DATE: ______________________ DOCTOR ______________________

TIME ______________________

ADULT INFORMATION SHEET

FULL NAME ______________________

NICKNAME: __________ SEX: ______ BIRTHDATE: __________ AGE: __________

SOCIAL SECURITY #: __________ HOME PHONE #: __________ CELL PHONE #: __________

MAILING ADDRESS: STREET ______________________

CITY: __________ STATE: __________ ZIP: __________

PLACE OF EMPLOYMENT: __________ E-MAIL ADDRESS: __________

OCCUPATION: __________ WORK PHONE #: __________

______ SINGLE ______ MARRIED ______ WIDOWED ______ SEPARATED ______ DIVORCED

SPOUSE'S FULL NAME: ______________________

LAST FIRST MI

BIRTHDATE: __________ SOCIAL SECURITY #: __________

SPOUSE'S PLACE OF EMPLOYMENT __________ EMAIL: __________

OCCUPATION __________ WORK PHONE: __________

HOW WOULD YOU LIKE TO BE NOTIFIED FOR APPOINTMENT CONFIRMATION?

❑ EMAIL ❑ PHONE

* *

** HOW DID YOU HEAR ABOUT OUR CLINIC? ______________________

** WHO IS RESPONSIBLE FOR THIS BILL? ______________________

** WHICH PHYSICIAN REQUESTED THIS CONSULTATION? __________ CITY/STATE __________

** FAMILY DOCTOR? __________ CITY/STATE __________

** WHO CAN WE CONTACT IN CASE OF EMERGENCY? ______________________

RELATIONSHIP: __________ PHONE #: __________

** I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATIO NNECESSARY TO PROCESS ANY CLAIM FILED OR RELEASE MEDICAL RECORDS ON MY BEHALF.

** I ALSO ASSIGN ANY BENEFITS FROM MY INSURANCE COMPANY LISTED ABOVE TO THE PHYSICIAN FOR SERVICES DESCRIBED ON THE CLAIM FORM.

FINANCIAL AGREEMENT: I fully understand that I am ultimately responsible for any and all charges associated with my account and that if I fail to pay any amount due, I will also be responsible for all collection fees, court costs, attorney fees, and any other charges incurred in the collection of any balance due.

SIGNED: ______________________ DATE: __________

SprintPrint — 662-841-9292

- **PATIENT NAME:** ____**DATE OF BIRTH**:________________

NEVER SMOKER: X	**CURRENT SMOKER: complete below**	**FORMER SMOKER: complete below**
	# Packs Per Day:	Year You Quit:
SMOKELESS TOBACCO?	# Cigarettes Per Day:	# Packs Per Day Used to Smoke:
	How Many Years Smoking?:	# Years You Smoked:

DRINK ALCOHOL : NO:____	**YES:____ (if yes complete below)**
	1.___SOCIALLY 2.____INFREQUENTLY 3.___FREQUENTLY
	1. BEER ___ 2. LIQUOR ___ 3. WINE ___
	# Drinks per Week_________ # Drinks Per Month_________

- **RECREATIONAL DRUG USE?** Yes / No : **(LIST TYPE)**:____
- **SURGERIES: LIST ALL SURGERY THAT THE PATIENT HAS HAD:**___________________________________

____

____

____

Date of Last Flu Shot, MONTH AND YEAR:	

Date of Last Pneumonia Shot, MONTH AND YEAR:	

- **FAMILY** **(Mother, Father, Sister, Brother, Daughter, Son)** **MEDICAL HISTORY :**

  (M) Mother ; (F) Father ; (S) Sister ; (B) Brother; (D) Daughter ; (SON) Son

ADOPTED HISTORY UNKNOWN			ALLERGIC RHINITIS	
FOOD ALLERGY-(LIST)			PET ALLERGY	
ALZHEIMER'S			ARTHRITIS	
ASTHMA			AUTISM	
CORONARY ARTERY DISEASE			COPD	
CANCER (LIST TYPE):			DIABETES	
GERD (ACID REFLUX)			FIBROMYALGIA	
HEADACHES/MIGRAINES			HEARING LOSS	
HEART DISEASE			HIGH BLOOD PRESSURE	
KIDNEY DISORDER			MENIERE'S DISEASE	
SLEEP APNEA			PARKINSON'S	
SEIZURES			SKIN DISORDER	
CHRONIC SINUS PROBLEM			STROKE	
THYROID DISORDER			VERTIGO (dizziness)	

