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

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

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

** 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)

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