BURLINGTON EAR, NOSE AND THROAT CLINIC, P.C. PATIENT INFORMATION

Patient Name: _____ **Sex:** ☐ M ☐ F
Last *First* *Middle*

Date of Birth: _____/_____/_____ **Age:** _____ **Social Security Number:** _____-_____-_____

Mailing Address: _____
Street Address *City* *State* *Zip*

Home Phone Number: _____ **Cell Phone Number:** _____

Email Address: _____

Employer: _____ **Work Phone Number:** _____

Marital Status: ☐ **S** ☐ **M** ☐ **Other Spouse's Name:** _____

Emergency Contact Person: (Someone not living with you) _____

Contact Phone #: _____ **Relationship to Patient:** _____

Family Physician: _____ **Referring Physician:** _____

Person Responsible for Bill: _____ **Relationship to Patient:** _____

Preferred Way to be Contacted: ☐ Mail ☐ Home Phone ☐ Cell Phone ☐ Email

Primary Language Spoken: _____

Race: ☐ Declined ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American
☐ Native Hawaiian/Pacific Islander ☐ Other Race ☐ White

Ethnicity: ☐ Declined ☐ Hispanic or Latino ☐ Not Hispanic or Latino

PERSON FILLING OUT PAPERWORK IF PATIENT IS A MINOR

Responsible Person Address: _____
Street Address *City* *State* *Zip*

Responsible Person DOB: _____/_____/_____ **SSN:** _____-_____-_____

Phone Number: _____ **Cell Phone Number:** _____

Employer: _____ **Work Phone Number:** _____

PLEASE PROVIDE YOUR INSURANCE INFORMATION

(We will also need to scan your insurance card and photo ID.)

Primary Insurance: _____

Name of Cardholder: _____ Employer: _____

Cardholder's DOB: _____ Cardholder's SSN: _____/_____/_____

Secondary Insurance: _____

Name of Cardholder: _____ Employer: _____

Cardholder's DOB: _____ Cardholder's SSN: _____/_____/_____

I certify that the above information is true and correct to the best of my knowledge. I have been presented with Burlington Ear, Nose and Throat Clinic's Financial Policy. I understand that I am financially responsible for all charges, regardless of my insurance coverage.

Patient or Authorized Person's Signature: _____ **Date:** _____

Burlington Ear, Nose & Throat Clinic, P.C.

NAME: _____ **AGE:** _____ **DATE:** _____

REASON FOR TODAY'S VISIT: _____

PERSONAL MEDICAL HISTORY, Write YES if applicable:

Allergies	Hearing Loss	Sinusitis
Anemia	Heart Disease	Skin Cancer
Asthma	Hepatitis	Stroke
Bleeding Disorder	High Blood Pressure	Thyroid Disease
COPD/Emphysema	HIV/AIDS	Tonsillitis
Coughing Blood	Irregular Heartbeat	Tuberculosis
Diabetes	Jaundice	Ulcer
Epilepsy	Kidney Disease	Vision Changes
Glaucoma	Pacemaker	OTHER

SURGICAL HISTORY

☐ No Prior Surgery
☐ Appendix
☐ D&C
☐ Ear Surgery
☐ Eye Surgery
☐ Gallbladder
☐ Heart Surgery
☐ Heart Stents
☐ Hysterectomy
☐ Joint Replacement
☐ Nasal Surgery
☐ Prostate
☐ Thyroidectomy
☐ Tonsil/Adenoid
☐ Other _____

Complications with anesthesia? _____

CURRENT MEDICATIONS

List all medications you are currently taking. Include over-the-counter, herbal and medications that you take only occasionally.

MEDICATION	**DOSE**	**FREQUENCY**
Are you allergic to medication?	If yes, please list medications:	If yes, please describe reaction:
☐ Yes		
☐ No		

Psychosocial History:

Tobacco Use: ☐ Currently ☐ Formerly ☐ Never

If yes: ☐ Smoke or ☐ chew tobacco?

Age started: _____ Age stopped: _____ How much and how often? _____

Are you exposed to secondhand smoke? ☐ Yes ☐ No

Do you consume alcohol? _____

If yes how much/often? _____

Do you take recreational drugs (cocaine, marijuana, etc.)? _____

Are you pregnant? ☐ Yes ☐ No

Pediatric Only: Are immunizations up to date? ☐ Yes ☐ No

Adult Only: Are you married? ☐ Yes ☐ No

FAMILY HISTORY Is there a family history of the following, and if so, what family member?

