DEPENDENT-ADULT PATIENT INFORMATION SHEET

ENT & Audiology Center of Southlake

Phone: (817) 416-9731 Fax: (817) 416-9751

PATIENT

Date:	**Patient Name: (Last, First, Middle)**	DOB:	AGE:
Address:	City:	State:	Zip Code:
Home Phone:	Patient's SSN:		Sex:

Other family members treated? Yes ☐ No ☐ If Yes, Name(s) & Relationship:

Referred by PCP? Yes ☐ No ☐ **Referred by Someone other than PCP?** Yes ☐ If Yes, Name: **Not Referred** ☐

PCP Name:	Phone and Fax Numbers:	City of Practice:

RESPONSIBLE PARTIES

Permanent Residence is With: Father ☐ Mother ☐ Other ☐ Name-Relationship

Father Name: Last:	First:	Middle:	DOB:

Father's Address/Phone Same as Patient? Yes ☐ No ☐

If No: Father's Address:	City:	State:	Zip:
Home Phone:	Mobile Phone:		SSN:
Employer:	Occupation:		Work Phone#
Mother's Name: Last	First	Middle	DOB:

Address/Phone Same as Patient? ☐ Yes ☐ No

If No: Mother's Address:	City:	State:	Zip:
Home Phone:	Mobile Phone:		SSN:
Employer:	Occupation:		Emp. Phone#

PRIMARY INSURANCE

Is patient a fulltime student in secondary education on parent's insurance? Yes ☐ No ☐

Name of Insurance Company:	Id/Member #:	Group#:
Policy Holder's Name:	Policy Holder's DOB	Member/Cust. Svc. Ph #:
Referral Required by your Insurance company? Yes ☐ No ☐	If yes, did you obtain one from your PCP? Yes ☐ No ☐	

SECONDARY INSURANCE

If no secondary insurance, circle: NONE

Name of Insurance Company:	Policy Holder's Name:	Policy Holder's DOB
Id/Member #:	Group#:	Member/Cust Svc Ph #:

I hereby authorize my physician to release any information acquired in the course of my treatment to my insurance company, employer, or third party payer as required for claims filed, quality assurance, health plan administration, or complaints/grievances. I understand that the specific information to be released may include, but is not limited to history, diagnosis and/or treatment of all related illnesses including HIV virus and Acquired Immune Deficiency Syndrome (AIDS). I authorize direct payment to be made to my physician for any and all medical or surgical services rendered. I understand that if any services or charges are not covered, or if ENT & Audiology Center of Southlake is unable to verify eligibility, that I am responsible for all charges incurred for services rendered. I hereby voluntarily consent to such healthcare encompassing diagnostic procedures and treatment by my physician as may be necessary in his/her judgment. I have relied on my physician for information in this regard and acknowledge that no warranty or guarantee has been made to me as a result or cure. This form has been fully explained to me, and I certify that I understand its contents.

Signature & Relationship to Patient _____ Date _____

ENT & Audiology Center of Southlake

Michael D. Bryan, M.D.
Diplomate of the American Board of Otolaryngology
Amy K. Mettman, M.D., P.A.
Otolaryngology-Head and Neck Surgery

Patient's Name: _____ **Today's Date:** _____

Date of Birth: _____ **Male / Female**
Reason for Today's Visit:
_____

Pharmacy: Name _____**Location**_____ **Phone**_____

Primary Care Physician: _____ **Phone:** _____ **Fax:** _____

Were you referred by your PCP or another provider?

- ☐ Not referred
- ☐ Yes, PCP
- ☐ Yes, another physician. Physician: _____
  Phone: _____ Fax: _____

If you were not referred by a physician, how did you obtain our practice's name (please circle all that apply):

Internet search / Family/Friend / Phone Book / Insurance Website / Other _____

Current Medications: (include OTC and supplements)
_____
_____
_____
_____

Medical History: (for example: Bleeding disorders, Sleep apnea, Diabetes, Hypertension, High Cholesterol, Asthma)
_____
_____
_____
_____

Are you allergic to any medications?

