OTOLARYNGOLOGY ASSOCIATES PATIENT PROFILE **Patient ID #:**_____

Oto MD: _____ **Refer MD:** _____ **Primary MD:** _____

PATIENT INFORMATION

Name: _____ Sex: ( )Male ( )Female

Address: _____ SSN: _____

_____ Birth Date: _____

City, State: _____ Zip: _____ Marital Status: ( )Married ( )Divorced ( )Single ( )Widowed

Phone #1: _____
( )Home ( )Work ( )Other

CONTACTS
_____

Phone #2: _____
( )Home ( )Work ( )Other

_____

PATIENT EMPLOYMENT

( )Employed ( )Retired Employer: _____

( )Student ( )Other Occupation: _____

GUARANTOR/RESPONSIBLE PARTY INFORMATION ( ) Same as Patient

Name: _____ SSN: _____

Address: _____ Birth Date: _____

_____ Employer: _____

City, State: _____ Zip:_____ Occupation: _____

Phone #1: _____ Phone #2: _____
( )Home ( )Work ( )Other ( )Home ( )Work ( )Other

PRIMARY INSURANCE

Insured Party: _____ Insured Same as: ( )Other ( )Patient ( )Guarantor

Insured SSN: _____ Insurance Co: _____

Insured Birth Date: _____ Effective Date: _____

Insured Phone: _____ Insured ID#: _____

Relation to Patient: _____ Policy Group #: _____

SECONDARY INSURANCE

Insured Party: _____ Insured Same as: ( )Other ( )Patient ( )Guarantor

Insured SSN: _____ Insurance Co: _____

Insured Birth Date: _____ Effective Date: _____

Insured Phone: _____ Insured ID#: _____

Relation to Patient: _____ Policy Group #: _____

Rev: 04/21/04

Otolaryngology Associates, PC
www.entmds.net

3801 University Drive, Fairfax, VA 22030
Privacy Officer: hrmanager@entmds.net
(703) 383-8130, x 1157

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *of Notice of Privacy Practices for more information.*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *of Notice of Privacy Practices for more information.*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *of Notice of Privacy Practices for more information.*

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Offi e for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Secured messages with patients are supported through our patient portal. Our technology base does not support secured messages through email nor texting.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective May 1, 2015

Privacy Office Contact Information: HRmanager@entmds.net; (703) 383-8130, x1157

OTOLARYNGOLOGY ASSOCIATES
FINANCIAL POLICY

This is an agreement between Otolaryngology Associates, as creditor, and the Patient/Debtor named on this form.

Payment Options: All previous balances are due at the time of service unless previous arrangements have been made with our Business Office. You may pay your out-of-pocket costs at the time of service by check, cash or credit card. If you are unable to pay your full out-of-pocket costs at the time of service, you may make payment arrangements through our Business Office by calling 703-383-7344. These options include a payment plan not to exceed three months on amounts less than $250.00 and six months on amounts over $250.00. Automatic payments can be arranged via credit card.

Past Due Accounts: If at any time you have a balance due which is more than 90 days old and have not made appropriate payment arrangements with our Business Office, your account may be referred to an outside collection agency. If you have established a payment plan and default on the agreed upon plan, your account may be referred to an outside collection agency. If we have to refer your account to a collection agency, you agree to pay for all collection costs and attorney fees incurred. Further, you understand that if your account is submitted to a collection agency, or if your past due status is reported to a credit reporting agency, the fact that you receive treatment at our office may become a matter of public record. We will also notify your insurance carrier.

Pre-Authorization: Many insurance companies, including worker's compensation carriers, require pre-authorization and/or referrals prior to obtaining specialty care. It is your responsibility to contact your insurer AND/OR Primary Care Physician to determine the need for a referral and/or pre-authorization. Failure to obtain a referral and/or preauthorization may result in lower reimbursement or claim denial from the insurance company.

Divorce: The parent authorizing treatment for a child will be the parent responsible for the charges related to that care. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Forms & Medical Records: From time to time, various forms, including but not limited to, disability or FMLA forms need to be completed. There is a $25 fee to complete each form. There are also fees associated with the copying of medical records. Please inquire at the Front Desk by requesting a Medical Record Release Form.

Returned Check Fee: There is a fee of $25 for any checks returned by your bank.