Heart Disease ☐ Parent ☐ Maternal/Paternal Grandparent ☐ Sibling ☐ Child
Stroke ☐ Parent ☐ Maternal/Paternal Grandparent ☐ Sibling ☐ Child
Hypertension ☐ Parent ☐ Maternal/Paternal Grandparent ☐ Sibling ☐ Child
Diabetes ☐ Parent ☐ Maternal/Paternal Grandparent ☐ Sibling ☐ Child
Bleeding Disorder ☐ Parent ☐ Maternal/Paternal Grandparent ☐ Sibling ☐ Child

PATIENT SIGNATURE/DATE _____

REVIEW OF SYSTEMS:

PLEASE PUT AN "X" ON THE LINE TO INDICATE WHETHER YOU PRESENTLY HAVE ANY OF THE FOLLOWING SYMPTOMS.

GENERAL ☐ Fatigue ☐ Weight Gain ☐ Daytime Sleepiness ☐ Fever ☐ Chills ☐ Weight Loss

EYES ☐ Eye Pain ☐ Watery/Itchy Eyes

ENT ☐ Change in Voice ☐ Hoarseness ☐ Difficulty Swallowing ☐ Ear Pain ☐ Hearing Loss ☐ Nasal Congestion ☐ Ringing/Sounds in Ears ☐ Sinus Pain/Pressure ☐ Sleep Apnea ☐ Snoring ☐ Sore Throat

CARDIAC ☐ Chest Pain ☐ Rapid Heart Rate ☐ Irregular Heartbeat ☐ Leg Swelling

RESPIRATORY ☐ Shortness of Breath ☐ Cough ☐ Wheezing ☐ Coughing Blood

GI ☐ Heartburn

GU ☐ Frequent Urination ☐ Painful Urination

SKIN ☐ Rash ☐ Pigmentation Changes ☐ Hair Growth Changes ☐ Hives ☐ Itching

NEURO ☐ Seizures ☐ Headache ☐ Passing Out ☐ Dizziness

MSK ☐ Joint Pain ☐ Muscle Pain

ENDO ☐ Feel Cooler Than Others ☐ Feel Warmer Than Others

PSYCHE ☐ Depression ☐ Mental Health Problems

HEME/LYMPH ☐ Night Sweats ☐ Bleeding Problems ☐ Easy Bruising ☐ Swollen Glands

ALLERGY ☐ Sneezing ☐ Throat Dryness/Itching ☐ Environmental Allergy ☐ Postnasal Drip

CHECK HERE IF NONE OF THE ABOVE ☐

PLEASE LIST MORE DETAILS ABOUT YOUR EAR, NOSE AND THROAT PROBLEMS BELOW:

_____

_____

_____

_____

_____

_____

_____

Financial Policy

Burlington Ear, Nose & Throat Clinic, P.C.
Douglas E. Henrich, M.D.
Jennifer K. Berge, M.D.

1225 South Gear Ave., Ste. 255
West Burlington, IA 52655
(319) 752-2725

This is an agreement between Burlington Ear, Nose & Throat Clinic, P.C., as a creditor, and the Patient/Debtor named on this form.

By executing this agreement, I agree to pay for all services that are received.

I acknowledge that all information given is true and correct and that it has been furnished to this office with the full knowledge that the patient is liable for all said services rendered and that he/she is contractually bound to pay for said services, including all costs of collection and reasonable attorney fees should collection become necessary. I hereby authorize and request that payments under my insurance plans be made directly to Burlington Ear, Nose & Throat Clinic, P.C. for any services furnished to me.

I hereby consent to the administration and performance of all diagnostic procedures and treatments that in the judgment of Burlington Ear, Nose & Throat Clinic, P.C. may be considered necessary and advisable. Burlington Ear, Nose and Throat Clinic, P.C. provides a variety of diagnostic testing, including, but not limited to, sinus and temporal bone CT scans, neck and thyroid ultrasounds, allergy testing, audiometry, fiberoptic endoscopies, excisions and biopsies. By signing this paragraph, I acknowledge that these tests may not be included in my office co-pay and may be considered part of my deductible or yearly out of pocket with my insurance company and that I am responsible for these charges. I have the option to decline such treatment and seek further information, but if I have the tests performed, I agree to be responsible for the fees.

I also authorize the release of any information required to process insurance claims, including any information relating to alcohol, drug abuse and AIDS. I authorize the release of my personal health information to billing agencies, laboratories, diagnostic testing facilities, referring physicians, and others involved in the medical and financial aspects of my care.

Payment Options If You Have Insurance:
Co-pay, deductible and any out-of-pocket expenses are due at the time-of-service and are payable by cash, check or credit card. No exceptions.

You will be charged a 1.5% interest monthly (18% annually) on balances 30 days and older.

Payment Options If You Do Not Have Insurance:
You may choose to pay by cash, check or credit card at the time the treatment is rendered. No exceptions.

On extensive treatment, you may prefer to secure a bank, credit union or other third-party financing for the entire amount and make payments to the lending institution or speak to our office manager/billing specialist about payment arrangements.

