Philip A. Scolaro, M.D.
David W. Cuthbertson, M.D.
Otolaryngology
Head and Neck Surgery

EAR NOSE & THROAT
ASSOCIATES OF LUBBOCK

Cathy M. Thackrey, Au.D., CCC-A
Audiology
Hearing Aids

PATIENT INFORMATION (ADULT)

Chart: _____

Last Name _____ First Name _____ Middle Name _____ Suffix _____

Date of Birth _____ ☐ male ☐ female Marital Status _____ SS# _____

Street / Mailing Address _____ City _____ State _____ Zip Code _____

Home Phone (with Area Code) _____ Cell Phone (with Area Code) _____ Work Phone (with Area Code) _____

May we contact you via email? ☐ No ☐ Yes Email address: _____

Employer _____ Occupation _____

Employer's Street Address _____ City _____ State _____ Zip _____

Race: ☐ Declined ☐ Caucasian ☐ Asian ☐ Black ☐ Pacific Islander ☐ Native American/Alaskan ☐ Other

Ethnicity: ☐ Declined ☐ Hispanic ☐ Non-Hispanic

Spouse or Emergency Contact _____ Relationship _____ Phone Number (with area code) _____

Insured Last Name _____ First Name _____ Middle Name _____

Date of Birth _____ ☐ male ☐ female Marital Status _____ SS# _____

Address _____ City _____ State _____ Zip Code _____

Cell Phone (with Area Code) _____ Work Phone (with Area Code) _____

Employer _____ Employer Address _____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Referring Physician _____ Phone (with Area Code) _____

Family/Primary Physician _____ Phone (with Area Code) _____

Preferred Pharmacy _____ Location _____ Phone (with Area Code) _____

How did you hear about us? ☐ Physician referral ☐ TV/Online Ad ☐ Web Search ☐ Other _____

Signature _____ **Date**_____

*Completed forms may be emailed to scheduling@entlubbock.com

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AUTHORIZATION FOR COMMUNICATION OF HEALTH INFORMATION

I have been informed and agree to the procedures by which this office may communicate my protected health information. I hereby consent to communication via:

□ Email: _____

□ Voice message on the following telecommunication lines:

_____ _____

OPTIONAL AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

My protected health information may be discussed with or released to the following family members and/or personal acquaintances:

1.) Name _____ Relationship _____

2.) Name _____ Relationship _____

3.) Name _____ Relationship _____

Please note that without this authorization, our office cannot discuss medical issues with spouses, children, etc. who may inquire on behalf of the patient, an exception being custodial parents of children under the age of 18 and/or personal representatives of incapacitated patients. You may be required to fill out an additional form to release records to other entities, including physician offices, etc. Authorization may be revoked at any time by providing written notice to our office or completing a new acknowledgement form.

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of the Notice of Privacy Practices and this signed document.

ACKNOWLEDGEMENT AND AGREEMENT AS TO GOVERNING LAW AND FORUM

The patient, including patient's representative and heirs or beneficiaries, and the health care provider, including employees and agents of the health care provider, rendering or providing medical care, health care, or safety or professional or administrative services directly related to health care to patient agree:

1. That all health care rendered shall be governed exclusively and only by Texas law, and in no event shall the law of any other state apply to any health care rendered to patient; and
2. In the event of a dispute, any lawsuit, action, or cause of which in any way related to health care provided to the patient shall be brought only in a Texas court in the county/district where all or substantially all of the health care was provided or rendered, and in no event will all lawsuit, action, or cause of action ever be brought in any other state. The choice of law and forum selection provisions of this paragraph are mandatory and are not permissive.

_____ _____
Patient Name (Print) Date

_____ _____
Patient/Patient Representative (Signature) Relationship

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ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I hereby authorize Ear, Nose & Throat Associates of Lubbock to release information requested by my insurance carrier, or any person, company or agency responsible for processing claims for my medical services. I also authorize assignment of all payments for medical services performed by this provider to be paid directly to Ear, Nose & Throat Associates of Lubbock.

I acknowledge that I am fully responsible for providing current insurance information, obtaining PCP referrals (if required by my plan), and updating any changes in coverage with this office in a timely manner. I acknowledge that I am fully responsible for charges not paid by my insurance or other agency including, but not limited to: copays, deductibles, coinsurance, balances resulting from failure to provide updated insurance information and/or lack of a PCP referral.

I acknowledge that payment is due at the time services are rendered, including collection of all copays, deductibles and coinsurance. I understand that some services rendered in a specialist's office (i.e. audio testing, scopes, minor surgical procedures, etc.) may be subject to deductible and/or coinsurance in addition to office visit copays. I understand that Ear, Nose & Throat Associates of Lubbock will verify my insurance benefits prior to my appointment and will make a good faith effort to collect based upon the information provided by my insurance company. This information may not reflect the finalized claim patient responsibility determined by my insurance plan.

