ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(To be filed in patient's medical record)

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding, my health information.

I authorize access to my health information to: _____

_____

I wish to place the following restriction on disclosure of my health information: _____

_____

I understand that, if requested, my health information will not be disclosed to a health plan for payment or healthcare operations if the PHI pertains solely to a healthcare service that was paid for in full by the patient (or someone other than the health plan) except when disclosure is required by law.

Signed: _____ Date: _____

Printed Name: _____

Internal Use Only: If patient representative refuses to sign acknowledgment, please document date and time notice was presented to patient and sign below.

Presented on (Date & Time) _____

By (Name & Title) _____

PERMISSION TO CALL CELL PHONE

I, the undersigned, give Central Alabama ENT Associates, its employees, and/or agents, express prior consent to contact me at all phone numbers, including cell phone numbers, and to leave messages if necessary, for the purpose of treatment, insurance and payment.

Signed: _____ Date: _____

Printed Name: _____

Central Alabama Ear, Nose & Throat Associates

PATIENT INFORMATION

First Name:	Middle:	Last:	Nickname:

Street Address:	City:	State:	Zip:

Home Phone:	Work Phone:	Cell Phone:

Marital Status (circle one) Single / Married / Divorced / Separated/ Widowed / Dependent Child	SSN:	Birth Date: / /	Age:	Sex: M / F

RESPONSIBLE PARTY INFORMATION

First Name:	Middle:	Last:	Nickname:

Street Address:	City:	State:	Zip:

Home Phone:	Work Phone:	Cell Phone:

Relation to Patient (circle one) Spouse / Mother / Father / Guardian / Child / Sibling / Other:	SSN:	Birth Date: / /	Age:

Emergency Contact: Name:_____ Daytime Phone: _____

EMPLOYER INFORMATION

☐ Patient's Employer ☐ Patient's Responsible Party's Employer	Employer's Phone:

PRIMARY INSURANCE INFORMATION

☐ BC/BS ☐ Work Comp ☐ Viva ☐ UHC ☐ Tricare Prime ☐ Tricare Standard ☐ Medicare ☐ Medicaid ☐ Other:

Subscriber's Name on Card:	Subscriber's Date of Birth:
Contract #	**Group #**

Relation of Insured to Patient (circle one): Self / Spouse / Mother / Father / Guardian / Grandparent / Other:

SECONDARY INSURANCE INFORMATION

☐ BC/BS ☐ Work Comp ☐ Viva ☐ UHC ☐ Tricare Prime ☐ Tricare Standard ☐ Medicare ☐ Medicaid ☐ Other:

Subscriber's Name on Card:	Subscriber's Date of Birth:
Contract #	**Group #**

Relation of Insured to Patient (circle one): Self / Spouse / Mother / Father / Guardian / Grandparent / Other:

REFERRAL SOURCE

Circle One: Family / Friend / ER / Primed / Primary MD / Other MD / WC / Physician Finder / Phone Book / Ad / I'm a returning patient / Other:

Referring Doctor's Name:	Primary Care Doctor's Name:

REASON FOR VISIT

Reason:	If work related, list name & phone of who can verify:

Do you have a living will: Yes___ No___

I assign any benefits payable to the provider of services who accepts assignment for services rendered. I authorize the submission of claims on my behalf to Medicare or other insurance carriers. I authorize the release of medical information necessary to process my claims to the Social Security Administration, its intermediaries or carriers or any other commercial carriers.

I am responsible for all financial obligations of health services for the above patient, and for reimbursement and payment of claim from my insurance company. I hereby assign, transfer and set over to Central Alabama ENT Associates, all of my rights, title, and interest to my medical reimbursement benefits, under my insurance policy. I authorize my insurance to pay the Doctor. AGREEMENT TO PAY: I, the undersigned accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court costs, if such be necessary.