Prescription Refills: Annual office visits are required for annual prescription refills. Prescription refills not obtained during office visits may be subject to a $25 service charge.

Missed Appointment Fee: The second time a patient does not arrive on time for an appointment, or cancels with less than 24 hours notice, a missed appointment fee of $25 may be charged. This fee must be paid before a new appointment is scheduled. Patients with four or more missed appointments may be asked to transfer their records to another physician.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient's Name:_____ Responsible Party:_____
(If not the patient)

Signature:_____ Date: _____

OTOLARYNGOLOGY ASSOCIATES, P.C.

RELEASE OF INFORMATION

I, the undersigned, authorize Otolaryngology Associates, PC (OA) to speak with the persons listed below regarding my medical care. I understand that with my signature I am authorizing the release of written or oral communication by OA to the listed persons and thereby release OA and their staff from all legal responsibility that may arise from the act hereby authorized.

Authorized Person	Relationship to Patient	Phone Number
Authorized Person	Relationship to Patient	Phone Number

Signature of Patient / Responsible Party _____ Date _____

ASSIGNMENT OF BENEFITS

I, _____ (Please print your name) hereby authorize Otolaryngology Associates, PC (OA) to apply for benefits for covered services rendered by OA, and to request that the payments from Medicare, Medicaid, Blue Cross/Blue Shield and/or _____ (other insurance company) be made directly to OA if they choose to accept assignment, or to myself or to the party who accepts assignment.

I certify that the information I have reported with regards to my insurance is correct and further authorize the release of any necessary information, including medical information for this or any related claim to Medicare, Medicaid, Blue Cross/Blue Shield and/ or _____ (other insurance as listed above).

I request that payment of authorized Medigap benefits be made either to me or on my behalf to the above-named provider for any services provided to me by that physician/supplier. I authorize any holder of medical information about me to release to _____ (name of Medigap Carrier) any information needed to determine these benefits payable for related services.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked at any time in writing.

Subscriber or Policy Holder Signature	Insurance ID Number	Date

CONSENT TO THE OTOLARYNGOLOGY ASSOCIATES NOTICE OF PRIVACY PRACTICES (DATED MAY 1, 2015)

I, _____, consent to the use and disclosure of my Protected Health Information by Otolaryngology Associates, PC (OA) for treatment, payment and operations as allowed under the Health Insurance Portability and Accountability Act (HIPAA). The Notice of Privacy Practices describes the use and disclosure of my Protected Health Information that Otolaryngology Associates may undertake as well as other important information about my rights and control of my Protected Health Information.

I had the opportunity to read OA's summary of the Notice of Privacy Practices that is displayed in the office as well as the complete Notice of Privacy Practices that was available at their office and on their website. I was encouraged to read the Notice of Privacy Practices before deciding to sign this consent form.

I know that I can revoke this consent at any time by written notice to the Privacy Office at Otolaryngology Associates.

Signature of Patient _____ Date _____

Welcome!

Otolaryngology Associates, P.C.

Medical History Form

Please complete all of this form and bring it with you to your office visit.

Patient's Name _____ Today's Date ___/___/___

Date of Birth ___/___/___ Gender ☐ Male ☐ Female

Who referred you here? _____ Phone _____

Name of Your Primary Care Physician _____ Phone _____

Your Preferred Pharmacy and City _____ Phone _____

REASON FOR THIS APPOINTMENT (HPI)

Primary Complaint/Symptom _____

Location: _____ Duration: _____

Severity: _____ Symptom Relieved when: _____

Related Symptoms: _____ Previous Diagnostic Testing: _____

MEDICINES

List all Prescription Medicines you take. Include oral medications, nasal sprays/steroids, and topical ointments.

Medication Name	Medical Condition	Dose (How much)	Frequency (How Often)

☐ Check here if you take no prescription medicines.

Check all NON-Prescription Medicine you take.

☐ Aspirin _____ mg ☐ Advil/Motrin/Nuprin (Ibuprofen) ☐ Naproxen ☐ Tylenol (Acetaminophen)

☐ Vitamin E ☐ Multi-Vitamin ☐ Cold/Allergy _____

☐ Other Vitamins/Supplements (list) _____ ☐ Herbals (list) _____

MEDICAL HISTORY

Please check any medical problems you have had: ☐ I have none of the below listed conditions and no known illnesses.

