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 Registration

Last Name _____ First Name _____ Middle _____

Date of Birth _____ Age _____ Gender _____ Marital Status _____

SSN _____-_____-_____ Email _____

Mailing Address _____ Preferred Language _____

City _____ State _____ Zip _____

Cell Phone (primary) _____ Home Phone _____

Employer _____ Work Phone _____

PCP Name _____ Referring Physician _____

Pharmacy _____ Cross Street _____ City _____

Emergency Contact _____ Phone _____ Relationship _____

Primary Medical Insurance (○ N/A)

Policy Holder Name _____ Policy Holder Date of Birth _____

Policy Holder Address (if different from patient address) _____

Policy Holder Phone _____ Relationship to patient ○ Self ○ Parent ○ Spouse ○ Other

Insurance Company Name _____ Insurance Phone _____

Group # _____ ID # _____

Secondary Medical Insurance (○ N/A)

Policy Holder Name _____ Policy Holder Date of Birth _____

Policy Holder Address (if different from patient address) _____

Policy Holder Phone _____ Relationship to patient: ○ Self ○ Parent ○ Spouse ○ Other

Insurance Company Name _____ Insurance Phone _____

Group # _____ ID # _____

Signature _____ Date Completed _____

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Parent/Guardian Information (Complete if patient is under 18 years old)

*The parent/guardian accompanying the child to the visit is responsible for payment due at the time of service. Respectfully, our office will not undertake second party billing as a result of custody, court order, or personal circumstances.

Parent/Guardian 1

Last Name _____ First Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Cell Phone (primary) _____-_____-_____ Home Phone _____-_____-_____

Employer _____ Work Phone _____-_____-_____

Relationship to Patient: ○ Mother ○ Father ○ Guardian ○ Other _____

Email _____

Parent/Guardian 2

Last Name _____ First Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Cell Phone (primary) _____-_____-_____ Home Phone _____-_____-_____

Employer _____ Work Phone _____-_____-_____

Relationship to Patient: ○ Mother ○ Father ○ Guardian ○ Other _____

Email _____

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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. ct scans, audio testing, scopes, minor surgical procedures such as excisions, tube placement, cautery, 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 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 of any changes or cancellations 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.

Patient Name _____ Date _____

Patient/Responsible Party Signature _____ Relationship _____

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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 (please check all that apply):

□ Email □ Voice message □ Text message

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:

Name _____ Relationship _____

Name _____ Relationship _____

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 acknowledge 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 _____ Date _____

Patient/Responsible Party Signature _____ Relationship _____

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Health Insurance Portability and Accountability Act (HIPAA)
Notice Of Privacy Practices

This notice describes your privacy rights, this office's duty to maintain the privacy of your personal health information, and how this office may use or disclose that information with/without your written permission. You have following rights regarding the health information this office maintains about you:

Right to View or Obtain a Copy: You may view and obtain a copy of the health information that this office has about you, in most situations. This office may require a written request for information.
Right to Amend: You may request this office to correct certain information, including certain health information, about you if you believe the information is wrong or incomplete. This office requires a written request for an amendment. If this office denies your request to amend your health information, you may have a written disagreement placed in your record.
Right to Record of Disclosures: You may request a record of your disclosed health information released for reasons other than treatment, payment, health care operations, and other reasons as provided by law, except those you have authorized or requested this office release.
Right to Request Restriction: You may request a restriction or limitation of the medical information disclosed by this office for treatment, payment, or health care operations. Additionally, you may request a restriction/limitation of health information disclosed about you to someone involved in your care, payment for your care, such as a family member or friend. *However, this office is not required to agree to your request for restriction.*
Right to Request Confidential Communications: Our office may attempt to contact you by phone, mail or email. You may request the method by which this office contacts you regarding your health information. Special confidential communication requests must be submitted in writing.
Right to a Paper Copy of this Notice: You may obtain a copy of this Notice from this office.

Privacy Practices

Treatment: This office is permitted to use and disclose your medical information to those involved in your treatment. For example, the physician in this office is a specialist; therefore, this office may request your health information from your primary care physician, in order to better provide treatment. Also, this office may provide your primary care physician information about your particular condition so that he/she can appropriately treat you for other medical conditions, if any.