COMPLETE NEXT 2 PAGES

• PATIENT'S MEDICAL CONDITIONS (NONE):_________

	(X) CURRENT	(X)PAST			(X) CURRENT	(X) PAST
ADHD				CANCER (LIST Type):		
ALCOHOLISM				ALLERGIC RHINITIS		
ALLERGY TESTS				EGG ALLERGY		
MILK ALLERGY				PEANUT ALLERGY		
PET ALLERGY				SEAFOOD ALLERGY		
ALZHEIMER'S				ANEMIA		
ANXIETY				ARTHRITIS / RHEUMATOID ARTHRITIS		
ASTHMA				ATRIAL FIBRILLATION		
AUTISM				NECK PAIN		
CHEST PAIN				CONGESTIVE HEART FAILURE		
COPD				CORONARY ARTERY DISEASE		
DENTAL CAVITIES				DEPRESSION		
DIABETES				EMPHYSEMA		
FIBROMYALGIA				TOBACCO SMOKE EXPOSURE AT HOME		
GERD (ACID REFLUX)				GRAVE'S DISEASE		
HEARING LOSS				HEART ATTACK		
HEART DISEASE				HIGH BLOOD PRESSURE		
HEPATITIS (Type):				HUMAN IMMUNODEFICIENCY VIRUS / HIV		
HIGH CHOLESTEROL				HIGH LIPIDS		
IMPACTED EAR WAX				INSOMNIA		
IRRITABLE BOWEL SYNDROME				KIDNEY DISORDER		
LARYNGEAL CANCER				HOARSENESS		
LUPUS				MENIERE'S DISEASE		
MIGRAINES				MITRAL VALVE DISORDER		
OSTEOARTHRITIS				OSTEOPOROSIS		
EAR INFECTIONS, CHRONIC				SLEEP APNEA: CPAP or BIPAP		
PARKINSON'S				CHRONIC SORE THROAT / TONSILLITIS		
SEIZURE DISORDER				SKIN DISORDER		
SINUS INFECTION				STROKE		
PARAthyroid DISORDER				THYROID DISORDER: Nodule, HYPOthyroid, HYPERthyroid; Goiter		
VERTIGO (DIZZINESS)				VISUAL IMPAIRMENT: Glasses, Contacts		
CURRENT SMOKER				SEXUALLY TRANSMITTED DISEASE		
OTHER CONDITION- PLEASE LIST:				OTHER CONDITION:		

COMPLETE NEXT PAGE

- **NAME & LOCATION OF YOUR LOCAL PHARMACY:**

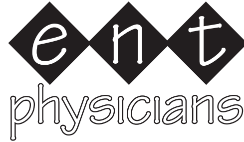
Name of Pharmacy:	**Location of Pharmacy:**

- **ALLERGIC TO:** LIST BELOW ALL MEDICINE THE PATIENT IS ALLERGIC TO:

- **MEDICATION:** LIST BELOW ALL MEDICINE THE PATIENT IS PRESENTLY TAKING:

1. **NAME OF MEDICATION**	**2.DOSAGE/Milligrams**	**3.HOW MANY TIMES PER DAY**

FINAL PAGE



Ear, Nose and Throat Physicians, P.A.

Consent for Treatment

Patient Name: ______________________________

Date of Birth: ______________________________

Relationship to Patient: ______________________________

CHILDREN (FAMILY MEMBERS ONLY)

PLEASE LIST ALL PERSONS THAT MAY BRING YOUR CHILD TO OUR CLINIC AND THAT WE MAY TALK TO REGARDING YOUR CHILD'S CARE AND TREATMENT:
(EXAMPLE: GRANDPARENTS, AUNTS/UNCLES, ETC.)

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

ONLY PARENTS OR LEGAL GUARDIANS MAY SIGN CONSENTS FOR SURGERY OR GET COPIES OF MEDICAL RECORDS.

ADULTS (FAMILY MEMBERS ONLY)

PLEASE LIST ALL PERSONS WHO MAY HAVE ACCESS TO YOUR MEDICAL RECORD:

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

____

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN DATE

PATIENT NAME ______________________________________ DOB: ______________________

ASSIGNMENT OF INSURANCE AND/OR MEDICARE AND MEDICAID BENEFITS

Medicare and/or Medicaid: I hereby request that payment of authorized Medicare/Medicaid benefits to or on my behalf for services rendered by ENT Physicians of North MS, P.A. or my physician(s) shall be made to ENT Physicians of North MS, P.A. or my physician(s), and I specifically assign such benefits to ENT Physicians of North MS, P.A. and my physician(s). I hereby certify that all information given by me in connection with applying for benefits under Title XVII of the Social Security Act is true, correct and complete in all respects. I understand that payment for certain services not deemed medically necessary by Medicare/Medicaid or, not authorized under the Medicare/Medicaid program, that I may be responsible for the entire charge incurred unless other third party coverage is available. I also understand that all deductibles are due unless they have been met within the period specified by Medicare.