Responsible Party:

Print_____ Sign_____ Date:_____

PLEASE FILL OUT BRIEF HISTORY ON BACK

PATIENT'S NAME _____
FIRST MIDDLE INITIAL LAST

AGE _____ HEIGHT _____ WEIGHT _____ DATE _____

Drug Allergies _____

Medications You Now Take: _____

Medical Illnesses You Have Had: _____

Medications You Have Taken in the Past Two Years: _____

List All Surgeries You Have Had to Date: _____

FAMILY HISTORY: Are Parents Living? Mother _____ Father _____

2. If Not What Was Cause Of Death? _____
3. Do Parents Have Any Illnesses? If So, Please List (EX. Diabetes, Heart Problems)

4. Do You Have Any Brothers or Sisters With Any Illnesses?
   If So, Please List _____

Personal History (Please circle Yes or No)

Have You Ever Had?		
Heart Attack or Heart Disease	Yes	No
Pneumonia, Tb or Abnormal Chest X-ray	Yes	No
Thyroid Problems	Yes	No
Anemia or Bleeding Tendencies	Yes	No
Jaundice, Hepatitis, Liver Disease	Yes	No
Diabetes	Yes	No
High or Low Blood Pressure	Yes	No
Eye Problems	Yes	No
Asthma or Hay Fever	Yes	No
Kidney Disease	Yes	No
Any Complication Other Than Nausea or Vomiting With Anesthesia	Yes	No
A Family Member Who Has		
1. Complications With Anesthesia	Yes	No
2. Muscular Dystrophy	Yes	No
Do You Have?		
Chest Pain or Angina	Yes	No
Chronic or Frequent Cough	Yes	No
A Cold	Yes	No
Shortness of Breath	Yes	No
Frequent Headaches	Yes	No
Heart Murmur	Yes	No
Heart Fluttering or Palpitation	Yes	No
An Arm or Leg That Becomes Weak or Numb	Yes	No
Chipped/Broken or Loose Teeth	Yes	No
Dentures, Caps, Bridgework	Yes	No
Do You Smoke: If Yes, Packs Per Day _____	Yes	No
Do You Drink More Than Occasionally	Yes	No
Are You Pregnant	Yes	No

FOR PHYSICIAN'S USE ONLY

Physical Examination (To be completed by Physician)

Present Complaint _____

Physical Exam:

General Appearance	Normal	Abnormal/Comments
Head: Ears		
Nose		
Throat		
Neck		
Heart		
Lungs		
Abdomen		
A Distention		
B Spleen		
C Liver		
Adenopathy		
A Neck		
B Axilla		
C Groin		
Genitalia		
Extremities		
Bones		
Joints		
Impressions:		
Evaluation by:		
		M.D.
Date:		

Central Alabama Ear, Nose & Throat Associates
6980 Winton Blount Blvd.
Montgomery, Alabama 36117
Office: (334) 277-0484 Fax: (334) 272-8877

Patient:_____ Medical Record Number:_____

Date of Birth:_____ Social Security Number:_____

I, _____, hereby authorize Central Alabama ENT Associates to:

☐ Release To

Name:_____
Address:_____
_____
Telephone:_____
Fax:_____

☐ Obtain From

Name:_____
Address:_____
_____
Telephone:_____
Fax:_____

Medical Information from my health record for the purpose of continuity of care, and/or the following information: (Please List)

_____
_____
_____

I understand that this consent is revocable by me in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable during a contestability period. In order for the revocation of this authorization to be effective, Central Alabama ENT Associates must receive the revocation in writing.

The revocation must include: 1. The patient's name and address. 2. The effective date of this authorization and the recipients of the protected health information according to this authorization.
3. The date of the revocation and the patient's signature. Central Alabama ENT Associates will accept written revocation of this authorization via:

☐ Certified U.S. Mail ☐ Facsimile at this number (334) 272-8877

All revocations must be sent to the Attention of the Privacy Office and **are not** effective until received by the Privacy Officer.

This authorization shall expire either ninety (90) days after the date of the signature or automatically when the records requested by this form have been mailed to the requester. After this date, Central Alabama ENT Associates can no longer use or disclose the patient's information without first obtaining a few authorization form.

I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information.

Date:_____ Signature:_____
(Patient)

IF PATIENT IS UNABLE TO GIVE CONSENT BECAUSE OF PHYSICAL CONDITION OR AGE, COMPLETE THE FOLLOWING:

☐ Is a Minor____Years of Age ☐ Is Unable to give consent because (describe patient's condition)

_____
_____

Date:_____ Signature:_____
(Parent/Guardian)