ENT and Allergy Associates
of Florida
Caring For Our Patients Since 1963
www.entaaf.com

(Print Patient Name)

Financial Consent

D.O.B: _____

I hereby authorize said assignee to release all information necessary to secure payment.

I certify that the information given by me for payment by my insurance plan(s) is correct. I authorize any holder of medical or other information about me to release to the above plan or its intermediaries or carriers any information needed for this or any related insurance claim. I request that the payments of authorized benefits be made to ENT and Allergy Associates of Florida, P.A. on my behalf. I assign the benefits payable for medical services to the physician or organization furnishing the services and authorize such physician/organization to submit a claim to the above insurance on my behalf.

I understand that I am financially responsible for all charges whether or not paid by my insurance, including any deductibles, co-pays, and co-insurance, and that payments are due at the time services rendered.

I understand and agree that in the event that I fail to make payment for services rendered to me, my name and account may be turned over to an attorney and/or a 3rd party collection agency and I agree to pay the additional collection fee of 30% of the outstanding amount owed, including any court cost, and/or reasonable attorney fees that may be incurred in the collection of any outstanding balance.

Privacy Consent

I have been provided a copy or access to a copy of the Practice's Notice of Privacy Practices.

Consent for Treatment

I hereby voluntarily consent to outpatient care at ENT and Allergy Associates of Florida, P.A., encompassing routine diagnostic procedures, examination, and medical treatment including, but not limited to, routine laboratory work (such as blood, urine and other studies), endoscopes, CT's, audiology testing, allergy testing and treatment, and administration of medications prescribed by the physician. I understand that the above diagnostic procedures and testing are separate from my office visit and may be subject to deductible and co-insurance.

I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the physicians and their mid-level providers, including audiologist, medical assistants, or their designees as is necessary in the physician' judgment.

Message Consent

It is our policy to verbally notify you, the patient, of all test results ordered by your care provider and to confirm scheduled appointments. By indicating a response below, you are authorizing our staff to leave a detailed message on your voicemail and/or answering machine. **Please check response: □ Yes □ No**

_____

Patient Initials

(Print Patient Name)

D.O.B: _____

PBM Consent

By signing this consent form I am authorizing ENT and Allergy Associates of Florida, P.A. to request and use my prescription medication history from other health care providers and/or third party pharmacy payors for treatment purposes.

Pharmacy Benefits Managers (PBM) are third party administrators, prescriptions programs, whose primary responsibility is processing and paying prescription drug claims. They also develop and maintain formularies which are lists of dispensable drugs covered by a particular benefit plan.

Appointment Reminders

ENT and Allergy Associates of Florida, P.A. uses a third party appointment reminder system, to notify patients of their upcoming appointment via email, text message and phone.

Consent Forms Acknowledgement

I, the patient, hereby have read and understand the following:

- Financial Consent
- Privacy Consent
- Consent for Treatment
- PBM Consent
- Message Consent

Furthermore, I acknowledge I have been given the opportunity to ask questions regarding these Consents.

Patient/ Guardian Signature:_____ Date:_____

Medicare Consent (applies to Medicare beneficiaries ONLY)

I certify that the information given by me in applying for payment under Title SVIII and/or Title XIX, 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 intermediary carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician/audiology services. I understand that I am responsible for my health insurance deductibles and co-insurance.

Patient/ Guardian Signature:_____ Date:_____

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MEDICAL HISTORY FORM

Patient Name: _____ Date of Birth: _____ M or F

Referring Physician: _____

*Pharmacy Name _____

*Pharmacy Cross Street _____

*Pharmacy Phone Number _____

Primary Care Physician: _____ **Weight:** _____ **Height**: _____

Briefly, why are you seeing our physician today? _____

1. Patient History - Please check your response

	Yes	No		Yes	No
Cancer (enter details below)	( )	( )	Nasal: Allergies	( )	( )
Heart (enter details below)	( )	( )	Nasal: Nasal Trauma	( )	( )
Cardio: Hypertension	( )	( )	Nasal: Nose Bleeds	( )	( )
Ear: Dizziness	( )	( )	Nasal: Sinusitis	( )	( )
Ear: Hearing Loss	( )	( )	Neuro: Headaches/Migranes	( )	( )
Ear: Tinnitus/Ringing in Ear	( )	( )	Neuro: Nervous System	( )	( )
Endocrine: Diabetes	( )	( )	Neuro: Seizure Disorder	( )	( )
Endocrine: Thyroid Disorders	( )	( )	Ophth: Eyes/Glaucoma	( )	( )
G.I.: Bowel Disorders	( )	( )	Oral: Sleep Apnea	( )	( )
G.I.: Liver Disorders	( )	( )	Pysch:PsychiatricDisorders	( )	( )
G.I.: Stomach Disorders/Ulcers	( )	( )	Pulm: Lungs	( )	( )
G.I.: Reflux/GERD/Heartburn	( )	( )	Pulm: Tuberculosis	( )	( )
Immuno: HIV	( )	( )	Uro:Bladder Disorders	( )	( )
Immuno: Immune Dieases	( )	( )	Uro: Kidney	( )	( )
Lymph: Anemia	( )	( )			
Lymph: Bleeding Disorders	( )	( )	Other: _____		

Details of Yes answers: _____

2. Surgeries - Please list any surgeries/hospitalizations: _____

3. Social History - Are you a current smoker? (Y or N) You now smoke _____packs of cigarettes a day.

You smoked_____packs per day and quit_____years ago.