☐ Allergies/seasonal environmental
☐ Asthma
☐ COPD/Emphysema
☐ Bronchitis; Recurrent/ Chronic
☐ Obstructive Sleep Apnea/ CPAP Use
☐ Sinus infection, recurrent
☐ Anxiety
☐ Concussion
☐ Migraines/Headaches
☐ Mental Illness: specify_____
_____
☐ Neuromuscular Disease
☐ Seizures/Epilepsy
☐ Blood Thinners
☐ DVT/Blood Clots
☐ Heart Disease
☐ High Blood Pressure
☐ High Cholesterol
☐ Peripheral Vascular Disease
☐ Stroke/TIA
☐ Autoimmune Disorder
☐ Bleeding Disorder
☐ Cancer
☐ Cataracts/Glaucoma
☐ Diabetes
☐ Gastroesophageal Reflux
☐ General Anesthesia/Previous Reactions
☐ Malignant Hyperthermia
☐ Hepatitis
☐ Hormonal Imbalance

MEDICAL HISTORY *continued*

☐ Kidney Problems
☐ Peptic or Gastric Ulcer
☐ **Pregnant Currently**
☐ Radiation Therapy
☐ Thyroid Problems
☐ Tuberculosis (TB)
☐ Chromosome Disorder
☐ Congenital Malformation
☐ Development Delay
☐ Premature Birth
☐ Other(s) not listed above (specify) _____

_____

ALLERGIES

Allergies to Medicine	Reaction	Environmental Allergies	Reaction

☐ Check here if no known allergies.

Are you allergic to latex? ☐ No ☐ Yes

SURGERIES

List all other surgeries, including plastic surgery and Lasik, and the month/year. ☐ Check here if none

- ☐ Adenoidectomy __/__
- ☐ Tonsillectomy __/__
- ☐ Ear Tubes __/__
- ☐ Ear Surgery __/__
- ☐ Nasal Surgery __/__
- ☐ Sinus Surgery __/__
- ☐ Abdomen Surgery __/__
- ☐ Brain Surgery __/__
- ☐ Breast Surgery __/__
- ☐ Facial Cosmetic Surgery __/__
- ☐ Facial Fracture Surgery __/__
- ☐ Heart Surgery __/__
- ☐ Larynx Surgery __/__
- ☐ Orthopedic Surgery __/__

Other (and year):_____

HOSPITALIZATIONS

List reason for hospitalization and the year. Do not include surgeries. Check here if none ☐ _____

_____

_____

_____

_____

FAMILY MEDICAL HISTORY

For your blood relatives, list medical conditions and their relationship to you. ☐ None

	Mother	Father	Sister	Brother	Daughter	Son	Other
Anesthesia Problems	☐	☐	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐	☐
Clotting Disorder	☐	☐	☐	☐	☐	☐	☐
Hearing Loss	☐	☐	☐	☐	☐	☐	☐
Heart Disease (<45 yrs)	☐	☐	☐	☐	☐	☐	☐
Cancer (Type?)	☐	☐	☐	☐	☐	☐	☐
Other (Specify)	☐	☐	☐	☐	☐	☐	☐
Alive? (Yes/No or N/A)	☐	☐	☐	☐	☐	☐	☐

Name _____ Date of Birth / /

PERSONAL AND SOCIAL HISTORY

Household and Family

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

☐ If patient under 18, specify parental marital status ☐ If parents divorced/separated, specify guardianship_____

Pets ☐ Yes ☐ No # Siblings _____

Employment (Check all that apply):

☐ Employed full-time ☐ Employed part-time Occupation _____

☐ Retired ☐ Disabled ☐ Unemployed ☐ Student ☐ Homemaker

If child, specify: Daycare ☐ Y ☐ N Pre-K ☐ Y ☐ N Grade _____

Tobacco and Alcohol

Do you use tobacco? ☐ Current Smoker ☐ Former Smoker ☐ Non-Smoker

(Check all that apply) ☐ Cigarettes ☐ Cigars ☐ Chew ☐ Pipe ☐ eCigarettes

How many cigarettes/cigars per day?_____

Second hand smoke exposure?_____

Do you drink alcohol? ☐ No, never drank ☐ No, but did in the past Year Quit_____

☐ Yes (Check all that apply) ☐ Beer ☐ Wine ☐ Mixed Drinks ☐ Straight Liquor/Shots

How many drinks do you have in the average week? _____

Have you ever used illegal drugs? ☐ No ☐ Yes

REVIEW OF SYSTEMS

Please check all of the following conditions you have.