CONSENT FOR RELEASE OF HEALTH INFORMATION FOR BILLING AND PAYMENT PURPOSES: I hereby consent to the release of my health information (medical records, medical results and an entire copy of my health information) by ENT Physicians of North MS, P.A. or my treating physician(s) for the purpose of billing, claims management, medical data processing, eligibility documentation, reimbursement, certification to any insurance company which is necessary for the billing and payment of this account. I understand that these records may contain information concerning my illness and/or treatment to other physicians or facilities that are involved in my medical care. I consent to the release of my entire medical record that may contain treatment notes regarding radiology, pathology including AIDS/HIV test results, genetic testing information, immunization, procedure(s), alcohol and drug abuse records, psychological or psychiatric conditions if any, protected by Federal Confidentiality Rule 42 CFR Park 2, and other common medical records documentation made by the physician, nurse or other ancillary personnel for the entire time I was treated at ENT Physicians of North MS, P.A..

NON-CERTIFICATION OF PRE-CERTIFICATION, ADMISSION OR REQUIRED SECOND OPINION

I hereby agree that as the policyholder or patient I have the responsibility of assuring certification is obtained from my insurance company or employer for service rendered. If certification or a second opinion is not obtained, I further agree that in the event the insurance company denies either all or part of their payment on the physician charges, I will pay the account in full upon demand from ENT Physicians of North MS, P.A.

FINANCIAL RESPONSIBILITY AGREEMENT: I understand that I am financially responsible to ENT Physicians of North MS, P.A. or my treating physicians(s) for all charges not covered or paid by insurance. I also understand and agree that all deductibles, co-insurance, co-pays, non-covered charges and other items that are not paid by insurance are due and payable at the time of service based on the best estimates available as determined by ENT Physicians of North MS, P.A. or my treating physician(s) and any charges remaining on this account not covered by insurance are payable on demand. If I do not have insurance, I take full responsibility for the payment of all charges incurred on this account. I also agree that in case of default of payment, if this account is placed in the hands of a collection agency or attorney for collection or suit, all reasonable collection fees, reasonable attorney fee, cost and other expenses will by paid by me. I also understand, agree and authorize ENT Physicians of North MS, P.A. or my treating physician(s) to verify employment status for the purpose of processing the bill for payment.

FINANCIAL RESPONSIBILITY FOR DIVORCED PARENTS: I understand and agree that if I am the parent that brings the child to the office or hospital for treatment by ENT Physicians of North MS, P.A. or my treating physician(s), it is my responsibility to pay all charges incurred for services rendered. I further understand that any arrangements made between the two parents concerning payment is the responsibility of the parents not ENT Physicians of North MS, P.A. or my treating physician(s).

CONSENT FOR RELEASE OF HEALTH INFORMATION FOR TREATMENT PURPOSE: I hereby consent to the release of my health information (medical records, medical results and an entire copy of my health information) by ENT Physicians of North MS, P.A. or my treating physician(s) for the purpose of medical treatment to other physicians or facilities that are involved in my medical care. I understand that these records may contain information concerning my illness and/or treatment to other physicians or facilities that are involved in my medical care. I consent to the release of my complete medical record that may contain treatment notes regarding radiology, pathology including AIDS/HIV test results, genetic testing information, immunization, procedure(s), alcohol and drug abuse records, psychological or psychiatric conditions if any, protected by Federal Confidentiality Rule 42 CFR Park 2, and other common medical records documentation made by the physician, nurse or other ancillary personnel for the entire time I was treated at ENT Physicians of North MS, P.A..

*A copy of this authorization is valid as the original.

I acknowledge that I have been given and received a copy of ENT Physicians of North MS, P.A. Notice of Privacy Practices.

This is to certify that I, the undersigned, being the patient or another person legally authorized to act for the patient, have read paragraphs 1-8 of this document, understand its content, and agree to the terms. I understand and agree that a copy of this authorization is as valid as the original. I understand and authorize the release of my personal health information or billing records by facsimile. I agree and understand that this authorization will remain valid until it is terminated by the patient or another person legally authorized to act for the patient.

Signature of Patient________________________________ Signature of Guardian____________________________________

Date__________________________ Relationship to Patient__________________________ Date____________________

Witness to Signature________________________________ Witness to Signature____________________________________

PRIVACY NOTICE

Your Privacy Is Important

This Notice Describes How Medical Information About You May Be Used and Disclosed and How You May Get Access to this Information. Please Read it Carefully.

