EAR, NOSE & THROAT INSTITUTE
The Center of Excellence for Ear, Nose & Throat Disorders

PATIENT INFORMATION

Name (Last, First, Middle Initial): _____
Sex: M F Date of Birth: _____/_____/_____ SSN: _____-_____-_____
Address: _____
City: _____ State: _____ Zip Code: _____
Is your mailing address the same as your street address? YES NO
If your answer was no, please indicate your mailing address:

Primary Language: _____ Race: _____ Ethnicity: _____
Marital Status: MARRIED SINGLE OTHER
Employer: _____ Phone Number: (_____)_____-_____
Occupation: _____ Industry: _____
Are you the Guarantor/Responsible Party? YES or NO
IF YOUR ANSWER WAS NO, PLEASE PROVIDE:
Guarantor Name: _____ Date of Birth: _____/_____/_____
(Last, First, Middle Initial)
Relationship to Patient: _____ Address: _____

COMMUNICATION WAIVER

I understand that as a part of my healthcare, Milton Hall Surgical Associate, LLC d/b/a Ear, Nose and Throat Institute ("ENT Institute") may need to contact me in order to remind me of an appointment, provide test results, give instruction, or provide other information. I authorize the above to contact me in the following ways:
Home Phone: (____) _____-_____Cell Phone: (_____)_____-_____ Work Phone: (____)_____-_____
Fax Number: (____) _____-_____ E-mail Address: _____
Do you give the ENT Institute permission to text your mobile device? YES or NO
Do you give the ENT Institute permission to leave voicemail to the phone number you provided above? YES or NO
Do you consent to receive automated phone calls from our practice on your mobile device? YES or NO
Preferred Contact Method: _____ Primary Language: _____

I give permission for Milton Hall Surgical Associates, LLC d/b/a Ear, Nose and Throat Institute ("ENT Institute") to discuss my information with the following person(s):

_____Relationship:_____

_____Relationship:_____

I understand that Milton Hall Surgical Associates, LLC d/b/a Ear, Nose and Throat Institute ("ENT Institute") has a secure server & encryption for e-mail communication. I understand that Milton Hall Surgical Associates, LLC d/b/a Ear, Nose and Throat Institute ("ENT Institute") will use the minimum necessary information needed when communicating with me indirectly. I understand that I may revoke or modify this communication waiver at any time. Any revocation or change will not apply to past communications.

PATIENT INFORMATION

Patient/Parent/Guardian/ Signature_____ Date: _____

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PATIENT INFORMATION

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PATIENT INFORMATION

NAME: DOB:

NOSE:

SYMPTOMS	ONSET DATE	FREQUENCY	LOCATION
FACIAL PAIN/HEADACHES			
POST-NASAL DRAINAGE			
BLEEDING			
CONGESTION			
NASAL DRAINAGE			
LOW ENERGY			
FEVER/FEVERISH			
NAUSEA			

OTHER SYMPTOMS/ ADDITIONAL COMMENTS:

EAR:

SYMPTOMS	LEFT	RIGHT	BOTH	PLEASE DESCRIBE
PAIN				
DRAINAGE				
SENSATION OF THE ROOM SPINNING				
HEARING LOSS				
RINGING NOISE				

OTHER SYMPTOMS/ ADDITIONAL COMMENTS:

THROAT:

SYMPTOMS	ONSET DATE	FREQUENCY	LOCATION
SORENESS			
SWOLLEN NODES			
SWOLLEN GLANDS			
HOARSENESS			
DIFFICULTY SWALLOWING			
COUGHING			
SENSATION OF SOMETHING IN YOUR THROAT			
PAIN			
SNORING			
SHORTNESS OF BREATH/WHEEZING			
HOARSENESS			

OTHER SYMPTOMS/ ADDITIONAL COMMENTS:

WHAT TREATMENT HAVE YOU HAD FOR THESE SYMPTOMS OVER THE PAST YEAR?