You consume_____alcoholic beverages per day / week / month (circle).

How many caffeinated beverages do you drink per day? _____

4. Family History - Please check your response

	Yes	No		Yes	No
Allergies	( )	( )	Premature Hearing Loss	( )	( )
Cancer	( )	( )	Sinusitis	( )	( )
Diabetes	( )	( )	Sleep Apnea	( )	( )
Headaches/Migraine	( )	( )	Thyroid Disorders	( )	( )
Immune Disease	( )	( )			

Details of Yes answers: _____

Patient Signature: _____ Date: _____

Ear, Nose and Throat Associates of South Florida, P.A.

Caring For Our Patients Since 1963

Place label here/or patient full name/account number

ALLERGY & MEDICATION LIST

ALLERGIES:

Allergy	Reaction

☐ **No Known Drug Allergies**

MEDICATIONS: Date: _____ Reconciled by:_____

Medication Name	Rx = Prescription OTC = Over the Counter, Vitamin/Mineral, Herb Dietary Supplement	Dose	Frequency	Route: Oral, topical, Injection, Inhalation

Message Consent

It is our policy to verbally notify you, the patient, of all test results ordered by your care provider and to confirm scheduled appointments. By indicating a response below, you are authorizing our staff to leave a detailed message on your voicemail and/or answering machine. **Please check response:** ☐ **Yes** ☐ **No**

Patient/Guardian Signature: _____

Print Patient Name: _____ D.O.B:_____

ENT and Allergy Associates of Florida, P.A. – Patient Information

Please Fill Out Form Completely

****Race and Ethnicity questions are required to be asked to the patient by the Federal Government****

Salutation/Titular: Mr.___ Mrs.___ Ms.____Miss____ Dr.____

Patient Name/Nombre del Paciente: _____
Date of Birth/Fecha de Nacimiento:_____ Age/Edad:_____

Sex/Sexo: F____ M ____ Marital Status/Estado Civil: M ___ S___ D ___ W___ Other___
Please check appropriate response:

*** *Race: American Indian/Alaska Native_____ Asian_____ Black/African American_____ Declined to answer _____**

Native Hawaiian/Pacific Islander_____ Other Race____ White_____

Please check appropriate response:

****Ethnicity: Hispanic or Latino _____ Not Hispanic or Latino: _____ Declined to answer: _____**

Religion: _____ Primary Language: _____ Maiden Name: _____

Responsible Party/Guarantor Name:_____

Patient's Address:_____
Street City, State Zip
Patient's 2nd Address:_____ _____Full-time _____Part-time Resident

Patient's Phone (Primary) (_____)_____Patient's Phone (Cell) (_____)_____

Please check your preference on how to contact you: Home Phone:___ Cell Phone: ___ Other: _____

Email Address:_____ Employer Name:_____

Emergency Contact:_____Relationship:_____Phone#_____

Whom may we thank for referring you?_____

Referring Physician:_____ Primary Care Physician:_____

Is this visit related to a Work Accident_____ Auto Accident _____ or Other Accident _____

Pharmacy Name_____Address:_____Tele#_____

Insurance Information

Primary Insurance Company:_____ Subscriber's Name:_____ _____

Relationship to Patient:_____Date of Birth:_____ID#_____Group#_____

Secondary Insurance Company:_____ Subscriber's Name:_____

Relationship to Patient:_____ Date of Birth:_____ID#_____Group#_____

I also authorize my Physician and ENT and Allergy Associates of Florida, P.A. to photograph me for medically related documentation purposes. Yes_____ No_____

Signature:_____Date:_____

ENT AND ALLERGY ASSOCIATES OF FLORIDA, P.A.'s NOTICE OF PRIVACY PRACTICES

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 Duty to Safeguard Your Protected Health Information.

We understand that medical information about you is personal and confidential. Be assured that we are committed to protecting that information. We are required by law to maintain the privacy of protected health information and to provide you with this Notice of our legal duties and privacy practices with respect to protected health information. We are required by law to abide by the terms of this Notice, and we reserve the right to change the terms of this Notice, making any revision applicable to all the protected health information we maintain. If we revise the terms of this Notice, we will post a revised notice and make paper and electronic copies of this Notice of Privacy Practices for Protected Health Information available upon request. We are required by law to notify you in the event of a breach of your protected health information.

In general, when we release your personal information, we must release only the information needed to achieve the purpose of the use or disclosure. However, all of your personal health information that you designate will be available for release if you sign an authorization form, if you request the information for yourself, to a provider regarding your treatment, or due to a legal requirement. We will not use or sell any of your personal information for marketing purposes without your written authorization.

