PATIENT INFORMATION FORM

LAST NAME:_____ FIRST NAME:_____ MIDDLE NAME:_____

SOCIAL SECURITY #:_____ DATE OF BIRTH:_____ SEX:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

HOME PHONE:_____ WORK PHONE:_____ CELL PHONE:_____

EMAIL ADDRESS:_____

MARITAL STATUS:_____ SPOUSE'S NAME:_____

PRIMARY CARE PHYSICIAN:_____ PHONE:_____

(If different from above)
REFERRING PHYSICIAN NAME:_____ PHONE:_____

IF NOT REFERRED BY A PHYSICIAN, PLEASE SPECIFY HOW YOU HEARD ABOUT OUR OFFICE: _____

EMPLOYER/SCHOOL INFORMATION:

EMPLOYER **(IF RETIRED OR STUDENT, PLEASE STATE**):_____

RESPONSIBLE PARTY INFORMATION:

IF PATIENT IS A MINOR, PLEASE PROVIDE NAME OF RESPONSIBLE PARTY:_____

RESPONSIBLE PARTY ADDRESS (IF DIFFERENT FROM ABOVE):_____

IN CASE OF EMERGENCY- Please list who we should contact in the event of an emergency:

NAME:_____ PHONE:_____ RELATION:_____

PHARMACY: (name and location)_____

In the event that I request the use of a mail-order pharmacy and the pharmacy charges my card on file for any medications prescribed by SAENT, I understand that SAENT is not responsible for any charge to the patient for any reason.

AUTHORIZATION TO PAY BENEFITS DIRECTLY TO PHYSICIAN AND RELEASE -INFORMATION:
I request that payment of authorized Medicare/insurance benefits be made on my behalf to St. Augustine Ear, Nose & Throat, LLC, for any services furnished to me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. Any service not covered or paid by your insurance plan will be your responsibility.

And

CONSENT FOR TREATMENT:
I hereby authorize treatment/care from the physician and/or ARNP at St. Augustine Ear, Nose & Throat, LLC.

PATIENT'S SIGNATURE (OR RESPONSIBLE PARTY):_____ DATE:_____

St. Augustine Sinus & Allergy

PATIENT HISTORY: GENERAL MEDICAL BACKGROUND

NAME: _____ **DATE:** _____

PLEASE CHECK ALL ANSWERS THAT APPLY

If NONE, please indicate

1. DO YOU HAVE OR HAVE YOU EVER HAD: ____NONE

____ Diabetes Type 1___Type 2___
____ Chronic Low blood pressure
____ Chronic High blood pressure
____ Multiple sclerosis
____ Seizures
____ Arthritis or skeletal problems
____ Unexplained weight loss
____ Cleft palate
____ Heart attack
____ AIDS/HIV
____ Hepatitis
____ Angina
____Meningitis
____ Heart Murmur
____ COPD
____ Asthma
____ Stomach Ulcers
____ Glaucoma
____ Cancer of _____
____ other tumor _____
____ Sleep Apnea
Do you use a machine? ___Y___ N
____PACE Maker
(If so, please provide card)

2. DO ANY BLOOD RELATIVES HAVE: ____NONE/UNKNOWN

(*please specify which family member*)

____Diabetes- Family Member: _____
____ MS- Family Member: _____
____ Heart attack - Family Member: _____
____ Cancer of _____- Family Member: _____