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PATIENT INFORMATION

NAME: DOB:

PATIENT HEALTH HISTORY

SURGERIES

YEAR	REASON	HOSPITAL

OTHER HOSPITALIZATIONS

YEAR	REASON	HOSPITAL

PLEASE LIST ALL CURRENT MEDICATIONS, DOSES AND FREQUENCY (PRESCRIPTION & NON-PRESCRIPTION):

MEDICATION	DOSE	FREQUENCY

MEDICATION ALLERGIES:

MEDICATION	REACTION

CAFFEINE	☐ NONE	☐ COFFEE	☐ TEA	☐ COLA	
	# OF CUPS PER DAY _____				
ALCOHOL	DO YOU DRINK ALCOHOL?				Yes No
	FREQUENCY: _____ DRINKS PER DAY/WEEK				
TOBACCO	DO YOU USE TOBACCO				Yes No
	☐ CIGARETTES- PACK(S)/DAY _____	☐ CHEW- #/DAY _____	☐ PIPE- #/DAY _____	☐ CIGARS- #/DAY____	
	☐ # OF YEARS _____	☐ OR YEAR QUIT _____			
DRUGS	DO YOU CURRENTLY USE RECREATIONAL STREET DRUGS?				Yes No
	HAVE YOU EVER GIVEN YOURSELF STREET DRUGS WITH A NEEDLE?				Yes No
OTHER	DO YOU TRAVEL INTERNATIONALLY? FREQUENCY: _____				Yes No
	ARE YOU EXPOSED TO SECONDHAND SMOKE?				Yes No

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PATIENT INFORMATION

	DO YOU HAVE PETS IN YOUR HOME?	Yes	No
	ARE YOU EXPOSED TO A CHILDCARE SETTING? FREQUENCY: _____	Yes	No

CURRENT OR HISTORICAL PATIENT HEALTH HISTORY

PLEASE MARK THOSE THAT APPLY:

ACID REFLUX/GERD	NO	YES	THYROID PROBLEMS	NO	YES
ADD/ADHD	NO	YES	HYPERTHYROIDISM	NO	YES
AIDS/HIV	NO	YES	HYPOTHYROIDISM	NO	YES
ALLERGIES/HAYFEVER	NO	YES	HEAD INJURY/CONCUSSION	NO	YES
ANEMIA	NO	YES	HEADACHES	NO	YES
ANESTHESIA COMPLICATIONS	NO	YES	HEARING LOSS	NO	YES
ARTHRITIS	NO	YES	IMMUNE SYSTEM DISORDER	NO	YES
ASTHMA	NO	YES	KIDNEY DISEASE	NO	YES
AUTISIM DISORDER	NO	YES	LIVER DISEASE	NO	YES
BASAL CELL CARCINOMA	NO	YES	MELANOMA	NO	YES
BEDWETTING	NO	YES	MIGRAINES	NO	YES
BIRTH DEFECTS/DISEASE	NO	YES	NASAL OR SINUS PROBLEMS	NO	YES
BLADDER/KIDNEY PROBLEM	NO	YES	OBESITY	NO	YES
BLEEDING DISORDER	NO	YES	NASAL POLYPS	NO	YES
BLOOD CLOT	NO	YES	OSTEOPOPORISIS	NO	YES
BLOOD DISEASE	NO	YES	OTHER SKIN CONDITIONS	NO	YES
BRONCHITIS	NO	YES	SKIN CANCER	NO	YES
CANCER	NO	YES	PACEMAKER	NO	YES
CHICKEN POX	NO	YES	PCOS	NO	YES
CHRONIC EAR INFECTIONS	NO	YES	PITUITARY DISORDER	NO	YES
CONGENITAL ANOMALIES	NO	YES	PNEUMONIA	NO	YES
CONSTIPATION	NO	YES	PULMONARY EMBOLISM	NO	YES
COPD	NO	YES	RHINITIS	NO	YES
CORONARY ARTERY DISEASE	NO	YES	SEIZURES/EPILEPSY	NO	YES
DEPRESSION	NO	YES	FIBROMYALGIA	NO	YES
DEVELOPMENTAL DELAY	NO	YES	FOOD ALLERGY	NO	YES
BEHAVIORAL DISORDERS	NO	YES	SLEEP DISORDER	NO	YES
DIABETES	NO	YES	SPEECH DELAY	NO	YES
DIFFICULTY SWALLOWING	NO	YES	SQAMOUS CELL CARCINOMA	NO	YES
ECZEMA	NO	YES	STROKE	NO	YES
EMPHYSEMA	NO	YES	TONSIL INFECTIONS	NO	YES
GLACOMA	NO	YES	TUBERCULOSIS	NO	YES
GOUT	NO	YES	VISION OR EYE PROBLEMS	NO	YES
HEART ATTACK	NO	YES	HIGH CHOLESTEROL	NO	YES
HEART DISEASE	NO	YES	HIVES	NO	YES
HEART CONDITIONS	NO	YES	HYPERLIPIDEMIA	NO	YES
HEPATITIS	NO	YES	HYPERTENSION	NO	YES