Payment: This office is permitted to use and disclose your health information to bill and collect payment for the services provided to you. For example, this office may complete a claim for to obtain payment from you insurer or HMO. The form will contain health information, such as a description of the health services provided to you, that your insurer or HMO needs to approve payment to us.

Health Care Operations: This office is permitted to use or disclose your health information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered. For example, this office may engage the services of a professional to aid this practice in its compliance programs. This professional will review billing and medical files to ensure this office maintains its compliance with regulations and the law.

Communication

Electronic Mail - With patient consent, this office may communicate with the patient or patient's legally authorized representative via electronic mail (e-mail) for non-urgent matters through a secured mechanism. No information will ever be sent electronically without permission given by you or your legally authorized representative. This office cannot and does not guarantee the privacy or security of any message being sent over the Internet.

Voice Message - With patient consent, members of this office will make a good faith effort to only leave voice messages containing health information on patient approved telecommunication lines.

Disclosures That Can Be Made Without Your Authorization

There are situations in which this office is permitted by law to disclose or use your health information without your written authorization or an opportunity to object. In other situations, this office will ask for your written authorization before using or disclosing any identifiable information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or taken in reliance on that authorization.

Public Heath, Abuse or Neglect, and Health Oversight

This office may disclose your health information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like birth and death), or injury by a public health authority. This office may disclose health information, if authorized by law, to a person who may have been exposed to a disease or

may be at risk for contracting or spreading a disease or condition. This office may disclose your health information to report reactions to medications, problems with products, or to notify people of recalls or products they may be using.

This office may also disclose health information to a public agency to received reports of child abuse or neglect. Texas law required physicians to report child abuse or neglect. Regulations also permit the disclosure of information to report abuse or neglect of elders or the disabled.

This office may disclose your health information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections which are all government activities undertaken to monitor the health care delivery system and compliance with other law, such as civil rights laws.

Legal Proceedings and Law Enforcement

This office may disclose your health information in the course of judicial or administrative proceedings in response to an order of the court (or the administrative decision-maker) or other appropriate legal process. Certain requirements must be met before the information is disclosed.

If asked by law enforcement officials, this office may disclose your health information under limited circumstances provided that the information:

- Is released pursuant to legal process, such as a warrant or subpoena;
- Pertains to a victim of crime and you are incapacitated;
- Pertains to a person who has died under circumstances that may be related to criminal conduct;
- Is about a victim of crime and the office is unable to obtain the person's agreement;
- Is released because of a crime that has occurred on these premises; or
- Is released to locate a fugitive, missing person, or suspect.

This office may also release information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health of safety of a person.

Worker's Compensation
This office may disclose your health information as required by the Texas worker's compensations law.

Inmates
If you are an inmate or under the custody of law enforcement, this office may release your health information to the correctional institution or law enforcement officials. This release is permitted to allow the institution to provide you with medical care, to protect your health or the health and safety of others, or for the safety and security of the institution.

Military, National Security and Intelligence Activities, Protection of the President
This office may disclose your health information for specialized government functions such as separation or discharge from military services, requests as necessary by appropriate military command officers (if you are in the military), authorized national security and intelligence activities, as well as authorized activities for the provision of protective services for the President of the United States, other authorized government officials, or foreign heads of state.

Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors
When a research project and its privacy protections have been approved by an Institutional Review Board or privacy board, this office may release heath information to researchers for research purposes. This office may release health information to organ procurement organizations for the purpose of facilitating organ, eye, or tissue donation if you are a donor. Also, this office may release your health information to a coroner or medical examiner to identify a decreased or a cause of death. Further, this office may release your health information to a funeral director where such a disclosure is necessary for the director to carry out his/her duties.

Complaints

If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the United States Department of Health and Human Services (seen contact information below). The office will not retaliate against you for filing a complaint with the government or us.

U.S. Department of Health and Human Services
HIPAA Complaint
7500 Security BLVD., C5-24-04
Baltimore, MD 21244

Alissa Downing, Administrator of ENT Associates of Lubbock
3802 22nd St, Suite 200
Lubbock, TX 79410
email: alissa@entlubbock.com

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. _____

_____