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

PRINT

Please complete and PRINT (one-sided) to bring with you. Paperwork cannot be submitted online.
To protect your patient privacy (HIPAA), please do not email paperwork.

Patient Name:_____ Social Security #_____

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

Address: _____ City _____ST _____ Zip_____

County: _____ Email:_____

Race: _____ Ethnicity: ◯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.

Parent/Guardian Signature_____Date _____

Patient Name: _____ Date of Birth: _____

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.

Parent/Guardian Signature:_____ Date: _____

Patient Name: _____ Date of Birth: _____

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 information requested by my insurance company. My signature below acknowledges that I have read and understand the information.

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.

Parent/Guardian Signature: _____ Date: _____

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

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

HEARING HISTORY FORM

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

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

_____

_____

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

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

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

Did anyone in your child's family experience childhood hearing loss? ◯ Yes ◯ No ◯ Unsure

Is there anything we need to know about your child?

_____

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

pediatric ENT OF OKLAHOMA

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

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:

_____

Parent/Guardian Signature: _____ Date: _____

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

pediatric ENT OF OKLAHOMA

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

HIPAA CONSENT FORM

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), established a Privacy Rule to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain healthcare providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or healthcare operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate or necessary, we provide the minimum necessary information only to those we feel are in need of your healthcare information regarding treatment, payment, or healthcare operations, in order to provide healthcare that is in your best interest.

We fully support your access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with the physician and not patients) and may have to disclose personal health information for purposes of treatment, payment, or healthcare operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be done in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your personal health information. If you choose to give consent in this document, as some future time you may request to refuse all or part of your personal health information. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

if you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our Privacy Notice (Compliance Assurance Notification to our Patients), to request restrictions, and revoke consent in writing.

Parent/Guardian Signature: _____ Date:_____

McBRIDE
ORTHOPEDIC HOSPITAL

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain **out-of-pocket costs**, like a **copayment**, **coinsurance**, or **deductible**. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care – like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency Services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services form an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most these providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're <u>never</u> required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

<u>When balance billing isn't allowed, you also have these protections</u>:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact 1-800-985-3059.

Visit <u>www.cms.gov/nosurprises/consumers</u> for more information about your rights under federal law.

_____	or	_____
Patient Signature		Guardian/Authorized Representative's Signature
_____		_____
Print Patient Name		Print Guardian/Authorized Representative's Name
_____		_____
Date		Date