HOUSTON ENT CLINIC

HOUSTON EAR, NOSE AND THROAT CLINIC, LLP

Physician: _____

Account #: _____

Patient Information

Patient's Social Security Number	Date of Visit	
Patient Name	Date of Birth	Gender M F
Address	City, State, Zip	
Home Phone	Work Phone	Cell Phone
Email	Patient's Relationship to Insured ☐ Self ☐ Child ☐ Spouse ☐ Guardian ☐ Other	

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated	Patient Employment ☐ Full Time ☐ Part Time ☐ None	Spouse Employment ☐ Full Time ☐ Part Time ☐ None	Student Status ☐ Full Time ☐ Part Time ☐ None

Name of Referring Physician/PCP or How did you hear about us?	List any immediate family members who are existing patients:

Is the patient currently a resident of a Skilled Nursing Facility? ☐ Yes ☐ No Name of Facility:

Responsible Party Information (Guarantor)

Name	Date of Birth	Gender M F
Address	City, State, Zip	
Home Phone	Work Phone	Cell Phone
SSN	Employer	

Insurance Coverage - Primary Carrier

Insurance Carrier/Network	Policy Number	Group Number	Effective Date
Claims Address		Plan Type ☐ HMO ☐ PPO/EPO ☐ POS ☐ Indemnity ☐ OTHER_____	
Insured's Name (if different than above)	Date of Birth	Gender M F	
Insured's Address	City, State, Zip		
Insured's Employer	Employer Phone #		

Insurance Coverage - Secondary Carrier

Insurance Carrier/Network	Policy Number	Group Number	Effective Date
Claims Address		Plan Type ☐ HMO ☐ PPO/EPO ☐ POS ☐ Indemnity ☐ OTHER_____	
Insured's Name (if different than above)	Date of Birth	Gender M F	
Insured's Address	City, State, Zip		
Insured's Employer	Employer Phone #		

Emergency Contact Information

Name	Date of Birth	Gender M F
Address	City, State, Zip	
Home Phone	Work Phone	Cell Phone
Relationship to Patient		

I hereby authorize payment directly to HENT for medical services rendered. I authorize the release of my medical information deemed necessary in processing the claim. It is my understanding that I am responsible for this amount, regardless of insurance coverage.

Signature	Date

Houston Ear, Nose and Throat Clinic, LLP

Patient Medical Consent Form

1. Consent to Medical Treatment / Authorization to Release Information

I (for) undersigned patient, do hereby voluntarily consent to such physician care involving routine diagnostic procedures and medical treatment by my personal physician, his/her assistants or designees. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of any treatment or examinations to be rendered during this visit. I further authorize HENT to release to the insurers herein, specified, or to any agency concerned with the payment of my medical charges, any and all information (including copies of records) relating to this visit.

2. Medicare Patients Certification (Medicare Only)

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carries any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

3. Responsibility of NonCovered Services

I have been informed that the medical procedures, treatments and services provided to me while I am a patient at HENT are furnished only at my direction or at the direction of my physician and that HENT makes no representations concerning the medical necessity or reasonableness of such procedures, treatments or services. The decision as to the necessity or reasonableness of any procedure, treatment or services is made by the appropriate state medical program, insurance company, or its health insurance agent. I understand that I am responsible for payment for any procedures, treatment or services, which were provided to me at my request by my physician and which are determined not to be reasonable and medically necessary as required by the appropriate government, or insurance medical program.

4. Assignment of Insurance Benefits / Distribution of Overpayment / Obligation or Guarantor

Each of the undersigned hereby authorizes all of (his/her) insurers, whether or not specified, to make payments of the Physician insurance benefits directly to HENT rather than to said undersigned, but such payments shall not exceed HENT's regular charges. The undersigned patient recognizes, however, that (he/she) remains financially responsible to HENT for charges not paid or covered by said insurers. Each of the undersigned insureds also hereby authorize any overpayment to HENT regarding this visit which would otherwise be payable to said undersigned to be applied and credited against any previous balance due to HENT for which said undersigned is the responsible party.

I also irrevocably assign to HENT all rights, title, and interest in benefits payable out of any third party action against any other person, entity, or insurance company, or out of recovery under the uninsured motorist provisions or the medical payment provision of any insurance policy(ies) or any other insurance policy(ies) under which I may be entitled.

I the undersigned guarantor, hereby guarantee full and prompt payment to HENT of all charges made as a result of services rendered the above named patient during this visit. I agree to pay HENT for said charges upon the failure of said patient, any responsible insurer or any other person or firm to pay same when due. The patient is responsible for any legal or court costs required in the collection of any unpaid accounts.

Patient/Insured/Guarantor Date	By: Date
Witness Date	Relationship Date

Houston Ear, Nose & Throat Clinic, L.L.P.

Patient Consent and Acknowledgement of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, Houston ENT Clinic creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosure have already made in reliance on my prior consent.

