pediatric ENT OF OKLAHOMA

NORTH OKC
9900 Broadway Ext., Suite 200
Oklahoma City, OK 73114
Phone: 405-608-8833
Fax: 405-608-8818

NORMAN
2002 E. Robinson Street
Norman, OK 73071
(inside JD McCarty Center)

Patient Name:_____ Social Security #_____

Date of Birth: _____Sex:_____ Home Phone: _____Cell:_____

Address: _____ City _____ST _____ Zip_____

County: _____ Email:_____

Race: _____ Ethnicity (circle one): Hispanic Non-Hispanic Preferred Language: _____

Primary Care Physician: _____ Phone Number:_____

Emergency Contact: _____ Phone Number: _____Relationship: _____

Emergency Contact: _____ Phone Number: _____Relationship: _____

Parent(s) or Legal Guardian (children only)

Parent:_____ Date of Birth:_____ Social Security Number: _____

Parent: _____ Date of Birth:_____ Social Security Number: _____

Insurance Company Name: _____Address:_____

Policy Number:_____ Group Number: _____ Effective Date:_____ Co-Pay: _____

Subscriber's Name:_____ Date of Birth: _____Social Security:_____

Relationship: _____ Insurance Phone _____

Secondary Insurance Company Name:_____Address:_____

Policy Number: _____ Group: _____ Effective Date:_____

Subscriber's Name:_____ Date of Birth: _____Social Security:_____

Relationship: _____ Insurance Phone:_____

I authorize my insurance benefits to be paid directly to Pediatric ENT of Oklahoma (if applicable). I understand that I am financially responsible for any balance. I authorize PEO or my insurance company to release any information needed to process my claims. I give permission to you and any agent of PEO to contact me on any phone number/email I have provided to you, including my cell phone, for the purpose of collecting my debt, appointment reminders and changes. I am aware of this office's Notice of Privacy practices and fully understand my rights as a patient/caregiver.

Signature _____Date _____

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CONSENT TO MEDICAL CARE

I hereby authorize the physician(s) in charge of the care of the patient of Pediatric ENT of Oklahoma to administer treatment as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I request admission to McBride Orthopedic Hospital and authorize the facility, staff and physicians to provide care. I request and consent to medical care and diagnostic procedures that my attending physician(s), or his/her designees, determine are necessary. I acknowledge that the medical care I receive while in McBride Orthopedic Hospital is under the direction of my attending physician(s) and that McBride Orthopedic Hospital is not responsible for acts of omission of my attending physician(s). I authorized McBride Orthopedic Hospital to retain or dispose of any specimen or tissue taken from the above named patient.

DISCLOSURE OF INFORMATION

I hereby authorize the physician(s) of Pediatric ENT of Oklahoma to disclose any or all information in my medical records to any person, corporation, or agency which is or may be liable for all or part of Pediatric ENT of Oklahoma charges or who may be responsible for determining the necessity, appropriateness, amount, or other manner to the physician's treatment of charge including carriers, welfare funds, the Social Security Administration or its intermediaries or carriers. The undersigned agrees that all records concerning this patient's hospitalization shall remain the property of the facility. The undersigned understands that medical records and billing information generated or maintained by the facility are accessible to facility personnel and medical staff. Facility personnel and medical staff may use and disclose medical information for treatment, payment and healthcare operations and to any other physician, healthcare personnel or provider that is or may be involved in the continuum of care for this admission. The facility is authorized to disclose all or part of the patient's medical record to any insurance company, third party payor, workers compensation carrier, self-insured employer group or other entity (or their authorized representatives) which are necessary for payment of patient's account. Law requires that the facility advise the undersigned that THE INFORMATION RELEASED MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT NOT BE LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA AND THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). The facility is authorized to disclose all or any portion of the patient's medical record as set forth in its Notice of Privacy Practices, unless the patient objects in writing. By signing this form, you are authorizing such disclosures.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment directly to my physician(s) of the medical insurance benefits otherwise payable to me for services rendered during my visit at Pediatric ENT of Oklahoma. I understand I am financially responsible for charges not covered by this assignment. You agree that, to the fullest extent permitted by law, we may remit all or a portion of any credit balances or other amounts due to you from us to any of our affiliates whom you have any balance owing for fees, items, or services.

