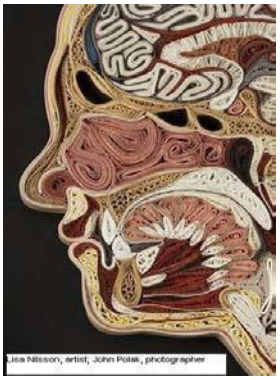

ENT SPECIALISTS OF AUSTIN

Robert Nason , M.D.
Lindsay E. Young, M.D.
Kelsey Mothersole, M.D.
Alexander Hansen, M.D.

Today's Date: _____

Patient Name :_ **DOB:** _ _ _ _ _ _ _ _ _ _ **Age:** _ _ _ _ _ _ _ _ _

Ethnicity: _

What is the main reason for your visit today? _

Please list all surgeries that you have had in the past and approximate dates:

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Please list all medical problems that you are currently being treated by another physician (ex. diabetes)

_____ _____

_____ _____

_____ _____

What medication allergies do you have? Please include the type of reaction you experienced:

_____

_____

What medications are you currently taking? Include any over-the-counter agents such as aspirin, Motrin, Aleve, ibuprofen, and any supplements you may be taking. If you have a list, please allow us to copy it.

_____ _____

_____ _____

_____ _____

_____ _____

Have you or any family member had any adverse reactions to general anesthesia? If yes, please explain:_____

Do you smoke? No _ ☐ _ _ Yes _ ☐ _ Packs/ day?_____How many years?_____When did you quit? _____

Do you chew tobacco? No _ _ ☐ _ _ Yes _ _ ☐ _ _ How many years? _ _ _ _ _ _ _ When did you quit? _ _ _ _ _ _

Do you drink alcohol? No _ ☐ _ _ Yes _ _ ☐ _ _ How many drinks per day? _ _ _ _ _ _ _ _

Do you consume caffeine? No _ ☐ _ _ Yes _ _ ☐ _ _ How many drinks per day? _ _ _ _ _ _ _ _

Do you use any other "recreational drugs"? No _ ☐ _ Yes _ _ ☐ _ _ Which ones?_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

ENT SPECIALISTS OF AUSTIN

The following list reviews a number of health problems. Please place a check mark if you or your family has experienced any of these health problems.

	PROBLEM	PATIENT	FAMILY	PLEASE EXPLAIN
Ear, Nose, and Throat	Nosebleeds	☐	☐	
	Sore throat or tonsillitis	☐	☐	
	Hoarseness	☐	☐	
	Swallowing problems	☐	☐	
	Hearing problems	☐	☐	
	Dizziness or vertigo	☐	☐	
	Sinus or nose problems	☐	☐	
	Tinnitus (ears ringing)	☐	☐	
Allergy	Seasonal hay fever	☐	☐	
	Food allergies	☐	☐	
	Allergy shots	☐	☐	
	Latex reaction	☐	☐	
Lung	Asthma	☐	☐	
	Chronic cough	☐	☐	
	Bronchitis or pneumonia	☐	☐	
Heart	Chest pain or palpitations	☐	☐	
	Congestive heart failure	☐	☐	
	Heart disease or surgery	☐	☐	
	High blood pressure	☐	☐	
	Coronary artery disease	☐	☐	
	High cholesterol/ triglycerides	☐	☐	
GI	Acid reflux/ heartburn	☐	☐	
	Abdominal pain	☐	☐	
	Peptic ulcer disease	☐	☐	
	Hepatitis/ jaundice	☐	☐	
GU	Prostate problems	☐	☐	
	GYN problems	☐	☐	
Constitutional	Fever/ chills	☐	☐	
	Fatigue	☐	☐	
	Weight changes	☐	☐	
Endocrine	Diabetes	☐	☐	
	Thyroid problems	☐	☐	
	Pituitary or adrenal problems	☐	☐	
	Perimenopausal symptoms	☐	☐	
Eye	Change in vision	☐	☐	
	Glasses	☐	☐	
	Cataracts or glaucoma	☐	☐	
Neurologic	Stroke	☐	☐	
	Seizures	☐	☐	
	Headaches or migraines	☐	☐	
	Neurologic problems	☐	☐	
Skin	Hives or rashes	☐	☐	
	Eczema	☐	☐	
	Breast disease	☐	☐	
Psych	Depression	☐	☐	
	Anxiety	☐	☐	
Immune	Bleeding disorders	☐	☐	
	Anemia problems	☐	☐	
	Enlarged lymph nodes	☐	☐	
	HIV/ AIDS	☐	☐	