Payments:
Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued and is considered past due if not paid by the end of the month.

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay, you must pay that at the time of service. If your insurance requires a referral or preauthorization, you are responsible for obtaining it. Failure to obtain the referral or preauthorization may result in a lower payment from the insurance company.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for that account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. 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 and not the responsibility of Burlington Ear, Nose & Throat Clinic, P.C.

Workers' Compensation: We require written approval/authorization by your employer or workers' compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for the payment in full.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury.

Patients may be charged directly for additional fees for the following: Prescription Renewals $20, Completing Disability/ Medical Leave/Insurance Forms $20, Completing Sport/Camp/School Physical Forms $15, Copies of Medical Records one to 20 pages $20, with each additional page at $0.75 and postage for mailing.

There is a fee of $30 for any checks returned by the bank.

NOTICE OF PRIVACY POLICIES FOR BURLINGTON ENT CLINIC, P.C.

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

INTRODUCTION

At BURLINGTON ENT CLINIC, P.C., we are committed to treating and using Protected Health Information (PHI) about you responsibly. This Notice of Private Health Information Practices describes the personal information we collect and how and when we use or disclose that information. This Notice is effective September 4, 2013, and applies to all (PHI) as defined by federal regulations. We reserve the right to revise this notice at any time.

Understanding Your PHI

Each time you visit BURLINGTON ENT CLINIC, P.C., a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. Understanding what is in your record and how your PHI is used helps to ensure its accuracy, better understand who, what, when, where and why others may access your PHI, and make more informed decisions when authorizing disclosure to others.

Your PHI Rights

Federal law grants you certain right with respect to your PHI. Specifically, you have the right to:

- Receive notice of our policies and procedures used to protect your PHI.
- Request that certain uses and disclosures of your PHI be restricted, provided however, if we may release the information without your consent or authorization, we have the right to refuse your request.
- Access to your PHI, provided however, the request must be in writing and may be denied in certain limited situations.
- Request that your PHI be amended.
- Obtain an accounting of certain disclosures by us of your PHI for the past six years.
- Revoke in writing any prior authorization for use or disclosure of PHI, except to the extent that action has already been taken.
- Request communications of PHI are done by reasonable alternative means or at alternative locations.
- Notification of any breach of unsecured PHI relating to you and actions you may take in relationship to such a breach.

Our Responsibilities

Federal law also imposes certain obligations and duties upon us with respect to your PHI. Specifically, BURLINGTON ENT CLINIC, P.C. is required to:

- Provide you with notice of our legal duties and our facility's policies regarding the use and disclosure of your PHI.
- Maintain the confidentiality of your PHI in accordance with state and federal law.
- Review your requested restrictions regarding the use and disclosure of your PHI and inform you if these restrictions will be used.
- Allow you to inspect and copy your PHI during our regular business hours with a scheduled appointment pursuant to any legal restrictions. Please contact our Privacy Officer for fees or an explanation of our fee structure for copies, staff time charges and postage.
- Act on your request to amend PHI within sixty (60) days and notify you of any delay that would require us to extend the deadline by the permitted thirty (30) day extension, although this does not guarantee that amendment is appropriate.
- Accommodate reasonable requests to communicate PHI by alternative means or methods.
- Abide by the terms of this notice.

We reserve the right to change our practices and to make the new provisions effective for all PHI we maintain. We will not use or disclose your PHI without your authorization, except as described in this notice. We will also discontinue to use or disclose your PHI after we have received written revocation of the authorization according to the procedures included in the authorization.

How Your PHI May Be Used and Disclosed

Generally, your PHI may be used and disclosed for treatment, payment or operations as required by law. This includes a variety of areas:

We will use your PHI for treatment purposes.
We may use or disclose your PHI for treatment purposes, including continuing care and case or care management. During your care at our office, it may be necessary for various personnel, including, but not limited to, physicians, nurses or other members of your health care team involved in your care to access your PHI in order to provide you quality care. We will also provide your physician and a subsequent health care provider outside of our office with copies of various reports that should assist him or her in treating you with your current or future care. We will also contact you to provide appointment reminders and information about treatment options.

We will use your PHI for payment.
Your PHI may also be used or disclosed for payment purposes. It is necessary for us to use or disclose PHI so that treatment and services provided by us may be billed and collected from you, your insurance company or other third-party payers. Bills requesting payment will usually include information that identifies you, your diagnosis, and any procedures or supplies used. It may also be necessary to release PHI to obtain eligibility information and to obtain prior approval for treatment from your health insurance. We may also disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

We will use your PHI for regular health operations.
Your PHI may be used for facility operations that are necessary to ensure our office provided the highest quality of care. For example, your PHI may be used for learning, quality assurance purposes, risk management or disclosed to accounting personnel for auditing purposes. We may also remove information that could identify you from your record so as to prevent others from learning who the specific patients are. We may also release information to business associates who perform various treatment, payment or operation functions.