WAIVER OF RESPONSIBILITY OF VALUABLES

I hereby release Pediatric ENT of Oklahoma from any claim for responsibility or damages in the event of loss of my property, including money and jewelry.

LATE TO APPOINTMENT POLICY

If you are a new patient, we request that you arrive 15 minutes before your appointment. If you are late by 30 minutes or more, you will likely be asked to reschedule unless the physician's schedule can still accommodate you. Priority will be given to the patients who arrive on time and you may have to be worked in between them. This may mean you will have a considerable wait. If this is not convenient for you, you may choose to reschedule. One or two late patients cause the entire daily schedule to fall behind. This is an inconvenience for everyone. We strive to see every patient as close to their appointment time as possible. We ask that you please be courteous of your provider's valuable time and attention. The physicians, office staff, and your fellow patients will thank you.

MISSED APPOINTMENT OR "NO-SHOW" POLICY

While we make every effort to provide a reminder email at least 24 hours before your appointment, it is your responsibility to remember your appointment. We charge a $50 missed appointment fee to patients who do not keep their scheduled appointment time or who cancel less than 24 hours in advance. If this should happen more than twice, a $100 charge will be incurred for the third incident. All fees must be paid before a new appointment can be scheduled. After three missed appointments, the practice may at its discretion choose to discontinue your care.

I understand a photocopy of this document is as valid as the original.

Patient: _____ Date: _____

Or _____

(Nearest relative or responsible party)

_____ Policy holder's signature: _____

(Relationship to patient)

FINANCIAL POLICY

Insurance

As a courtesy to our patients, we will gladly file the forms necessary so that you receive full benefits of your medical coverage. We ask that you read your insurance policy to be fully aware of any limitations of the benefits provided. If you are concerned about coverage for any of the services, please contact your insurance company prior to your visit. If your insurance company denies coverage, or otherwise we do not receive payment 60 days from filing your claim, the amount will then become due and payable by you. Remember that your coverage is a contract between you and your insurance company and/or your employer and your insurance company. Although we will make a good faith effort in obtaining your efforts, we cannot force your insurance company to pay for the services we provide to you.

Appointments/Cancelations

We gladly reserve appointment times for you and appreciate that you have chosen Pediatric ENT of Oklahoma for your child's care. As a courtesy, we will remind you of your appointment by calling or emailing you two days prior to your scheduled date and time. If we cannot speak to you directly, we will leave a message for you. However, in the event your mailbox is full or your line is busy, our efforts to contact you may be unsuccessful. An appointment is a contract of time reserved for your child's care. We respect our patient's valuable time and we request the same courtesy from our patients. Please extend this courtesy should you need to cancel and/or reschedule your appointment. We reserve the right to charge $50 for regular appointments cancelled or broken without advance notice of one business day. We charge a $100 cancellation fee for cancelling surgery without providing us notice three business days prior to the appointment.

Patient/Parent/Guardian Responsibility

- I understand that whoever accompanies my child to their appointment has authorization to consent to medical care as needed, and is responsible for payment of medical services.
- I acknowledge my responsibility for payment of all services provided by Pediatric ENT of Oklahoma in accordance with the practice's fees and terms.
- In the cases where a parenting plan exists, the parent that brings the child in for the appointment is considered the guarantor and is responsible for payment.
- At the initial visit, you may sign our consent for minor treatment form that allows us to render care at follow-up visits without the presence of a parent or guardian.

Assignment and Release

I authorize payment to be made directly to Pediatric ENT of Oklahoma by my insurance company, and I accept financial responsibility if services are not covered by my insurance. I authorize release of any medical are information requested by my insurance company. My signature below acknowledges that I have read and understand the information.

Credit Card on File Policy

Pediatric ENT of Oklahoma is committed to making our billing processes as simple and easy as possible. We require all initial patients provide a credit card on file with our office. We enter your card information into our credit card processor. For security reasons, only the last four digits will be visible to our staff. Credit cards on file will be used to pay copays when you are seen in our office, including account balances, after your insurance processes your claim. Once we have filed your medical claims, you will receive an invoice notifying you of any services and charges not covered by your insurance. For your convenience, your outstanding balance will be charged to your credit card after 30 days unless we've received another form of payment from you.