3. MEDICATION ALLERGIES: _____

____NONE/UNKNOWN

4. OTHER ALLERGIES: _____

____NONE/UNKNOWN

5. LIST ALL CURRENT MEDICATIONS AND DOSES (INCLUDE BIRTH CONTROL PILLS AND VITAMINS): ____NONE

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

NAME: _____

6. LIST OPERATIONS: ____NONE

____ **Tonsillectomy/adenoidectomy** ____ **Sinus Surgery**

____ **Thyroid Surgery** ____ **Other ENT Surgeries:** _____

7. SMOKING HISTORY:

____ **Never.**

____ **Quit. When?** _____ **How long did you smoke?** _____ **How much per day?** _____

____ **Smoke. For how long?** _____ **How much per day?** _____

8. CAFFEINE CONSUMPTION:

____ **cup(s) or glass(es) per day (coffee, tea, cola, chocolate, etc.)**

9. ALCOHOL CONSUMPTION:

____ **No (rarely) alcohol.**

____ **Yes. How many glasses in one sitting?** _____ ____ **Daily** ____ **Weekly** ____ **On Occasion**

10. LIST OTHER DRUGS YOU USE:

____**Marijuana** ____**Cocaine** ____**Other:**_____ **(please specify)**

11. ETHNIC BACKGROUND

____ **HISPANIC OR LATINO** ____ **NON HISPANIC OR LATINO** ____ **NOT SPECIFIED**

12. RACE

____ **AMERICAN INDIAN** ____**WHITE** ____**ASIAN**

____ **BLACK OR AFRICAN AMERICAN** ____ **OTHER** ____**NOT SPECIFIED**

13. PREFERRED LANGUANGE

____ **ENGLISH** ____ **SPANISH** ____ **NOT SPECIFIED**

14. When was your last Colonoscopy? _____ **15. When was your last Flu Vaccine?** _____

16. Have you ever had the Pneumococcal Vaccine?: _____**Yes** _____ **No If so, what year?**_____

17. FOR FEMALES

Are you pregnant? Yes / No

Are you post-menopausal? Yes / No

18. When was your last Mammogram?

Date: _____

Acknowledge of Receipt of Privacy Notice for St. Augustine Ear, Nose & Throat, LLC

Patient Name:_____Date of Birth:_____

Social Security Number:_____

We are required by law to make available to you a copy of our Notice of Privacy Practices. A copy is available for you at the reception window and you may take this copy with you if desired. Please sign below to acknowledge that a copy of our privacy practices was made available to you.

_____ _____
Signature of Patient or Legal Guardian Date

☐ Received a copy of the privacy policy ☐ Declined a copy of the privacy policy

---

You may authorize certain individuals to be involved in your care. This consent for disclosure includes both health and financial as it relates to your care. Below you may list those individuals for which our office is allowed to release your Protected Health Information.

Individual's Name (Please Print) ***Relationship to Patient***

_____

_____

_____

_____

_____ _____
Your Signature is Needed for Permission Date

Welcome to St. Augustine Ear, Nose & Throat, LLC!

Our goal is to provide you with quality, state-of-the-art patient care in a cost effective manner. In order to maintain that goal we have established the following policies to improve communication regarding appointments, medical records, and your financial responsibility at the time of service or prior to any scheduled surgery. If you have any questions, please feel free to ask a staff member.

YOUR INSURANCE POLICY: While we make every attempt to obtain your current insurance benefit information for services rendered, we are unable to guarantee that the benefit information that has been communicated to us by your insurance company is correct. Your insurance company will process your claim(s) according to your benefit information that is applicable on the date of service. This may mean that after the claim has been processed, you may owe a different and/or greater amount than what was provided to us at the time of our call for your benefit information.

Copay/Coinsurance and Deductibles: It is the policy of St. Augustine Ear, Nose & Throat to collect all applicable co-pay's, coinsurance's and/or deductibles prior to seeing the provider or prior to surgery. In the event you are unable to pay the co-pay, coinsurance and/or deductible, your appointment will be rescheduled. Please be aware that your insurance may require a higher co-payment for a specialist office visit.

At this time our office is a participating provider for most insurance plans and most of the major insurance networks. If we are not a participating provider for your insurance plan, we will still file an insurance claim as a courtesy. However, you will ultimately be responsible for any fees. It is your responsibility to verify whether we are in-or-out of network with your insurance plan.

If you are enrolled in a managed care insurance plan (HMO), you must obtain a referral from your Primary Care Physician (PCP) before your office visit. We will assist you in this process if applicable. Please be aware that without a referral from your PCP, your office visit may have to be rescheduled. A referral is not a guarantee of payment by your insurance company.

Pre-certification or authorization for a service is not a guarantee of benefits. Benefits are determined when your insurance company receives our claim. If no benefits are due, you will be responsible for any balance pertaining to denied services. In certain situations there may be appeal rights for our office. If so, we will attempt an appeal even without you requesting us to do so. If no appeal rights are available for our office, you will be mailed a statement for the balance due. Please be aware that any appeal rights available to the patient will have to be handled by the patient.

If your insurance policy is new, you may be subjected to a pre-existing condition waiting period. This does not apply to Medicare coverage. Any services not paid by your insurance company for this reason will be your responsibility.

Any fees we charge are for our services only. Any services provided outside of our office will be billed separately by that provider. This would include laboratory, CT Scans, MRI Scans, anesthesia, surgery performed at the hospital or another facility. Please speak directly with those providers regarding their fees.

