number:

Rick E. Erickson, M.D. 1001 E. Austin Street, Paris, Texas 75460, (903) 785-5800

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NORTHEAST TEXAS EAR, NOSE & THROAT CENTER
NORTHEAST TEXAS HEARING SERVICES

PAYMENT POLICIES

Please read and sign:

FOR EVERY OFFICE VISIT:

COPAYS Are Due In Full.

CO-INSURANCE AMOUNTS (Usually 20%) Are Due In Full.

MEDICARE ONLY PATIENTS Owe Their 20% Of Medicare's Allowed Amount.

MEDICARE W-SUPPLEMENT Insurance Will Be Filed w-Any Balance Billed to Patient.

INSURANCE BENEFITS UNKNOWN: 20% Of Charges Are Due In Full.

NO INSURANCE: Total Visit Amount Is Due In Full.

FOR EVERY OFFICE PROCEDURE AND OFFICE SURGERY:

CO-INSURANCE AMOUNTS (Usually 20%) Are Due In Full.

MEDICARE ONLY PATIENTS Owe Their 20% Of Medicare's Allowed Amount.

MEDICARE W-SUPPLEMENT Insurance Will Be Filed w-Any Balance Billed to Patient.

INSURANCE BENEFITS UNKNOWN: 20% Of Charges Are Due In Full.

NO INSURANCE: Total Amount Is Due In Full Unless Other Prior Arrangements Have Been Made. Please Ask Receptionist.

SURGERY SCHEDULED:

SURGERY DEPOSIT Is Due 48 hours Prior To Surgery Date.

SURGERY DEPOSIT AMOUNT Is Based On The Estimated Patient Balance Owed.

ANY BALANCES REMAINING after the above amounts are collected will be billed to the patient.

I have read the above payment policy and agree to pay as stated.

______________________________ ________________________

Patient or Responsible Party Date