Emergency Use:
If an emergency situation exists and providing you with this notice is not practicable, we may use or disclose PHI to the extent necessary during the emergency.

Notification:
Unless you have informed us otherwise, your PHI may be used or disclosed by us to notify or assist in notifying you, a family member or other person responsible for your care. This may include, but is not limited to, voicemail messages, emails or letters. In most cases, PHI disclosed for notification purposes will be limited to your name, location and general condition. In addition, unless you have notified us otherwise, PHI may be released to a family member, relative or close friend who is involved in your care to the extent necessary for them to participate in your care. If you wish for any of these uses and disclosures to be limited, please contact facility personnel.

Disaster Relief:
In the event of a disaster, we may provide information to public or private entities as needed to facilitate treatment, locate family members and caregivers and to facilitate public health needs.

Marketing:
Your PHI may be used with your authorization to send you information about products and services from manufacturers used in our office. The marketing is paid for in whole or part by the manufacturer.

Research:
Your PHI may be used or disclosed for research purposes. All research projects that use PHI are subject to a special approval process that will, among other things, evaluate the precautions used to protect patient medical information. In some cases, information that identifies you as the patient will be removed.

Special Circumstances:
We may also use or disclose your PHI without your authorization as permitted or required by law. These would include public health activities, health oversight activities, judicial and administrative procedures, abuse reporting, law enforcement, organ donation, coroners, medical examiners, workers' compensation processes and research purposes. Some PHI may be subject to other laws and regulations and afforded greater protection than what is reviewed in this Notice of Privacy Policy. This may include HIV/AIDS, substance abuse and mental health information and genetic information. In the event your PHI is afforded greater protection under federal or state law, we will comply with the applicable law.

Contact Information:
This notice has been provided to you as a summary of how we will use your PHI and your rights with respect to your PHI. If you have any questions, would like a copy of our current privacy policy or need more information regarding you PHI, please contact Kelli Fountain at Burlington Ear, Nose & Throat Clinic, P.C. Information can also be found on our website at www.burlingtonent.com.

If you believe your privacy rights have been violated, you may file a complaint with our office by contacting Kelli Fountain at Burlington Ear, Nose & Throat Clinic, P.C. You may also file a complaint with the Secretary of Health and Human Services. All complaints must be submitted in writing. There will be no retaliation for the filing of a complaint.

Nondiscrimination and Accessibility
Burlington Ear, Nose & Throat Clinic, P.C. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, and gender identity or expression.

Revision 11/2017

PATIENT NAME: _____ DATE OF BIRTH: _____

PHARMACY AUTHORIZATION

The undersigned agrees to give Burlington Ear, Nose & Throat Clinic, P.C. permission to access my pharmacy benefits and list of all medications prescribed for patient by any provider.

PHARMACY NAME AND LOCATION _____.

ASSIGNMENT OF INSURANCE BENEFITS

In the event the undersigned is entitled to medical benefits of any type whatsoever arising out of any policy of insurance or any other party liable to the patient, said benefits are hereby assigned to Burlington Ear, Nose & Throat Clinic, P.C. for application to the patient's bill, and it is agreed that the undersigned is responsible for the charges not covered by this assignment.

RELEASE OF INFORMATION

Burlington Ear, Nose & Throat Clinic, P.C. may disclose all or any part of the patient's record to any person or corporation that is or may be liable under a contract to Burlington Ear, Nose & Throat Clinic, P.C. or to the patient or to the family member or employer of the patient for all or part of the charges including, but not limited to, office, hospital or medical service companies, workmen's compensation carriers, welfare funds or the patient's employer. Please list any family members that you allow to call and speak with the office in regard to any/and or all of your patient information.

_____

_____

MEDICARE AUTHORIZATION

I certify that the information given me in applying for payment under Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries and carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

I have read this form, and I understand its content and significance. I have received (previously or today) a copy of Burlington Ear, Nose & Throat Clinic, P.C. "Notice of Privacy Practices." This consent will expire one (1) year from the date of the signature.

GUARANTY OF ACCOUNT

The undersigned agrees, whether he/she signs as patient or as guarantor, that in consideration of the services to be rendered to the patient, he/she obligates himself/herself to pay the account of the clinic in accordance with regular rates and terms of the clinics.

I have received and read the Burlington Ear, Nose & Throat Clinic, P.C. "Financial Policy" and agree to follow the terms of the contract.

A copy of the Burlington Ear, Nose & Throat Clinic, P.C. "Notice of Privacy Policies" and "Financial Policy" can also be found on our website at www.burlingtonent.com.

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Signature of Witness Date