ENT Physicians of North MS, P.A. is dedicated to protecting your medical information. We are required by law to maintain the privacy of your medical information and to provide you with this Notice of our legal duties and privacy practices with respect to your medical information. ENT Physicians of North MS, P.A. is required by law to abide by the terms of this Notice.

How your Medical Information Will Be Used and Disclosed

We will use your medical information as part of rendering patient care. For example, your medical information may be used by the doctor or nurse treating you, by the business office to process your payment for the services rendered and by the administrative personnel reviewing the quality of the care you receive.

AUTHORIZATIONS

We will not use or disclose your protected health information for purposes not listed in this Notice of Privacy Practices without your written authorization. Specifically, we will not use or disclose your protected health information without your written authorization in the following circumstances: (1) most uses and disclosures of psychotherapy notes; (2) uses and disclosures of protected health information for marketing purposes, including subsidized treatment communications; and (3) uses and disclosures that constitute a sale of protected health information. Once given, you may revoke your authorization in writing at any time except to the extent that we have taken an action in reliance on the authorization. To revoke an authorization, you or your authorized representative may contact the Privacy Officer, at:

ENT Physicians of North MS, P.A.
618 Pegram Drive, P.O. Box 2180 ● Tupelo, MS 38801
(662) 844-6513

We may use and/or disclose your medical information in accordance with federal and state laws for the following purposes.

Appointment Reminders. We may contact you to provide appointment reminders.

Treatment Information. We may contact you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Disclosure to Department of Health and Human Services. We may disclose your medical information when required by the U.S. Department of Health and Human Services as part of an investigation or determination of our compliance with relevant laws.

Family and Friends. Unless you object, we may disclose your medical information to family members, other relatives, or close personal friends when the medical information is directly relevant to that person's involvement with your care.

Notification. Unless you object, we may use or disclose your medical information to notify a family member, a personal representative, or another person responsible for your care of your location, general condition, or death.

Disaster Relief. We may disclose your medical information to a public or private entity, such as the American Red Cross, for the purpose of coordinating with that entity to assist in disaster relief efforts.

Abuse or Neglect. We may disclose your medical information when it concerns abuse, neglect or violence to you in accordance with federal and state law.

Coroners, Medical Examiners and Funeral Directors. We may disclose your medical information to a coroner, medical examiner or funeral director.

Health Oversight Activities. We may use or disclose your medical information for public health activities including the reporting of disease, injury, vital events, and the conduct of public health surveillance, investigation and/or intervention. We may disclose your medical information to a health oversight agency for oversight activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions, administrative and/or legal proceedings.

Legal Proceedings. We may disclose your medical information in the course of certain judicial or administrative proceedings.

Law Enforcement. We may disclose your medical information for law enforcement purposes or other specialized governmental functions.

Organ Donation. If you are an organ donor, we may disclose your medical information to an organ donation and procurement organization.

Research. We may use or disclose your medical information for certain research purposes if an Institutional Review Board or a privacy board has altered or waived individual authorization, the review is preparation to research or the research is only decedent's information.

Public Safety. We may use or disclose your medical information to prevent or lessen a serious threat to the health or safety of another person or to the public.

Workers' Compensation. We may disclose your medical condition as authorized by laws relating to workers' compensation or similar programs.

Business Associates. We may disclose your medical information to a business associate with whom we contract to provide services on our behalf. To protect your medical information, we require our business associates to appropriately safeguard the medical information of our patients.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

- You have the following rights with respect to your medical information:
- You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, except to an insurance company or health plan for services you have paid for in full and out of pocket, but only if we are not otherwise required by law to do so. Otherwise, if we do agree to your request for restrictions, we will abide by our agreement except in emergencies. Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.
- You have the right to receive communications from us in a confidential manner.
- Generally, you may inspect and copy your medical information. This right is subject to certain specific exceptions, and you may be charged a reasonable fee for any copies of your medical information.
- You may ask us to amend your medical information. We may deny your request for certain specific reasons. If we deny your request, we will provide you with a written explanation for the denial and information regarding further rights you may have at that point.
- You have the right to receive an accounting of the disclosures of your medical information made by ENT Physicians of North MS, P.A. during the last six years (or following April 14, 2003) except for disclosures for treatment, payment or healthcare operations, disclosures which you authorize and certain other specific disclosure types. The right to receive this information is subject to certain exceptions, restrictions and limitations.
- You may request a paper copy of this Notice of Privacy Practices.
- You have the right to complain to us and/or to the U.S. Department of Health and Human Services if you believe that we have violated your privacy rights. If you choose to file a complaint, you will not be retaliated against in any way. To complain to us, please contact:

ENT Physicians of North MS, P.A.
618 Pegram Drive
PO Box 2180
Tupelo, MS 38801

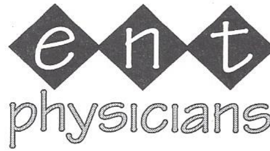
REVISION OF NOTICE OF PRIVACY PRACTICES

We reserve the right to change the terms of this Notice, at any time making any revision applicable to all the protected health information we maintain. If we revise the terms of this Notice, we will post a revised notice at ENT Physicians of North MS, P.A. and will make paper copies of the revised Notice of Privacy Practices available upon request.

If you would like further information regarding your rights or regarding the uses and disclosures of your medical information, you may contact:

ENT Physicians of North MS, P.A.
618 Pegram Drive
PO Box 2180
Tupelo, MS 38801
(662) 844-6513

THIS NOTICE IS EFFECTIVE AS OF September 23, 2013



PRIOR EXPRESS CONSENT FORM

I, ___________________, "Consumer" agree to give express consent to ENT Physicians of North Ms "Service Provider" or an Authorized Entity (as defined below) to be able to communicate with me by telephone at any number associated with me, including wireless telephone numbers, that could result in charges to me. In consideration of Service Provider or Authorized Entity providing me services and other good and valuable consideration the receipt and sufficiency of which is hereby acknowledged, Consumer expressly consents and agrees to the terms and conditions contained in this Prior Express Consent Form.

Authorized Entities: The term "Authorized Entities" shall mean the above referenced Service Provider and any related or affiliated health care provider, physician, service provider, independent contractor (including but not limited to billing services) and each of their respective successors, assigns, agents, attorneys, insurers, representatives, employees, officers, shareholders, partners, parents, subsidiaries, affiliated entities, and all agents and representatives of the previously listed persons/entities, and all corporations, persons, or entities in privity with any of the previously listed persons/entities, including any collection agency or debt collector retained or hired by any of the previously listed persons/entities, and all corporations, persons, or entities in privity with any of them. The term Authorized Entities shall also include any person or entity conducting business or providing services relating to health care at the same physical location at which the Service Provider or any of the previously listed persons/entities conducts some or all of its business, and any person or entity Consumer is referred to by Service Provider, and any person or entity who provides health care services related to the services provided by Service Provider.

Communication Consent: I understand that the purpose of this agreement is to authorize the delivery of calls to me, including, but not limited to, using an automatic telephone dialing system or an artificial or prerecorded voice, or calls to a telephone number assigned to a paging service, cellular telephone service, specialized mobile radio service, or other radio common carrier service, or any service for which I am charged for the call (hereinafter "Authorized Communications"). I also understand that my agreement to the terms of this Prior Express Consent Form is not a condition of any Authorized Entity's willingness to provide services to me. To the extent permitted by applicable law, and without limiting any other rights the Authorized Entities may have, I expressly consent and authorize the Authorized Entities to communicate with me for any reason, including reasons related to the services provided by Authorized Entities or services to be provided in the future by the Authorized Entities, including collection of amounts owed for said services, via Authorized Communications at the telephone number or numbers I provide below, or that is provided on my behalf, or any phone number that any Authorized Entity obtains or finds on its own which is not provided by me. In addition, I further expressly consent and authorize the Authorized Entities to communicate with me via SMS text messages, other forms of electronic messages, electronic mail, or other electronic communication sent or directed to me through any medium, no matter how the Authorized Entity obtain such contact information. Any Authorized Entity may communicate with me using any current or future means of communication, even if those means are not now known to the Authorized Entity or Consumer. I authorize any and all of the communication methods described in this paragraph even if I will incur a fee or a cost to receive such communications. I further promise to immediately notify the Authorized Entity if any telephone number or email address or other unique electronic identifier or mode of communication that I provided to any Authorized Entity changes or is no longer used by me. I agree that the consent and authorizations I have provided herein may be revoked only in writing addressed to the Service Provider and any Authorized Entity. Finally, I understand that the Authorized Entities have relied upon my statements contained herein and on my promise to fulfill my obligations contained herein.

I hereby consent and authorize that a photocopy of this authorization may be considered as valid as the original.

This Consent shall enure to the benefit of and be binding upon my heirs, agents, spouses, executors, administrators, successors, and assigns. I intend for all Authorized Entities to be third party beneficiaries of the consent I have provided herein.

Signed:__________________________ Print Name: ___________________________ Date_________________

My landline telephone number(s):____

My cell telephone number(s):____

DOB:_______________________