ENT SPECIALISTS OF AUSTIN **PATIENT DEMOGRAPH IC SH EET**

Patient's Full Name	Marital Status M☐ S☐ D☐ W☐	Date of Birth	Age	Sex
Mailing Address:		City and State		Zip Code
Home Phone #	Cell Phone # / Work Phone #	Spouse Name		Phone #
Occupation/ Place of Employment:		Ethnicity:		
Email:		Social Security Number:		

You may leave medical information on my: ☐ home phone ☐ cell phone ☐ work phone ☐ email

Name of referring doctor and phone number	Family/ primary care doctor and phone number
Pharmacy phone number:	

How did you hear about our practice? ☐ Friend ☐ Family ☐ Physician ☐ Phone book ☐ Ad ☐ Website ☐ Internet search ☐ Loc Doc ☐ Other

Responsible Party Parent or Guardian of a minor (under 18 years old or a dependent child):

Divorce d Parents

In the case of divorced parents or shared custody arrangements, the court specifies the healthcare responsibilities for the child and boundaries of the involved parties. If the patient is a child of divorced parents or shared custody, please answer the following questions based on the court document that specifies the child's healthcare needs. **TH IS CONSENT REMAINS IN PLACE UNTIL REVOKED IN WRITING OR CH ILD IS NO LONGER A MINOR**

According to the decree, which parent m ay co n sent to give treatment an d coordinate health care needs (not surgical)?

According to the decree, which parent m ay give co n sent for surgical procedures (invasive procedures)?

FILL OUT TH IS SECTION BELOW IF TH E PATIENT IS UNDER TH E AGE OF 18 :

1st Guardian's Name	Soc. Sec. Number	Date of Birth	Relationship to Patient	Home Phone Number
Street Address		City and State	Zip Code	Cell Phone Number
1st Guardian's Employer		Occupation	Business Phone	
2nd Guardian's Name	Soc. Sec. Number	Date of Birth	Relationship to Patient	Home Phone Number
Street Address		City and State	Zip Code	Cell Phone Number
2nd Guardian's Employer		Occupation	Business Phone	

I give my permission for Dr. Nason/ Dr. Young/ Dr. Mothersole/ Dr. Hansen or authorized representatives of this office to discuss medical care or payment of medical care with the follow in g individuals:

Name	Relationship to Patient	Phone Number
Name	Relationship to Patient	Phone Number

I hereby give my consent for Dr. Nason/ Dr. Young/Dr. Mothersole/ Dr. Hansen and office staff to evaluate and treat the above patient. I have reviewed a copy of the HIPPA Notice of Privacy Practices. I understand that my personal health information will be used for the purpose of treatment, payment, and the coordination of health care needs of the patient. I acknowledge that I have had the opportunity to review and ask questions regarding this policy. I have also been provided and agree with the Financial Policy of ENT Specialists of Austin.

Signature of Patient or Guardian :_____

ENT SPECIALISTS OF AUSTIN
FINANCIAL POLICY

Thank you for choosing ENT Specialists of Austin as your healthcare provider. The following is our Financial Policy. If you have any questions or concerns about our payment policies, please do not hesitate to ask our business office personnel. We ask that all patients read and sign our Financial Policy prior to seeing the physician.