I acknowledge the following fees: a **$25 fee for returned checks**, a **$35 fee for office appointments not cancelled within 24 business hours of appointment time and same day cancellations and a $250 cancellation fee for surgeries not cancelled or rescheduled within three (3) business days of the scheduled procedure (unless cancelled by the surgeon).** I understand that this office closes at noon on Fridays, so Monday afternoon appointments must be notified before close of business on Friday to avoid a cancellation fee. For surgeries, I understand that I must notify this office directly and not the surgery center or facility where the procedure is scheduled. I agree to be considerate when cancelling or rescheduling a surgery or appointment so that Ear, Nose and Throat Associates has enough time to accommodate other patients.

Ear, Nose & Throat Associates accepts cash, checks, credit/debit cards and CareCredit. I understand that it is my responsibility to manage, maintain and track any payment plans that have been put in place with this office. I acknowledge that my account may be referred to a collection agency for unpaid balances after reasonable attempts to collect the balance have been exhausted.

By signing below, I acknowledge receipt of, and agreement to this practice's patient financial responsibility.

_____ _____

Printed Patient Name Date

_____ _____

Signature of Patient/Guarantor Printed Guarantor Name (if different from patient)

PATIENT MEDICAL HISTORY

Date _____

Name _____ Age _____ DOB _____ Height _____ Weight _____

1) Reason for todays visit: _____

_____

How long has this been present? ____ Days ____ Weeks ____ Months ____ Years
Previous episodes: □ Yes □ No When: _____
Any medications taken or other doctors consulted? _____

2) Illnesses: Do you have or have you ever had any of the following? Check all that apply.

□ No Significant History	□ High Blood Pressure	□ Chronic Tonsillitis	□ Hepatitis
□ Asthma	□ Previous Stroke	□ Heart Disease	□ HIV
□ Recent Pneumonia	□ Gastric Ulcers	□ Heart Attack	□ Recent Dental Issues
□ Kidney Disease	□ Migraine Headaches	□ Chronic Sinusitis	□ Malignant Hypothermia
□ Chronic Lung Disease	□ Allergies	□ Thyroid Disease	□ Bleeding Disorder
□ Diabetes: □Type I □Type II	□ Chronic Ear Infections	□ Seizure Disorder	□ Cancer (describe below):

_____

3) Surgeries: Have you ever had any of these surgeries? Check all that apply.

□ No Surgical History	□ Endoscopic Sinus Surgery	□ Appendectomy	□ Cesarean Section
□ Tonsillectomy	□ Balloon Sinuplasty	□ Hysterectomy	□ Hemorrhoidectomy
□ Adenoidectomy	□ Septoplasty	□ Hernia Repair	□ Pacemaker
□ Ear Tubes	□ Thyroidectomy	□ Cholecystectomy	□ Heart Stents

Please list ANY other surgeries (including all cardiac, general, orthopedic, etc. AND previous ear, nose, neck or throat surgeries): _____

4) Depression Screening (Required CMS Quality Measure):

Little interest or pleasure in doing things:	□Not at all	□Several Days	□More than half days	□Nearly everyday
Feel down depressed or hopeless:	□Not at all	□Several Days	□More than half days	□Nearly everyday

5) Medications: Please list prescription medications being taken OR provide a medication list.

Medication	Strength	Medication	Strength
_____		_____	
_____		_____	
_____		_____	
_____		_____	

Do you take aspirin or fish oil? □ Yes □ No Specify: _____
Does your religion prohibit you from receiving blood products or transfusions? □ Yes □ No

6) Allergies to medications, tape, latex or iodine: □ No Known Drug Allergies

Drug: _____	Reaction: _____
Drug: _____	Reaction: _____
Drug: _____	Reaction: _____

7) Other Physicians: Do you see any other specialists (i.e. Neurologist, Pulmonologist, Gastroenterologist, etc)?

Cardiologist: □ Yes □ No	Name: _____
Specialty: _____	Name: _____
Specialty: _____	Name: _____

8) Social History:

Smoking Status	Alcohol Status	Recreational Drugs
□ Current, PPD: _____	□ Currently	□ Currently, Type: _____
□ Former, Yrs: _____	□ Socially	□ Previously, Type: _____
□ Never	□ Occasionally / Rare	□ Never
	□ Never	

9) Family History: Please list any significant family history, including the family member relation (i.e. mother, brother, paternal grandfather, etc) and disease. _____

_____