

Patient Information (Please Print)

Patient Name _____ Date _____
Address _____ City/State _____ Zip Code _____
Home Phone _____ Cell _____ Appointment Reminder: Phone/Text/Email _____
Date of Birth _____ Gender M / F / _____ Single / Married / Widow / Divorced _____
Email Address _____ Language _____ Ethnicity/Race _____
Employer _____ If Married - Name of Spouse _____ Spouse DOB _____
Local Pharmacy _____ Cross Streets _____ City _____
Person Financially Responsible for Patient _____ Relationship _____
Emergency Contact _____ Relationship _____ Phone _____
Name to release Medical information _____ Relationship _____ Phone _____
Primary Physician _____ Referring Physician _____ *HIPAA Read/Initial* _____

ACKNOWLEDGEMENTS AND AGREEMENTS

CONSENT FOR EXAMINATION AND TREATMENT: I understand that medical treatment may be necessary for the patient by Southeast Michigan Ear Nose and Throat. I understand the examination procedures will be explained to me and I shall consent to the partial or complete examination. I understand that the examination results will be provided to me with recommendations. I hereby consent to and authorize the administration of all diagnostic and therapeutic treatments that may be considered advisable or necessary in the judgment of Southeast Michigan Ear, Nose and Throat. No guarantee of assurance has been given by anyone as to the results that may be obtained by such treatments. The responsibility for any follow-up examinations to check abnormalities found and treated, lies with me and not Southeast Michigan Ear, Nose and Throat.

PAYMENT POLICY: Payment is due at the time of service. We accept cash, checks, and credit cards. **All co-payments, deductibles and non-covered services must be paid in full at the time of service.** If your insurance is a managed care plan please review your coverage. If you require services that require a referral - adequate planning is essential. Referrals must be authorized by your primary care physician (PCP) and usually require an office visit. Authorization from managed care plans for your referrals may take one or more days. Please be aware that we are often unable to accommodate call in requests for referrals. Failure to obtain necessary authorizations often leads to out of pocket expense. We are happy to assist you in any way with your managed care plan, however, our experience with these plans has demonstrated that planning and adequate lead time are essential. If your insurance company requires laboratory specimens be sent to a specific lab, it is your responsibility to know the participating lab. **Your knowledge of your plan regulations and benefits as well as adequate planning will be your responsibility.** ****INITIAL HERE**** _____

Your doctor is here to manage your medical care. The physicians are not experts on insurance and cannot be aware of all financial arrangements. Please discuss insurance problems and financial arrangements with the business office staff. If you are experiencing financial difficulties please discuss this with the practice manager. We will gladly work with you to make payment arrangements. Accounts over ninety (90) days past due may be referred to a collection agency. In case of estranged or divorced parents, the parent accompanying the child to the visit is responsible to pay for services rendered, regardless of overage arrangements. We will gladly furnish you with statements for reimbursement.

Failure to give 24 hours' notice for cancellation of an appointment with the doctor will result in the charge of twenty-five dollars (\$25) being applied to your account. Failure to give forty-eight (48) hours' notice for cancellation of an appointment for ALLERGY TESTING will result in the charge of seventy-five (\$75) being applied to your account. Time reserved for those that miss appointments without advanced notice takes from other patients who otherwise may have been scheduled to see the doctor. Please schedule your appointments appropriately. We wish for all patients' timely care.

ASSIGNMENT OF BENEFITS: I request that payment of authorized insurance benefits be made to me or on my behalf to Southeast Michigan Ear, Nose and Throat, for any services furnished to me by that provider. I authorize any holder of medical information about me to release to my insurance company (or its managing company) and its agents any information needed to determine benefits payable for related services. This authorization is in effect for my lifetime, or until I choose to revoke it.

I have read the above Acknowledgements and Agreements and fully understand and accept the same.

Patients Name (Print) _____

Signature of Patient or Legal Guardian _____ Date _____

Southeast Michigan Ear, Nose and Throat
Notice of Privacy Practices

This notice describes how your medical information may be used, disclosed, and your patient rights. Please review this carefully.