II. How We May Use and Disclose Your Protected Health Information.

For uses and disclosures relating to treatment, payment, or health care operations, we do not need an authorization to use and disclose your medical information:

For treatment: We may disclose your medical information to doctors, nurses, and other health care personnel who are involved in providing your health care. We may use your medical information to provide you with medical treatment or services. For example, your doctor may be providing treatment for a heart problem and need to make sure that you don't have any other health problems that could interfere. The doctor might use your medical history to determine what method of treatment (such as a drug or surgery) is best for you. Your medical information might also be shared among members of your treatment team, or with your pharmacist(s).

To obtain payment: We may use and/or disclose your medical information in order to bill and collect payment for your health care services or to obtain permission for an anticipated plan of treatment. For example, in order for Medicare or an insurance company to pay for your treatment, we must submit a bill that identifies you, your diagnosis, and the services provided to you. As a result, we will pass this type of health information on to an insurer to help receive payment for your medical bills.

For health care operations: We may use and/or disclose your medical information in the course of operating our practice. For example, we may use your medical information in evaluating the quality of services provided, or disclose your medical information to our accountant or other professional for audit purposes.

In addition, unless you object, we may use your health information to send you appointment reminders or information about treatment alternatives or other health-related benefits that may be of interest to you. For example, we may look at your medical record to determine the date and time of your next appointment with us, and then send you a reminder or call to help you remember the appointment. Or, we may look at your medical information and decide that another treatment or a new service we offer may interest you.

We may also use and/or disclose your medical information in accordance with federal and state laws for the following purposes:

- We may disclose your medical information to law enforcement or other specialized government functions in response to a court order, subpoena, warrant, summons, or similar process.
- We may disclose medical information when a law requires that we report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity, or in response to a court order. We must also disclose medical information to authorities who monitor compliance with these privacy requirements.
- We may disclose medical information when we are required to collect information about disease or injury, or to report vital statistics to the public health authority. We may also disclose medical information to the protection and advocacy agency, or another agency responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents
- We may disclose medical information relating to an individual's death to coroners, medical examiners or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.
- In certain circumstances, we may disclose medical information to assist medical research.
- In order to avoid a serious threat to health or safety, we may disclose medical information to law enforcement or other persons who can reasonably prevent or lessen the threat of harm, or to help with the coordination of disaster relief efforts.
- If people such as family members, relatives, or close personal friends are involved in your care or helping you pay your medical bills, we may release important health information about you to those people We may also share medical information with these people to notify them about your location, general condition, or death.
- We may disclose your medical information as authorized by law relating to worker’s compensation or similar programs.
- We may disclose your medical information in the course of certain judicial or administrative proceedings.

Other uses and disclosures of your medical information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you provide permission to use or disclose medical information about you, you may revoke that

permission, in writing, at any time. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided you.

III. Your Rights Regarding Your Medical Information.

You have several rights with regard to your health information. If you wish to exercise any of these rights, please contact our Privacy Officer at 561-939-0177. Specifically, you have the following rights:

- You have the right to ask that we limit how we use or disclose your medical information. You have the right to ask that we send you information at an alternative address or by an alternative means. We will consider your request, but are not legally bound to agree to the restriction. We will agree to your request as long as it is reasonably easy for us to do so. To request confidential communications, you must make your request in writing to our medical records department. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted.
- You have the right to restrict disclosure of medical information to a health plan in the event that you have paid out of pocket in full for such service or healthcare item.
- With a few exceptions (such as psychotherapy notes or information gathered for judicial proceedings), you have a right to inspect and copy your protected health information if you put your request in writing. If we deny your access, we will give you written reasons for the denial and explain any right to have the denial reviewed. We may charge you a reasonable fee if you want a copy of your health information. You have a right to choose what portions of your information you want copied and to have prior information on the cost of copying.
- If you believe that there is a mistake or missing information in our record of your medical information you may request that we correct or add to the record. Your request must be in writing and give a reason as to why your health information should be changed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your medical information. If we approve the request for amendment, we will amend the medical information and so inform you.
- In some limited circumstances, you have the right to ask for a list of the disclosures of your health information we have made during the previous six years. The list will not include disclosures made to you; for purposes of treatment, payment or healthcare operations, for which you signed an authorization or for other reasons for which we are not required to keep a record of disclosures. There will be no charge for one such list in each 12-month period. There may be a charge for more frequent requests.
- You have a right to receive a paper copy of this Notice and/or an electronic copy from our Web site. If you have received an electronic copy, we will provide you with a paper copy of the Notice upon request.

IV. How to Complain about our Privacy Practices:

If you want more information about our privacy practices or have questions or concerns, we encourage you to contact us.

If you think we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, we encourage you to speak or write to our Privacy Officer. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services at the Office for Civil Rights' Region IV office. We will provide the mailing address at your request.

We support your right to the privacy of your health information.

If you have questions about this Notice or any complaints about our privacy practices, please contact our Privacy Officer, either by phone or in writing at:

Dawn Villacci, Privacy Officer
1601 Clint Moore Road, Suite 212
Boca Raton, FL 33487
561.939.0175

V. Effective Date: This Notice was effective on **April 14, 2003, updated June 19, 2017.**