VALLEY EAR, NOSE, AND THROAT ASSOCIATES, P.C.

Sam F. Frankel, M.D. • R. Keith Hill, M.D.

Athens Professional Plaza
1005 West Market St., Suite 8
Athens, AL 35611
(256) 233-1650
Fax (256) 233-7244

Madison Surgery Center
460 Lanier Rd., Suite. 202
Madison, AL 35758
(256) 772-7148
Fax (256)

PATIENT INFORMATION

Patient Name: _____ _____ _____
Last First Middle

Address: _____ _____ _____ _____
City State Zip

Home Phone: _____ Cell Phone: _____ Email: _____

Date of Birth: _____ SS# _____ Driver's License # _____

Sex: M F Patient relationship to responsible party: Self Spouse Child Other

Primary Care Physician: _____ Referred By: _____

Patient Employer: _____ Phone: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Address: _____ Phone: _____

RESPONSIBLE PARTY INFORMATION

Responsible Party Name: _____

Address: _____

Phone: _____ DOB: _____ SS#: _____

INSURANCE INFORMATION

Primary Ins. Co.: _____ Insured DOB: _____

Contract#: _____ Group#: _____

Secondary Ins. Co.: _____ Insured DOB: _____

Contract#: _____ Group#: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request that payment of authorized Medicare / Other Insurance Company benefits be made to Valley Ear, Nose and Throat Associates, P.C. for any services furnished to me. I authorize any holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services. I understand that the patient is responsible only for the deductible, coinsurance, and non-covered services. I requested that the above remain in effect until written notice is received from me.

Signature: _____ Date: _____

Past Medical History and Review of Symptoms

Please list ALL MEDICATIONS you are currently taking

_____

_____

Past Surgery History (list type of surgery and date)

_____

_____

Past Medical History (list medical illnesses)

_____

_____

Past Family History (list family history of illnesses or cancer)

_____

_____

Do you smoke cigarettes? Y/N If **YES**, then how many per day? _____ How many years? _____

Do you drink alcohol? Y/N If **YES**, then how much? _____

If you are Female, are you or could you be pregnant? _____

Review of Symptoms (please circle all that apply)

Eye:
- Blurry Vision
- Double Vision
- Itchy Eyes
- Watery Eyes

Ear:
- Ear Drainage
- Hearing Problems
- Balance Problems
- Ringing in Ears
- Stuffy Ears

Nose:
- Snoring
- Runny Nose
- Excessive Sneezing
- Nasal Itching
- Watery eyes
- Decreased Sense of Smell
- Stuffy Nose

Throat:
- Difficulty Swallowing
- Painful Swallowing
- Change in Taste
- Sore Throat
- Heartburn
- Hoarseness

Gastrointestinal:
- Vomiting
- Nausea
- Blood in Stool or Vomit
- Hepatitis
- Liver Disease

Urinary:
- Blood in Urine
- Kidney Problems

Pulmonary System:
- Asthma
- Bronchitis
- Emphysema
- TB
- Pneumonia
- Coughing Blood

Central Nervous System:
- Seizures
- Paralysis
- Stroke
- Headache
- Migraine

Musculoskeletal:
- Bone/Joint Pain
- Arthritis

Psychiatric:
- Depression
- Panic Attacks

Blood:
- Anemia
- Blood Transfusion
- Clotting Problems
- High Cholesterol

Cardiovascular:
- Heart Attack
- Chest Pain
- High Blood Pressure
- Foot Swelling

Endocrine:
- Thyroid Problems
- Diabetes

Reason for Today's Visit _____

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Valley Ear, Nose & Throat Associates, P.C. originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Valley Ear, Nose & Throat Associates, P.C. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Valley Ear, Nose & Throat Associates, P.C. reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Sam F. Frankel M.D. change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline the terms of this consent.

_____
Patient's Signature

_____
Date

FOR OFFICE USE ONLY

- ☐ Consent received by _____ on _____.
- ☐ Consent refused by patient and treatment refused as permitted.
- ☐ Consent added to the patient's medical record on _____.