1. ***All health plans are not the same and do not cover the same services. It is your responsibility to understand the specifics of your individual policy. Any copays, coinsurance amounts, and deductibles that need to be met prior to insurance payment will be due at the time of the visit. For our Medicare patients, this includes any remaining deductible amounts and 20% coinsurance amounts, if no secondary insurance is on record.***
2. If we are providers under your insurance plan, we will file your claim for you if you provide proof of insurance (insurance card). You are responsible for obtaining any necessary referrals prior to your visit or you will be asked to reschedule your appointment.
3. We do not file secondary insurances for any commercial insurance policies.
4. Any outstanding balances on your account must be paid in full prior to your visit with the physician unless other payment arrangements have been made.
5. In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. If you disagree with your insurance company's determination, you must contact your insurance carrier.
6. If it is discovered after the fact that you did not present the current insurance ID card at the time of service, you will be responsible for all charges.
7. Returned checks will be subject to a $50.00 collection fee.
8. . Medical records requests are subject to a $ 25.00 charge for the first 20 pages, and 50 cents each page thereafter. Records will be furnished within 15 days of receipt, as outlined in the Texas Administrative Code, Rule 165.2.
9. No show or cancellations without 24 hour notice may be subject to a $25.00 charge.
10. . Unpaid balances after 3 consecutive statements from our office will be subject to collections via small claims court, attorney, and/ or collection agency with applicable collection fees. All collection fees are the responsibility of the patient.
11. We do not file third party insurance for your motor vehicle accidents or liability claims.
12. We will expect payment from the adult accompanying a minor for all services rendered to minor patients.

We understand that temporary financial problems may affect timely payment of your balance. We ask that you communicate any such problems so that we can assist you in the management of your account. Please call our billing manager at 346-7600 to discuss such issues.

AUTHORIZATION TO RELEASE AND ASSIGN INSURANCE BENEFITS

I authorize release of any information required to act on any insurance claim and I permit photographic, digital, or other facsimile reproduction of this authorization to be used in place of the original assignment. I hereby assign to ENT Specialists of Austin the medical benefits I am entitled from my insurance company(ies) including Medicare, Medicaid, and Medigap. This authorization is in effect for all future claims, until I choose to revoke it in writing.

I, the undersigned, understand and agree to the above Financial Policy. I understand that I am financially responsible for all the charges incurred for my medical treatment. I have had the opportunity to ask and have my questions answered to my satisfaction.

DIGITAL TRANSMISSION OF INFORMATION AUTHORIZATION/ DISCLAIMER

Any digital requests via traditional email or secure patient portal can be expected to be returned within 48 hours of receipt of such transmission. I understand that traditional email is not a secure mode of communication and all correspondence of a confidential nature is only secure if sent via the patient portal. If there is an emergent need to contact the medical staff, please call our office during regular business hours. If you have an after hours emergency, please dial 911 or go to the nearest emergency room. If there is a postop problem, or you need to speak with a physician after hours, call MedLink at (512)660-6831.

I authorize Dr. Nason/ Dr. Young/Dr. Mothersole/ Dr. Hansen and/ or office personnel to obtain electronic transmissions of myprescription history for the purpose of medical evaluation and treatment.

_____
Patient or Parent/ Guardian Signature

IMPORTANT NOTICE TO PATIENTS
INSURANCE BENEFITS/ FINANCIAL POLICY

It is the policy of our office to verify insurance benefits for your visit. It is helpful if you have a clear understanding of your insurance policy; as any **co pays, co insurance amounts and/ or deductible portions due will be collected at the time of your visit.**

Some plans only have a specialist copay. This amount is generally higher than the copay to see a primary care physician. Other plans have a percentage of the contracted (allowable) amount that the patient is responsible for. Many of the Exchange policies or "high deductible" plans will have the patient be responsible for ALL the allowable fees until the deductible is met.

Much of what a specialist does in the office is considered "surgical" – such as a scope to better visualize the nose and throat anatomy. This very often will fall under a plan's deductible guidelines and the patient will be responsible for these costs. Procedures such as this can range anywhere from $ 100 upwards depending on the complexity of the case. If you need a specific cost estimate and are not supplied one, please ask the medical assistant who preps you for the procedure.

Hearing tests (audiology services) can either be included in the copay amount, be part of the coinsurance, or may apply to the deductible, depending on your carrier and your particular policy. Most carriers allow anywhere from $ 50 to $ 150 for such tests.

It is the policy here at ENT SPECIALISTS OF AUSTIN to collect all amounts owed by the patient at the time services are rendered. If you have a financial concern, please ask to speak with the office manager prior to your visit.

I understand the financial policy of ENT SPECIALISTS OF AUSTIN. **Any patient responsibility costs estimated by ENT SPECIALISTS OF AUSTIN and/ or my insurance carrier will be due at the time services are re n de re d.**

_____
Signature of patient

_____
Printed name