IF YOU ANSWERED YES TO ANY OF THE ITEMS ABOVE PLEASE EXPLAIN:

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PATIENT INFORMATION

FAMILY HISTORY

EVENT	RELATION	NOTE
ALLERGY		
ANEMIA		
ASTHMA		
BLOOD COAGULATION DISORDER		
CORONARY ARTERIOSCLEROSIS		
DEVELOPMENTAL DISORDER		
DIABETES		
ENDOCRINE DISORDER		
THYROID GLAND DISORDER		
ENVIRONMENTAL ALLERGY		
CANCER		
HEARING LOSS		
HEART DISEASE		
HYPERTENSION		
IMMUNODEFICIENCY DISORDER		
MENTAL DISORDER		
HEART ATTACK		
MENIERE'S DISEASE		
OTOSCLEROSIS		
SEIZURE		
SLEEP APNEA		
TUBERCULOSIS		

_____ _____/_____/_____

PATIENT/AUTHORIZED GUARDIAN SIGNATURE DATE

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AUTHORIZATION AND CONSENT TO PARTICIPATE IN TELEMEDICINE CONSULTATION

PATIENT INFORMATION

The purpose of this form is to obtain your consent to participate in a telemedicine consultation with our specialist.

1) **Purpose and Benefits:** The purpose of the telemedicine platform is to allow patients, new and established, access to our providers for healthcare outside of normal office hours with the additional benefit of cost effective care.

2) **Nature of Telemedicine Consultation:** During the telemedicine consultation:
   a) Details of you and/or your child's medical history, examinations, radiological films, and tests will be discussed with other health professionals through the use of interactive video, audio and telecommunications technology.
   b) Physical examination of you or your child may take place.
   c) Nonmedical technical personnel may be present in the telemedicine studio to aid in video transmission.
   d) Video, audio, and/or digital photo may be recorded during the telemedicine consultation visit.

3) **Medical Information and Records**: All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine consultation. Additionally, dissemination of any patient-identifiable images or information from this telemedicine interaction to researchers or other entities shall not occur without your consent, unless authorized under existing confidentiality laws.

4) **Confidentiality:** Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation. All existing confidentiality protections under federal and Georgia State law apply to information disclosed during this telemedicine consultation.

5) **Risks and Consequences:** The telemedicine consultation will be similar to a routine medical office visit, except interactive video technology will allow you to communicate with a physician at a distance. At first you may find it difficult or uncomfortable to communicate using video images. The use of video technology to deliver healthcare and educational services is a new technology and may not be equivalent to direct patient to physician contact. Following the telemedicine consultation, your physician may recommend a visit to a Hospital in the Atlanta area for further evaluation.

6) **Rights:** You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your right of future care or treatment, or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled. You have the option to consult with the specialist in person if you travel to his or her location.

7) **Financial Agreement:** This telemedicine consultation will be paid for by you and **your insurance company will not be billed for this visit.**

____ I authorize the ENT Institute to disclose my **full** medical record to my insurance carrier.

____ I authorize the ENT Institute to disclose my medical record **without any self pay services** to my insurance carrier.

I have been advised of all the potential risks, consequences and benefits of telemedicine. My health care practitioner has discussed with me the information provided above. I have had an opportunity to ask questions about this information and all of my questions have been answered. I understand the written information provided above.

Signature:_____Date:_____

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PATIENT INFORMATION

Patient (or person authorized to give consent)

If signed by person other than patient, provide relationship to patient:_____

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PATIENT INFORMATION

Authorization to Release Information

I hereby authorize Milton Hall Surgical Associates, LLC d/b/a Ear, Nose and Throat Institute ("ENT Institute") to furnish to my insurance carrier or to health care financing or its intermediates or carrier, any information needed regarding my medical treatment. Regulations pertaining to Medicare assignments of benefits apply. I authorize an associate from Milton Hall Surgical Associates to act on my behalf, if necessary, to the insurance commissioner governing my insurance company.