OUR PLEDGE REGARDING MEDICAL INFORMATION

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, was enacted on August 21, 1996. Southeast Michigan ENT is committed in protecting your medical information. To comply with the HIPAA requirement, we are providing our Notice of Privacy Practices (NPP). This notice describes the medical privacy practices and that of all its employees and staff. This notice will not only offer an explanation of how your medical information may be used and disclosed, but also your patient rights and responsibilities.

HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED

The following categories describe different ways your medical information may be used or disclosed.

Treatment: Medical information may be used and disclosed to provide the patient with medical care.

Payment: Medical information may be used and disclosed in order to receive payment for services rendered from patient, insurance company or a third party.

Health Care Operations: Your medical information may be used and /or disclosed within the medial practice to enhance the quality of care of our patients.

Appointment Reminders: Disclosure of medical information may be utilized to contact and remind patient of an appointment for the treatment or medical care.

Treatment Alternatives: Medical information may be used and disclosed to inform or recommend possible treatment options to patient.

Health-Related Benefits and Services: Medical information may be used and disclosed to inform patient of health related benefits or services.

Individuals Involved in your care or payment: With the permission of the patient, medical information may be released to a close personal friend or family member who is involved in the patient's medical care and /or payment of care.

Special Situations When Permitted or Required by Law:

Medical information about patient may be disclosed in special situations when permitted or required by law, including the following:

- To Advert a serious threat to health and safety to the patient or public
- For public health and administrative oversight activities such as disease control abuse or neglect reporting health and vital statistics, audits, investigations and licensure reviews.
- For organ and tissue donation and transplant to facilitate organ or tissue donation
- For research purposes certain or limited information may be disclosed as permitted by law
- To Workers compensation or similar programs for the payment of the benefits for work-related injuries.
- To coroners, medical examiners, and funeral directors to identify a deceased person, to determine the cause of death or to carry out duties.
- To comply with court orders, judicial proceedings, or other legal processes related to law enforcement, custody of inmates, legal and administrative actions and criminal activity.

For U. S. Military and Veteran reporting regarding members and veterans of the armed forces of U. S. or foreign military.

For National security and intelligence activities such as protective services for the President and other authorized personnel.

STATE AND OTHER FEDERAL LAWS: Southeast Michigan Ear, Nose and Throat will comply with all applicable state and federal laws.

Other uses of Medical Information Required and Authorization: Other uses and disclosures of medical information not covered by this NOTICE or the laws that apply to us will be made only with the patient's written authorization. Authorization from patient to obtain or give medical information may be revoked at any time, in writing. Disclosure of medical information made prior to receiving written notice cannot.

Your Rights regarding Patient Medical Information:

Right to Inspect and Copy: Patient have the right to inspect and copy medical information that may be used to make decisions regarding their care. A reasonable fee may be charged.

Right to Amend: Patient has the right to request their medical records be amended or corrected if needed. All requests must be in writing.

Right to request Confidential Communications: Patient has the right to request that we communicate with them regarding their medical information by utilizing a particular venue or mailing to a certain location.

Right to Paper Copy of this Notice: Patient has the right to request a copy of this notice at any time.

Right to file a Complaint: A patient as the right to file a complaint regarding the privacy practices or if they believe that their privacy rights have been violated. Complaints maybe filed with SEMIENT. Patient may also file a complaint with the Secretary of Department of Health and Human Services. Under no circumstances with the patient be penalized for filing a complaint.

You have many rights with regard to your medical information. If you wish to exercise any of these rights, please submit your request in writing to:

Southeast Michigan Ear, Nose and Throat
2454 Monroe St, Suite A
Dearborn, MI 48124

Changes to Notice

Southeast Michigan Ear, Nose and Throat reserve the right to make any revisions or changes to the NOTICE. Any changes or revisions made to this notice will be effective for medical information already in our possessions as well as any information received in the future.