Credit/Debit card number: _____ CVV: _____ Expiration: _____

Parent or Guardian's Signature: _____

I give Pediatric ENT of Oklahoma permission to charge my credit card for any patient balance due on my account. If I have insurance coverage, my card will be charged AFTER my insurance has paid their portion. I have read a copy of Pediatric ENT of Oklahoma's Notice of Privacy Practices. I understand a written copy will be provided to me at any time upon my request.

Patient: _____ Date: _____

Or _____ Relationship: _____

(Nearest relative or responsible party)

ENT CASE HISTORY

Date: _____ Patient Name: _____ Date of Birth: _____

Pediatrician/Family physician: _____

Pharmacy Name & Address: _____ Phone: _____

Have you ever seen one of our providers in the past? ◯ Yes ◯ No
Are your child's immunizations up to date? ◯ Yes ◯ No
Is the child exposed to second hand smoke? ◯ Yes ◯ No

Surgical History:

◯ Patient has had no surgeries ◯ Sinus surgery ◯ Airway surgery ◯ VP shunt
◯ Ear surgery ◯ Ear tube insertion ◯ Tonsils removed ◯ Other: _____
◯ Cleft lip/palate repair ◯ Heart surgery ◯ Adenoids removed

Allergies: ◯ No known allergies _____

Medications: ◯ No medications at this time _____

_____

Please check any symptom below that is currently a problem for the patient:

General:
- ◯ Fevers
- ◯ Chills
- ◯ Swelling
- ◯ Anorexia
- ◯ Fatigue
- ◯ Sleepiness
- ◯ Sleep problems
- ◯ Malaise
- ◯ Weight gain
- ◯ Weight loss
- ◯ Speech delay

Eyes:
- ◯ Eye pain
- ◯ Vision loss
- ◯ Excessive tears
- ◯ Blurring
- ◯ Diplopia
- ◯ Irritation
- ◯ Discharge
- ◯ Photophobia

Genitourinary:
- ◯ Urinary tract infections
- ◯ Incontinence

Ears/Nose/Throat:
- ◯ Ear pain/discharge
- ◯ Tinnitus
- ◯ Decreased hearing
- ◯ Nasal obstruction or discharge
- ◯ Nosebleeds
- ◯ Sore throat
- ◯ Hoarseness
- ◯ Difficulty swallowing

Cardiovascular:
- ◯ Chest pain
- ◯ Palpitations
- ◯ Syncope
- ◯ Dyspnea on exertion
- ◯ Orthopnea
- ◯ Peripheral edema

Respiratory:
- ◯ Cough
- ◯ Difficulty breathing
- ◯ Excessive sputum
- ◯ Hemoptysis
- ◯ Wheezing

Gastrointestinal:
- ◯ Nausea
- ◯ Vomiting
- ◯ Diarrhea
- ◯ Constipation
- ◯ Change in bowel habits
- ◯ Abdominal pain
- ◯ Melena
- ◯ Hematochezia
- ◯ Jaundice

Musculoskeletal:
- ◯ Back pain
- ◯ Joint pain
- ◯ Joint swelling
- ◯ Muscle cramps
- ◯ Muscle weakness
- ◯ Stiffness

Skin:
- ◯ Rash
- ◯ Itching
- ◯ Ulcers/growths
- ◯ Excessive scarring
- ◯ Bleeding problems
- ◯ Dryness
- ◯ Suspicious lesions

Neurologic:
- ◯ Paralysis
- ◯ Weakness
- ◯ Seizures
- ◯ Syncope
- ◯ Tremors
- ◯ Vertigo

Psychiatric:
- ◯ Depression
- ◯ Anxiety
- ◯ Memory loss
- ◯ Mental disturbance
- ◯ Suicidal ideation
- ◯ Hallucinations
- ◯ Paranoia

Endocrine:
- ◯ Cold intolerance
- ◯ Heat intolerance
- ◯ Polydipsia
- ◯ Polyphagia
- ◯ Polyuria
- ◯ Weight changes

Heme/lymphatic:
- ◯ Abnormal bruising
- ◯ Bleeding
- ◯ Enlarged lymph nodes

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ENT CASE HISTORY, CONTINUED

Date: _____ Patient Name: _____ Date of Birth: _____

MEDICAL HISTORY: Please mark all conditions the patient or patient's family has had.