This consent is given freely with the understanding that:

1.Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purpose of treatment, payment or health care operations, be restricted. I also understand that the Practice and I must: agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information; and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

(PATIENT'S NAME PRINTED)	DATE
PATIENT'S SIGNATURE (OR GUARDIAN, IF A MINOR)	SOCIAL SECURITY NUMBER (FOR IDENTIFICATION PURPOSES ONLY)
WITNESS (Optional)	DATE

EAR · NOSE · THROAT
HOUSTON
& ALLERGY est. 1907

MAIN: (281) 649-7000

Otolaryngologists
Jim F. Waldron, MD, PA
G. Walter McReynolds, MD, PA
G. Gary Card, MD, PA
Stanford M. Shoss, MD, PA
Mark Lynn Nichols, MD, PA
Bradford S. Patt, MD, PA
Walter P. Moore, III, MD, PA
Thomas J. Clegg, MD, PA
John K. Yoo, MD, PA
David Devorkin, MD, PA
James C. Martin Jr., MD, PA
Marvin W. Lerner, MD, PA
Kasthuri Rangan, MD, PA
Kathleen McDonald, MD, PA
Tracy F. Jakob, MD, PA
Tara Morrison, MD, PA
R. Bruce Buechler, MD, PA
Becky McGraw-Wall, MD, PA
Cynthia P. Tarver, MD, PA
Brian S. Wang, MD, MPH
Jing Shen, MD
Patricia A. Maeso, MD

Allergists
Puneet Shroff, MD
Patricia A. Leonard, MD

Administrator
Reji Varghese, MHA/MBA

Director of Audiology
Kelsy F. John, MS, CCC-A

MISSED APPOINTMENTS AND CANCELLATION POLICY

OFFICE VISITS

A scheduling fee of $25.00 will be assessed on cancellations made within 48 hours of the scheduled office visit appointment or a missed appointment.

SURGERY

A scheduling fee will be assessed on cancellations or rescheduling occurring less than ten days before the procedure.

See the schedule below for the fees that will be accrued.

3 – 9 days before the procedure	15% of surgeons fees
Less than 48 hours before the procedure	$400.00

*Canceling on Friday for a scheduled procedure the following Monday would be considered less than 48 hours.

Patient Acknowledgement:_____ Date: _____

CITAS de OFICINAS

Un cobro de $25.00 sera cobrado en cancelaciones hechas antes de 48 horas de la cita original; o una cita perdida.

CIRUGIAS

Un cobro se aplicara en cancelaciones o cambio de cita que ocurran menos de 10 dias antes del procedimiento.

Vea el horario enseguida para los cobros:

3 – 9 dias antes del procedimiento	15% de cobro de cirujanos
Menos de 48 horas antes del procedimiento	$400.00

*Cancelando el Viernes para procedimientos el Lunes, seran considerados menos de 48 horas.

Reconocimiento del Paciente: _____ Fecha: _____

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TEST RESULTS

IF THERE ARE ANY TEST RESULTS TO BE REPORTED AND THE PHYSICIANS AND/OR STAFF OF HOUSTON ENT & ALLERGY ARE UNABLE TO REACH ME, I GIVE MY PERMISSION TO DISCUSS MY RESULTS WITH:

FAMILY/FRIEND/SPOUSE MEMBER ONLY

PATIENT'S NAME

_____

_____	_____
NAME	**RELATIONSHIP**
_____	_____
NAME	**RELATIONSHIP**
_____	_____
PATIENT'S SIGNATURE	**DATE**

☐ **PLEASE CHECK THE BOX IF A VOICEMAIL MESSAGE IS ALLOWED IN THE EVENT THAT THE HOUSTON ENT & ALLERGY PHYSICIAN AND/OR ITS STAFF ARE UNABLE TO REACH YOU.**

CONFIDENTIAL PATIENT HEALTH HISTORY

(Historia Clinica Confidencial)

Date _____
(Fecha)

Patient Name_____ **Age** _____
(Nombre) *(Edad)*

Name of Referring Physician _____
(Nombre de su Medico de Cabezera)

Reason for your office visit today _____
(Razon de la vista)

When did your problem(s) start?

___ minutes	___ hours	___ days	___ weeks	___ years
◻ gradual	◻ ongoing	◻ since birth	◻ sudden	◻ unknown

How long does each episode last?

◻ lasts days	◻ lasts 1-4 mins	◻ lasts 5-10 mins	◻ lasts <1 min	◻ lasts > 1 min
◻ lasts 15-30 mins	◻ lasts 30-60 mins	◻ lasts seconds	◻ lasts months	◻ lasts weeks
◻ occurs constantly	◻ occurs fleetingly	◻ occurs intermittently		

Please state the 'severity' of your symptoms?

◻ mild	◻ moderate	◻ severe	◻ other

Please state the 'status'?