Financial Responsibility

Insurance, Medicare, and Medicaid: I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Milton Hall Surgical Associates, LLC d/b/a Ear, Nose and Throat Institute ("ENT Institute") for any and all medical/healthcare services, supplies, tests, treatment, and/or medications that have been or will be rendered or provided; as well as designating and appointing Milton Hall Surgical Associates, LLC d/b/a Ear, Nose and Throat Institute ("ENT Institute") my beneficiary under all health insurance or medical plans which I may have benefits under.

I understand that I am financially responsible for all services rendered including any charges or penalties made to Milton Hall Surgical Associate for any outside collection assistance. I realize that the physician is not responsible for any financial decisions of non-payment made by an insurance company contracted by the insured to assist in payment of medical services.

I also understand my insurance policy may not cover all services. I understand that it is my responsibility to understand my insurance policy and acknowledge that I am responsible for payment of any service not covered by my insurance plan. If a service provided by Milton Hall Surgical Associates, LLC d/b/a Ear, Nose and Throat Institute ("ENT Institute") is not covered by my insurance, I agree to pay for this service as an out-of-pocket expense. I understand that additional diagnostic evaluations may be performed based upon my symptoms and at provider expertise. These include, but are not limited to endoscopies, wax removal, etc. Due to insurance regulations, these additional diagnostic evaluations maybe processed according to my insurance benefits and may be applied towards my deductible and/or co-insurance, leaving me responsible for any out of pocket expense.

I understand that ENT Institute utilizes Chestatee Pathology, Diatherix, and Microgen Laboratories for specialized testing that Labcorp and Quest laboratories do not offer. Chestatee Pathology, Diatherix, and Microgen Laboratories may be considered "Out of Network" with my insurance carrier. Should my Provider order these specialized tests, I acknowledge that I may receive an invoice from Chestatee Pathology, Diatherix, or Microgen Laboratories.

I understand that copayment is due at time of service and I will not be seen if I do not pay my copay and my outstanding balance, or make mutually agreed upon payment arrangements for my balance. If I do not have insurance at time of service, I understand I will be considered a Self-Pay patient and full payment is due at the time of service.

I understand and acknowledge under Medicare law, I must pay the annual Medicare deductible for Part B services and a co-payment/co-insurance on claims for services that are submitted after meeting the deductible. A waiver form must be signed even if Medicare does not apply at this time. By signing the above clause, I am agreeing that if at any time after completing this form I become eligible for Medicare, I agree to pay according to the Medicare law.

I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, or to pursue any other remedies necessary in connection with the same.

This assignment, appointment, and designation will remain in effect unless revoked by me in writing. It is my intent at the effective date of this document that it shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider. A photocopy or scan or this document is to be considered as valid and enforceable as the original.

Referral

I understand that I may require a referral by my policy contract from my primary physician before seeing a specialist. If I am required to have a referral for today's visit, I understand that I will be financially responsible for all services rendered should I not have a referral.

Appointment

I understand that it is my responsibility to cancel or reschedule an appointment 24 hours prior to the scheduled appointment and that if I fail to do so, I will be assessed a cancellation fee of $75.00. I understand that this fee is not covered by my insurance plan. This charge also applies to sleep studies, ENG/VNG or audiology appointments.

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Signature

I understand that my initials signed to any documents will be sufficient for the use of my full signature.
I understand that all signed documents become electronic format and allow a photocopy to be used in place of the original.

Fees

Medical Record: I understand there is a charge for copying records to me, including disability and FMLA forms. The fee for copying records in paper form is 97 cents per page for the first 20 pages and 83 cents per page for page 21-100. Pages over 100 are charged at 66 cents per page. Cost of certification (notary) is up to $9.70 per record. The fee for disability record is $15, and FMLA forms are $75. There is a fee for search and retrieval and direct administrative cost of $25.88. Postage is charged separately and will determined prior to payment. All fees will be due at the time of release of records/forms. (There will be no charge for records sent to another physician for continuation of care)
Shipping: Applicable shipping fees will be applied for any items shipped to any other location outside our practice.
Interpreter: If during my medical care I require the use of an interpreter, Milton Hall Surgical Associates will provide this service via a communications company of their choice at no additional charge to me. If I choose to bring an outside interpreter, I will be financially responsible for the cost.
Collection: I agree to reimburse the fees of any collection agency or attorney firm, which may charge based on a percentage of 28% maximum of the debt, and all costs and expenses, including reasonable attorneys' fees, which may occur in such collection efforts.