GENERAL HEALTH (Constitutional) ☐ *None*

☐ Unintentional weight loss or gain ☐ Fever/Chills ☐ Fatigue/Tiredness

EYES ☐ *None*

☐ Vision changes (decreased acuity, blurry, blindness) ☐ Double vision ☐ Eye pain ☐ Dry eyes ☐ Itching/Burning ☐ Tearing/Discharge

EARS, NOSE, MOUTH AND/OR THROAT ☐ *None*

☐ Hearing loss
☐ Itchy ears
☐ Ear pain
☐ Feeling of fluid in ears
☐ Ear discharge or drainage
☐ Ringing/Buzzing sound in ears
☐ Dizziness
☐ Mass or lump in nose
☐ Loss of sense of smell
☐ Breathing difficulty
☐ Nasal discharge or drainage
☐ Nasal obstruction or blockage
☐ Nosebleeds
☐ Sneezing
☐ Mass or lump in throat or neck
☐ Difficulty swallowing
☐ Drooling
☐ Recurrent/Chronic sore throat
☐ Snoring
☐ "Stuffy" nose or congestion
☐ Mouth growth, ulcer
☐ Pronunciation difficulty
☐ Dental, gum, or mouth pain
☐ Dental problems/Poorly fitting dentures
☐ Voice changes/ Hoarseness
☐ Facial weakness
☐ Facial pain
☐ TMJ problems
☐ Other_____

HEART, VEINS, AND/OR ARTERIES (CARDIOVASCULAR) ☐ *None*

☐ Chest pain/Angina
☐ Leg pain with walking
☐ Leg pain at rest
☐ Swelling or fluid in legs
☐ Varicose veins
☐ Irregular heart beat
☐ Other_____

LUNGS (RESPIRATORY) ☐ *None*

☐ Shortness of breath
☐ Wheezing
☐ Coughing up blood
☐ Cough
☐ Other_____

REVIEW OF SYSTEMS *continued*

STOMACH, INTESTINES, GALLBLADDER, OR LIVER (GASTROINTESTINAL) ☐ *None*

☐ Decrease in appetite ☐ Nausea or vomiting ☐ Diarrhea or constipation
☐ Heartburn or reflux ☐ Food intolerance ☐ Other_____
☐ Indigestion ☐ Blood in stool _____

BONES, JOINTS, MUSCLES (MUSCULOSKELETAL) ☐ *None*

☐ Muscle weakness/fatigue ☐ Cramping ☐ Hip/knee problems ☐ Other_____
☐ Joint stiffness/pain ☐ Neck pain ☐ Bone fractures _____
☐ Back/spine problems which bone(s): _____
_____

SKIN (INTEGUMENTARY SYSTEM) ☐ *None*

☐ Rash ☐ Recent baldness
☐ History of cold sores ☐ Other_____

BRAIN AND/OR NERVES (NEUROLOGICAL) ☐ *None*

☐ Headaches ☐ Blackouts/Fainting ☐ Other_____
☐ Paralysis ☐ Tremors _____
☐ Numbness or tingling ☐ Sleep problems

PSYCHIATRIC ☐ *None*

☐ Insomnia (trouble sleeping) ☐ Feeling depressed ☐ Eating disorders
☐ Feeling anxious ☐ Cutting/Self-inflicted injuries ☐ Other_____
_____

HORMONES (ENDOCRINE) ☐ *None*

☐ Heat/cold intolerance ☐ Excessive thirst/hunger/urination ☐ Other_____
☐ Excessive sweating _____

KIDNEYS, BLADDER, GENITALS (GENITOURINARY) ☐ *None*

☐ Blood in urine ☐ Painful urination ☐ Other_____
☐ Difficulty passing urine ☐ Frequent urination _____
☐ Incontinence

BLOOD (HEMATOLOGIC/LYMPHATIC) ☐ *None*

☐ Problems with blood clots ☐ Easy bruising ☐ Bleeding too long (will not clot) ☐ Other_____

PHYSICIAN REVIEW WITH PATIENT

☐ No Past Medical Conditions

_____

_____

_____

_____

_____

_____

Physician's Signature Date