◻ improving	◻ unchanged	◻ worsening	◻ resolved	◻ other

Do you now have or have you ever had any of the following: (Please check)
(A tenido: (Por favor marquee))

◻ Alcoholism/drug addication (Alcholismo)	◻ Hepatitis (Hepatitis)
◻ Allergies	◻ Hypertension
◻ Anemia (Anemia)	◻ Jaundice (Hictericia)
◻ Arthritis (Arttitis)	◻ Kidney disorder (Enfermedad renales)
◻ Bleeding Disorder (Sangra amenudo o po periodos prolongado)	◻ Liver disease *(Problemas hepaticos)*
◻ Blood transfusion (Transfsion sanguine)	◻ Psychiatric treatment
◻ Cancer (Cancer)	◻ Seizures/Epilepsy
◻ Chronic lung disease (Enfermedas pulmonares cronicas)	◻ Stroke
◻ Diabetes (Diabetes)	◻ Thyroid disease *(Problemas de tiroides)*
◻ Heart disease (Problemas cardiacos)	◻ Tuberculosis (tuberculosis)

Other problems not listed: _____
(Otros problemas no listados)

List drug allergies and reactions: _____
(Alergia a medicamentos)

List current medications (continue on back or bring in list)**:**_____
(Lista de medicamentos)

List and date any operations you have had: _____
(continue on back or bring in list)
(Lista de ciruglas y fechas) _____

Women- & (Mujeres) are you pregnant now, or think you may be? Yes *(Si)* /**No** *(No)*
Mujeres esta usted embarazada o puede estarlo?

Family History

□ No relevant family history

Yes/No	Family Member	
	Thyroid disease *(hyper/hypo)*	Mother / Father/ Sister / Brother
	Hearing Loss	Mother / Father/ Sister / Brother
	Cancer *(what type)*	Mother / Father/ Sister / Brother
	Heart *(what type)*	Mother / Father/ Sister / Brother
	Diabetes	Mother / Father/ Sister / Brother

Do you or have you smoked or used tobacco in any form? **YES** *(Si)* / **NO** *(No)* **If so, in what form and how much?_____**
(Fuma o usa tobacco en cualquier forma?) *(Si marca 'Si, la cantidad?)*
Smoking Tobacco History

□ current	□ former	□ never	□ unknown

Passive smoke exposure?

□ yes	□ no

How many years? _____
(por cuantos anos ha consumido tabaco?)

Do you drink alcohol? Yes *(Si)* / **No** *(No)* /**Quit** **If so, in what form and how much?** _____
(Bebe alcohol?) *(Si marca 'Si' la cantidad?)*

Do you use Caffeine? Yes *(Si)* / **No** *(No)* **If so in what form and how much?** _____

Do you feel any reason you may be at risk for AIDS? **Yes** *(Si)* **/No** *(No)*

Primary Language
□ English
□ Spanish
□ Vietnamese
□ Other:_____

Race
□ American Indian or Alaska Native
□ Asian
□ Black or African American
□ Other Race:_____
□ White

Ethnicity
□ Hispanic or Latino
□ Non Hispanic or Latino

PHARMACY INFORMATION

Pharmacy Name:_____

Pharmacy Address or Location:_____

City:_____ Zip Code_____

Pharmacy Phone:_____

_____ _____
Signature of Patient or Guardian **Date**
(Firma del paciente/padre tutor) *(Fecha)*

Patient Name: _____

Date: _____

Do you have any of the following Symptoms?

Yes	No	**Constitutional**
__	__	chills
__	__	fatigue
__	__	fever
__	__	night sweats
__	__	weight gain
__	__	weight loss

Yes	No	**Cardiovascular**
__	__	chest pain
__	__	heart murmur
__	__	irregular heartbeat

Yes	No	**Metabolic**
__	__	cold intolerance
__	__	heat intolerance
__	__	increased thirst

Yes	No	**Head, Eyes, Ears, Nose, Throat**
__	__	blurred vision
__	__	choking on liquids
__	__	choking on solids
__	__	double vision
__	__	dizziness
__	__	drooling
__	__	difficulty swallowing
__	__	ear drainage
__	__	hearing loss
__	__	itchy eyes
__	__	dry eyes
__	__	nasal congestion
__	__	hoarseness
__	__	mouth ulcers
__	__	ear ache
__	__	sore throat
__	__	ringing in the ears
__	__	visual changes
__	__	ear itching
__	__	nosebleed
__	__	ear wax
__	__	Other _____

_____

Yes	No	**Gastrointestinal**
__	__	abdominal pain
__	__	constipation
__	__	diarrhea
__	__	heartburn
__	__	nausea or vomiting

Yes	No	**Neurological**
__	__	difficulty falling asleep
__	__	difficulty staying asleep
__	__	daytime sleepiness
__	__	non-restorative sleep
__	__	numbness in extremities
__	__	fainting
__	__	tingling
__	__	tremor
__	__	weakness
__	__	dizziness
__	__	headache

Yes	No	**Respiratory**
__	__	apnea during sleep
__	__	shortness of breath
__	__	snoring
__	__	wheezing
__	__	cough

Yes	No	**Genitourinary**
__	__	change in urine color
__	__	painful urination
__	__	frequent urination

Yes	No	**Hemo/Lymp**
__	__	easy bleeding
__	__	easy bruising

Yes	No	**Psychiatric**
__	__	anxiety
__	__	depression
__	__	hallucinations

Patient Signature: _____