Review of Symptoms

Name: _____ DOB: _____ Date: _____

Drug Allergies: _____

Current Medications & Dosage: _____

Please check any of the following that you are **currently** experiencing:

EAR, NOSE & THROAT	<input type="radio"/> Bad breath	<input type="radio"/> Loss of hearing
	<input type="radio"/> Dental problems	<input type="radio"/> Nasal congestion
	<input type="radio"/> Difficulty swallowing	<input type="radio"/> Nasal discharge
	<input type="radio"/> Dryness of mouth	<input type="radio"/> Nosebleeds
	<input type="radio"/> Earache	<input type="radio"/> Snoring
	<input type="radio"/> Facial pain	<input type="radio"/> Sore throat
	<input type="radio"/> Hoarseness	<input type="radio"/> Tinnitus/Ear ringing
Other: _____		
IMMUNOLOGIC	<input type="radio"/> Environmental allergies	<input type="radio"/> Immune deficiency
	<input type="radio"/> HIV exposure	<input type="radio"/> Persistent infections
	<input type="radio"/> Hives	<input type="radio"/> Strong allergic reactions
CARDIOVASCULAR	<input type="radio"/> Palpitations	<input type="radio"/> Chest pain
	<input type="radio"/> Lightheadedness	
CONSTITUTIONAL	<input type="radio"/> Generally feeling well	<input type="radio"/> Fever
	<input type="radio"/> Chills	<input type="radio"/> Headache
	<input type="radio"/> Loss of appetite	<input type="radio"/> Tired
	<input type="radio"/> Weight gain	<input type="radio"/> Weight loss
ENDOCRINE/HEME/ONC	<input type="radio"/> Hot flashes	<input type="radio"/> Hair problems
	<input type="radio"/> Excessive sweating	<input type="radio"/> Night sweats
	<input type="radio"/> Excessive thirst	<input type="radio"/> Temperature intolerance
	<input type="radio"/> Jaundice	<input type="radio"/> Bleeding disorder
EYES	<input type="radio"/> Blurred vision	<input type="radio"/> Double vision
	<input type="radio"/> Cataracts	
GASTROINTESTINAL	<input type="radio"/> Constipation	<input type="radio"/> Diarrhea
	<input type="radio"/> Heartburn	<input type="radio"/> Ulcer
GENITOURINARY	<input type="radio"/> Burning on urination	<input type="radio"/> Kidney stones
	<input type="radio"/> Hesitancy	<input type="radio"/> Frequent urination
HEMATOLOGIC	<input type="radio"/> Easy bleeding tendency	<input type="radio"/> Excessive bleeding
	<input type="radio"/> Easy bruising tendency	<input type="radio"/> Swollen lymph nodes
NEUROLOGICAL	<input type="radio"/> Difficulty walking	<input type="radio"/> Seizures
	<input type="radio"/> Dizziness	<input type="radio"/> Speech difficulties
	<input type="radio"/> Headache	<input type="radio"/> Tingling
	<input type="radio"/> Memory loss	<input type="radio"/> Tremors
	<input type="radio"/> Numbness	<input type="radio"/> Weakness
MUSCULOSKELETAL	<input type="radio"/> Arthritis	<input type="radio"/> Joint stiffness
	<input type="radio"/> Back pain	<input type="radio"/> Joint swelling
	<input type="radio"/> Bone pain	<input type="radio"/> Leg pain
	<input type="radio"/> Joint pain	<input type="radio"/> Muscle aches
PSYCHIATRIC	<input type="radio"/> Anxiety	<input type="radio"/> Hallucinations
	<input type="radio"/> Depression	<input type="radio"/> Sleep disturbances
RESPIRATORY	<input type="radio"/> Cough	<input type="radio"/> Difficulty breathing
	<input type="radio"/> Coughing up sputum	<input type="radio"/> Shortness of breath
		<input type="radio"/> Wheezing

