



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 <input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Guardian <input type="checkbox"/> Other	
Marital <input type="checkbox"/> Single <input type="checkbox"/> Married	Patient <input type="checkbox"/> Full Time <input type="checkbox"/> None	Spouse <input type="checkbox"/> Full Time <input type="checkbox"/> None	Student <input type="checkbox"/> Full Time <input type="checkbox"/> None
Status <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	Employment <input type="checkbox"/> Part Time	Employment <input type="checkbox"/> Part Time	Status <input type="checkbox"/> Part Time
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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> HMO <input type="checkbox"/> PPO/EPO <input type="checkbox"/> POS <input type="checkbox"/> Indemnity Type <input type="checkbox"/> 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 <input type="checkbox"/> HMO <input type="checkbox"/> PPO/EPO <input type="checkbox"/> POS <input type="checkbox"/> Indemnity Type <input type="checkbox"/> 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
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HOUSTON EAR, NOSE & THROAT CLINIC, L.L.P.

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 visita)

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

Heart trouble
(Problemas cardiacos)
High blood pressure
(Alta presión)
Rheumatic fever
(Fiebre reumatica)
Prolonged Bleeding
(Problemas sanguineos)
Blood disorder
(Sangra amenudo o por periodos prolongado)
Diabetes
(Diabetes)
Stroke
(Embolia/accidente cerebrovascular)
Jaundice
(Hictercia)
Hepatitis
(Hepatitis)

Asthma
(Asma)
Chronic lung disease
(Enfermedas pulmonares cronicas)
Tuberculosis
(Tuberculosis)
Chest Pain
(Dolor en el pecho)
Alcoholism
(Alcoholismo)
Psychiatric treatment
(Tratamiento psiquiatrico)
Arthritis
(Artritis)
Blood transfusion
(Transfusion sanguinea)

Thyroid problem
(Problemas de tiroides)
Kidney disease
(Enfermedad renales)
Drug addiction
(Adicción a drogas)
Anemia
(Anemia)
Cancer
(Cancer)
Eye disease
(Enfermedades de los ojos)
Epilepsy
(Epilepsia)
Liver problems
(Problemas hepaticos)

Other problems not listed _____
(Otros problemas no listados)

List drug allergies and reactions _____
(Alergia a medicamentos)

List current medications _____
(Lista de medicamentos)

List and date any operations you have had _____
(Lista de cirugias y fechas)

(Women) Are you pregnant now, or think you may be? _____ Yes _____ No
(Mujeres) Esta usted embarazada o puede estario? (Si) (No)

Do you smoke or use tobacco in any form? _____ Yes _____ No If so, in what form and how much? _____
(Fuma o usa tobacco en cualquier forma?) (Si) (No) (Si marca "Si", la cantidad?)

How many years? _____
(Por cuantos años ha consumido tabaco?)

Do you drink alcohol? _____ Yes _____ No If so, in what form and how much? _____
(Bebe alcohol?) (Si) (No) (Si marca "Si", cuanto consume por dia?)

Do you feel that for any reason you may be at risk for AIDS? _____ Yes _____ No
(Hay algun motivo para pensar que tiene riesgo de contraer o contrajo SIDA?) (Si) (No)

Signature of Patient or Guardian _____
(Firma del paciente/padre o tutor)

Date _____
(Fecha)

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 Non-Covered 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