Dispute Resolution

Any dispute that arises between me and The ENT Institute and/or its doctors (including any claims of medical malpractice) that have not been resolved through good faith discussions must be submitted to mediation with American Arbitration Association, and any disputes that are not resolved through the mediation, at the sole option of The ENT Institute, must be submitted to arbitration with American Arbitration Association. As The ENT Institute is engaged in interstate commerce, the Federal Arbitration Act applies.

_____ _____
Patient Name (Please Print) Date of Birth

_____ _____
Patient/Parent/Guardian Signature Date

EAR, NOSE & THROAT INSTITUTE
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PATIENT INFORMATION

Notice of Privacy Practice Acknowledgement Statement and Release of Information Authorization

1. Notice of Privacy Practice Acknowledgement Statement

I hereby acknowledge that I have been made aware that Milton Hall Surgical Associates, LLC d/b/a Ear, Nose and Throat Institute ("ENT Institute") has a Privacy Practice in place in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and subsequent revisions.

As a patient of Milton Hall Surgical Associates, LLC d/b/a Ear, Nose and Throat Institute ("ENT Institute"), I understand and acknowledge the following:

1. Milton Hall Surgical Associates, LLC d/b/a Ear, Nose and Throat Institute ("ENT Institute") has a notice of Privacy Practice in effect in their offices.
2. Milton Hall Surgical Associates, LLC d/b/a Ear, Nose and Throat Institute ("ENT Institute") has made this policy available to me for review, by placing a complete version in a binder that resides in the reception area and/or by placing a poster version of this policy in the reception area and a copy is also accessible via our website: www.entinstitute.com.
3. Milton Hall Surgical Associates, LLC d/b/a Ear, Nose and Throat Institute ("ENT Institute") has made me aware, that as a patient I am entitled to a copy of the Notice of Privacy Practice (NPP) if I desire a copy for my personal file.

Upon your review of the above statements, please sign at the bottom acknowledging that you have been advised of the Notice of Privacy Practice (NPP) implemented by Milton Hall Surgical Associates, LLC d/b/a Ear, Nose and Throat Institute ("ENT Institute") and have read and understand the acknowledgement form. If you desire a copy of the Notice of Privacy Practice, please request one at this time.

_____ **No, I do not want a copy but I acknowledge the Notice of Privacy Practice exists.**
_____ **Yes, I do want a copy of the Notice of Privacy Practice.**

2. Release of Information Authorization

I hereby authorize Milton Hall Surgical Associates, LLC d/b/a Ear, Nose and Throat Institute ("ENT Institute") and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

I understand that I have a right to revoke this authorization by providing written notice to. However, this authorization may not be revoked if, its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.
I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

I have been advised of this practice's Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority.

_____ _____

Patient name (Please Print) Date of Birth

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PATIENT INFORMATION

_____

Patient/Parent/Guardian Signature Date

EAR, NOSE & THROAT INSTITUTE
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PATIENT INFORMATION

REQUEST TO RESTRICT USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. Introduction

Overview: The Health Insurance Portability and Accountability Act ("HIPAA") allows you to request that Milton Hall Surgical Associates d/b/a the Ear, Nose, and Throat Institute ("ENT Institute") limit certain uses and disclosures of your protected health information ("PHI"). For example, you may request that we not share your PHI with a particular person.

The ENT Institute considers protecting your PHI very important. While the ENT Institute considers all restriction requests, in certain circumstances, the ENT Institute may be unable to limit how we use and/or disclose your PHI because it would harm our ability to provide quality services or because the disclosure of your PHI may be required by law.

2. Patient Information

Patient Name: _____ DOB: _____

Mailing Address: _____ City: _____ State: _____
Phone Number: _____ Zip Code: _____

3. Specific Restriction Requested

Please state how you would like the ENT Institute to restrict the ways we use and/or disclose your PHI and the reason(s) for your request:

_____

_____

_____

4. Patient/Authorized Representative Signature

Authorized signature of individual or personal representative of individual for whom the restriction is being requested:

_____ _____
Patient Signature Date

_____ _____
Authorized Representative Signature Date

Important: If legal documentation is not on file with the ENT Institute, the authorized representative, including the parent, legal guardian, or executor of an estate, must attach a copy of legal documentation to this form.

_____
Authorized Representative's Name Mailing Street Address City State

_____
Relationship to Patient and Authority to Act for Patient Phone Number Zip Code