Southeast Michigan Ear, Nose and Throat

Dr. Danny Kewson Dr. Roger Toma Dr. Mark Toma

Tania Caballero, ACNP Deana Yasso-Vander Vliet, FNP Karen Bochenek, FNP

Past Medical History

- | | | |
|--|---|---|
| <input type="radio"/> Anemia | <input type="radio"/> Hay Fever | <input type="radio"/> Reflux/Heartburn |
| <input type="radio"/> Anxiety | <input type="radio"/> Headaches | <input type="radio"/> Peptic Ulcer |
| <input type="radio"/> Arthritis | <input type="radio"/> Hearing Loss | <input type="radio"/> Seizures |
| <input type="radio"/> Asthma | <input type="radio"/> Heart Attack | <input type="radio"/> Multiple Sclerosis |
| <input type="radio"/> Cholesterol | <input type="radio"/> Heart Failure | <input type="radio"/> Sinusitis |
| <input type="radio"/> Cancer | <input type="radio"/> Heart Problems | <input type="radio"/> Sleep Apnea |
| Type _____ | <input type="radio"/> Hepatitis | <input type="radio"/> Snoring |
| <input type="radio"/> Cardiovascular Disease | <input type="radio"/> Hernia | <input type="radio"/> Shortness of Breath |
| <input type="radio"/> Depression | <input type="radio"/> High Blood Pressure | <input type="radio"/> Stroke |
| <input type="radio"/> Developmental Problems | <input type="radio"/> Hypothyroidism | <input type="radio"/> Swelling |
| <input type="radio"/> Diabetes | <input type="radio"/> Injury | <input type="radio"/> Thyroid Disease |
| <input type="radio"/> Difficulty Breathing | <input type="radio"/> Kidney Infections | <input type="radio"/> TIA |
| <input type="radio"/> Ear Infection | <input type="radio"/> Language Barriers | <input type="radio"/> Tonsillitis |
| <input type="radio"/> Eczema | <input type="radio"/> Liver Disease | <input type="radio"/> Tuberculosis |
| <input type="radio"/> Emphysema | <input type="radio"/> Meningitis | |
| <input type="radio"/> GERD | <input type="radio"/> Mental Illness | |
| <input type="radio"/> Glaucoma | | |

HIV/STD POSITIVE:

Yes _____ No _____

Recent Hospitalization _____

Other Medical History _____

Tobacco Assessment: Smoking Status

Are you a current smoker? Yes _____ No _____ If yes, start date _____ Pack(s) per day _____

Are you a former smoker? Yes _____ No _____ If yes, quit date _____

Social History

Alcohol Use: Non-Drinker _____ Occasional Drinker _____ Heavy Drinker _____ Former Drinker _____

Illicit Drug Use: Yes _____ No _____ If yes, what drug? _____

Noise Exposure: Yes _____ No _____ If yes, do you use hearing protection? Yes _____ No _____

Exercise: Yes _____ No _____ If yes, how often? _____ Caffeine Servings per day: _____

Occupation: _____

Family History

- | | | |
|---|--|---------------------------------------|
| <input type="radio"/> Allergies | <input type="radio"/> Congestive Heart Failure | <input type="radio"/> Hypertension |
| <input type="radio"/> Alcoholism | <input type="radio"/> Depression | <input type="radio"/> Mental Illness |
| <input type="radio"/> Anemia | <input type="radio"/> Diabetes | <input type="radio"/> Obesity |
| <input type="radio"/> Asthma | <input type="radio"/> Drug Use | <input type="radio"/> Stroke |
| <input type="radio"/> Bleeding Disorder | <input type="radio"/> GERD | <input type="radio"/> Thyroid Disease |
| <input type="radio"/> Cancer (Type _____) | <input type="radio"/> Hearing Loss | <input type="radio"/> Tuberculosis |

Other Family History: _____

Surgical/Procedural

- | | | |
|---|--|--|
| <input type="radio"/> No prior surgical history | <input type="radio"/> GYN/OB surgery | <input type="radio"/> Rhinoplasty |
| <input type="radio"/> Appendectomy | <input type="radio"/> Gall bladder | <input type="radio"/> Septoplasty |
| <input type="radio"/> Back/Neck surgery | <input type="radio"/> Heart surgery | <input type="radio"/> Stomach |
| <input type="radio"/> Brain surgery | <input type="radio"/> Hemorrhoids | <input type="radio"/> Sinus surgery |
| <input type="radio"/> Breast surgery | <input type="radio"/> Hernia | <input type="radio"/> Thyroid |
| <input type="radio"/> Cataract surgery | <input type="radio"/> Hysterectomy | <input type="radio"/> Tonsil/Adenoidectomy |
| <input type="radio"/> Cancer surgery | <input type="radio"/> Orthopedic surgery | <input type="radio"/> Tubal Ligation |
| <input type="radio"/> Ear surgery | | |

Other Surgical Procedures: _____