Federal Law prohibits our office from writing off any balance due after insurance. Patients that are experiencing financial difficulties should speak to the office manager prior to their office visit. We do offer payment plans when applicable.

You agree to be financially responsible for and to pay any amount deemed your financial responsibility as indicated by your Insurance Company and detailed on your Explanation of Benefits.

MISSED APPOINTMENTS/LATE CANCELLATIONS: Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to your appointment for an office visit and we reserve the right to charge $40 for missed or late cancelled appointments. Cancellations are requested 48 hours prior to your appointment for vng balance tests and audiograms. These procedures require a 45 minute block of time and the use of outside technicians so a fee of $80 may be applied to these missed or late cancelled procedures. This fee is not covered by your insurance company. Excessive abuse of scheduled appointments may result in discharge from the practice. Our office understands that emergencies do arise, but please call our office to discuss this with a staff member.

REFUNDS: Overpayments for medical services will be refunded upon request to the responsible party within 30 days. Please keep in mind that an overpayment from your insurance company is not a credit to you and cannot be refunded to you. All purchases of products are a final sale. If you prepay for a procedure and decide not to have it you can credit the balance to another product or service.
WALK INS: Our office is by appointment only.
MEDICAL RECORDS: Upon request we will provide you with copies of you medical records. However, this can be time consuming, so we charge $1 per page with a minimum of $5. Your insurance company does not cover this fee. Please allow 3 days for these requests.

MEDICAL FORMS: A fee of $25 is charged for completion of a medical form. A charge of $40 will apply to forms consisting of more than one page.

PATIENT CALLS/MESSAGES: The practice maintains an automated attendant with voice mail. We make every effort to answer patient calls as they come in, however if the staff member you are trying to reach is not available, please leave a message. **It is not necessary to leave several messages.** Patient calls are handled in order of priority within 48 hours. If you are experiencing an emergency and unable to reach a staff member, please go to the nearest emergency room.

YOUR ACCOUNT: You will be mailed a statement on a monthly basis for any balance due. We request that you pay upon receipt of the statement. Should you have any questions concerning your statement, please do not hesitate to call our office. We will make an attempt to collect any prior balance at your office visit, as well as any applicable co-payment and/or deductible. Your account must be current prior to any scheduled appointment. If your account is past due, then future services may be postponed. For your convenience our office accepts cash, checks, and most major credit cards. **There will a $25 charge for returned checks. IF A CHECK IS RETURNED, FUTURE CHECKS WILL NOT BE ACCEPTED.**

Seriously past due accounts - those older than 90 days or those failing to honor agreed-upon payment terms - will be sent to a collection agency. Our office will forward your account balance plus any fees charged by the collection agency. Once the collection agency receives your information, your past due debt will be reported on your credit history. Additionally you will be dismissed from our practice for financial matters and will have to seek health care elsewhere. As a courtesy, we bill our patient's insurance companies, but any remaining insurance balances after 90 days become the patient's responsibility and are subject to being sent to collections as well. In the event that a patient pays off their balance with the collection agency, we will allow them to reestablish within our practice. However, they will be responsible to pay any outstanding balance with the collection agency as well as an additional 25% of their balance for fees, processing, etc.

PATIENT DISMISSAL: Failure to observe these policies, demonstration of unacceptable behavior, or medical non-compliance can result in dismissal from the practice.

I hereby understand and agree to the financial policies of St. Augustine Ear, Nose, & Throat, LLC.

Patient Name:_____

Signature_____**Date**_____

Medical Records Release

Patient: _____
Last First M. Maiden/Other

Date of Birth: _____ Social Security #: _____

Address: _____ City: _____ ST: ____ Zip: _____

Day Phone: _____ Other Phone: _____

I hereby authorize:

_____

to release information from my medical records as indicated below to: **St. Augustine Ear, Nose & Throat & St. Augustine Sinus & Allergy 1301 Plantation Island Drive South, Suite 401A St. Augustine, FL 32080 or Fax to: (904) 461-6622**

OR

I hereby authorize **St. Augustine Ear, Nose & Throat & St. Augustine Sinus & Allergy** to release my records to:

_____

_____

Information to be released:
All medical records
including:_____

_____

1. I understand the information to be released or disclosed may include information regarding to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), Drug or Alcohol Abuse, and other medically relevant information.

2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already taken in reliance upon it.

3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the
recipient and no longer be protected by federal privacy regulations.

_____ OR _____

Signature of Patient Date Parent/Legal Guardian Date