PATIENT	FATHER	MOTHER	SIBLING	CONDITION
				Alcoholism
				Allergic rhinitis
				Allergy to penicillin
				Anemia
				Anxiety
				Arthritis
				Asthma
				Atrial fibrillation
				Attention deficit hyperactivity disorder
				Auditory processing disorder
				Autistic disorder
				Bipolar disorder
				Bleeding disorder
				Cardiac arrhythmia
				Celiac disease
				Cerebral aneurysm
				Cerebral palsy
				Chest pain
				Chromosomal abnormality
				Chronic kidney disease
				Circulatory system disorder
				Congestive heart failure
				Depression
				Diabetes
				Down syndrome
				Epileptic seizures
				Family history of deafness or hearing loss
				Family history of sudden infant death syndrome
				Gastroesophageal reflux disease (GERD)
				Graves' disease
				Headache
				Hearing loss
				Heart disease
				High blood pressure
				Hypothyroid
				Impacted cerumen
				Laryngitis
				Leukemia
				Migraine
				Muscular dystrophy
				Obesity
				Obstructive sleep apnea
				Pharyngitis
				Sinusitis
				Smoking
				Stroke
				Thyroid cancer
				Vertigo

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HEARING HISTORY FORM

Date: _____ Patient Name: _____ Date of Birth: _____

What is your primary concern regarding your child's hearing and/or speech and language development?

_____

_____

Do you have any concerns about your child's hearing? ◯ Yes ◯ No

_____

_____

Since your last visit, has your child had their hearing tested outside of our office? ◯ Yes ◯ No

Has your child ever used a hearing aid, BAHA, Cochlear Implant, or other hearing technology? ◯ Yes ◯ No

Is your child considered at-risk for hearing loss? Help us monitor by answering these questions:

Did your child pass the newborn hearing screen or follow-up? ◯ Yes ◯ No ◯ Unsure

Birth mom's name (when baby was born): _____
(this is how we confirm newborn screen results)

Did your child have to stay in the NICU after birth? ◯ Yes ◯ No ◯ Unsure

How long? _____

What for? _____

Is there anyone in your child's family with hearing loss? ◯ Yes ◯ No ◯ Unsure

_____

BEHAVIORAL DEVELOPMENT

Do you have any concerns about your child's overall development?

_____

Is there anything we need to know about your child?

_____

SPEECH AND LANGUAGE DEVELOPMENT

Do you have any concerns about your child's speech and language development? ◯ Yes ◯ No ◯ Unsure

Is your child in speech therapy? ◯ Yes ◯ No

If yes: You will need a copy of today's hearing test results to give to your speech therapist.

Can we send this to the email address we have on file? ◯ Yes ◯ No

if yes, please sign to authorize release: _____

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9900 Broadway Ext Ste 200 Oklahoma City, OK 73114
Phone: 405.608.8833
Fax: 405.608.8818

NORMAN
Located inside the J.D. McCarty Center
2002 E. Robinson Street
Norman, OK 73071

Authorization for the Release Protected Health Information

Patient Name: _____Date of Birth: _____ / _____/ _____

I hereby authorize (Pediatric ENT of Oklahoma) to release the following information to:

_____

Information to be shared:

☐ Entire medical record ☐ Operative report(s)

☐ Audiology exam(s) ☐ Office visit notes

Medical information compiled between _____and _____

Other: _____

The information may be disclosed for the following purpose(s) only:

☐ Continued treatment ☐ Legal ☐ At my or my representative's request ☐ Insurance

Other:_____

I understand that by voluntarily signing this authorization:

- I authorize the use or disclosure of my PHI as described above for the purpose(s) listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke this authorization at any time. The revocation must be made in writing to the person/organization disclosing the information and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I understand that unless the purpose of this authorization is to determine payment of a claim for benefits, signing this authorization will not affect my eligibility for benefits, treatment, enrollment or payment of claims.
- My medical information may indicate that I have a communicable and/or non-communicable disease which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea or HIV or AIDS and/or may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.
- I understand I may change this authorization at any time by writing to the person/organization disclosing my PHI.
- I understand I cannot restrict information that may have already been shared based on this authorization.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by the Privacy Regulation.

Unless revoked or otherwise indicated, this authorization's automatic expiration date will be one year from the date of my signature or upon the occurrence of the following event:

_____

Signature of Patient/Legal Representative: _____ Date: _____

Please fax all medical records to:
Pediatric ENT of Oklahoma
405.608.8818