- ☐ No
- ☐ Yes Allergic to: _____
  _____

Surgical History: (please circle any surgeries you have had, and include year if you can recall)

Ear tubes _____	Septum Repair _____	Skin Cancer _____
Ear drum repair _____	Sinus Surgery _____	Gallbladder _____
Mastoidectomy _____	Thyroid Surgery _____	Appendix _____
Tonsillectomy _____	Hysterectomy _____	
Adenoidectomy _____	C-Section _____	Orthopedic _____

Other_____
_____

Past Hospitalizations: (other than those related to surgeries listed)
_____
_____
_____

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Patient Name: _____

Family History: (for example: hearing loss, ear surgeries, thyroid disease, cancer, complications with anesthesia, bleeding disorders)

- Father: _____
- Mother: _____
- Paternal Grandfather: _____
- Paternal Grandmother: _____
- Maternal Grandfather: _____
- Maternal Grandmother: _____
- Siblings: _____
- Children: _____

Social History:

- Do you use any tobacco products?
  - □ Never
  - □ Not currently, quit ____months / yrs ago; (circle) Smokeless tobacco or cigarettes? Amount _____for _____yrs
  - □ Yes. (circle) Smokeless tobacco or cigarettes? Amount _____for _____yrs

- Marital Status: Single / Married / Divorced / Widowed / Partner
- Pets: _____
- Do you drink alcohol?
  - □ No
  - □ Yes Number of drinks per week? _____

Are you CURRENTLY experiencing any of the following?

EARS/NOSE/MOUTH/ THROAT

Hearing loss	□ none □ right □ left □ both
Ringing in ears	□ none □ right □ left □ both
Ear pain	□ none □ right □ left □ both
Ear Drainage	□ none □ right □ left □ both
Snoring	□ no □ yes_____
Nasal obstruction	□ no □ yes_____
Nosebleeds	□ no □ yes_____
Mouth sores	□ no □ yes_____
Sore tongue	□ no □ yes_____
Sore throat	□ no □ yes_____
Voice change	□ no □ yes_____
Hoarseness	□ no □ yes_____
Difficulty swallowing	□ no □ yes_____
Painful swallowing	□ no □ yes_____
Good General health	□ no □ yes_____
Easy bleeding	□ no □ yes_____
Easy bruising	□ no □ yes_____
Chest pain	□ no □ yes_____
Cough	□ no □ yes_____
Heartburn	□ no □ yes_____
Frequent Headaches	□ no □ yes_____
Weight changes	□ no □ yes_____
Vision Changes	□ no □ yes_____
Upset Stomach	□ no □ yes_____

ALLERGIC

Hay fever	□ no □ yes_____
Food allergies	□ no □ yes_____
Eye itchiness	□ no □ yes_____
Nose itchiness	□ no □ yes_____
Sneezing	□ no □ yes

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ENT & AUDIOLOGY CENTER OF SOUTHLAKE
FINANCIAL AND BILLING POLICY

Patients with Insurance: Deductibles, co-insurance, and co-payments are due at the time of service. Uncovered services are the patient's responsibility. Delays in processing due to pre-existing clauses or administrative delays become the patient's immediate responsibility. A statement will be sent if additional payment is owed after insurance processing. In accordance with Tex Admin Code 28 TAC 3.3703 (a)(28) you may be referred for non-emergency treatment to a facility that is out of network. Please ask staff if you have questions.

No-Show Fee: Failure to provide 24 hours advance notice of the cancellation of your appointment will result in a 'no-show' fee of $50 per provider appointment, which must be paid prior to rescheduling the appointment. New patients who no-show their first appointment will not be rescheduled.

Referrals: If your insurance plan requires a current referral, it is your responsibility to ensure that the referral is in this office before your visit. If you see the doctor without a referral, you will be responsible for the cost of the visit.

Minor Children: Responsibility for payment for treatment of minor children, regardless of the legal status between the parents, rests with the parent who seeks the treatment on that date of service.

Statements: Statements are sent every 30 days. After the first statement, a $5.00 charge will be assessed to each statement. These monthly late fees may be charged collectively for unpaid balances. Balances are due before further services will be provided. Failure to pay an outstanding balance may result in termination of the physician/patient relationship.

Copies of Medical Records: Texas law allows the provider to collect a $25.00 fee, with additional charges due if the records exceed 20 pages. However, we want to provide this service at a cost that simply covers the expense of record retrieval and duplication. This charge is $20.00, payable before the records are prepared. If your records are voluminous, however, this fee may be higher. Please allow a minimum of SEVEN business days to obtain copies of records. A signed authorization is required to release all records.

Completion of Additional Forms, Reports, Letters: Documents/forms that require the physician's input and attestation, such as FMLA, disability papers, letters to attorneys, etc., require a prepayment of $20.00 for each set of forms. The fee is due upon submission of the forms to the physician, and prior to their preparation. Such forms require a minimum of TEN business days for completion.

Surgical Deposit: NOTE: Credit card payments made over the phone are charged a 5% non-refundable fee**.** Based upon your insurance benefits, a deposit may be due prior to surgery. The deposit amount is based on the anticipated surgical procedures, and is only an estimate. The fee is due seven days before the procedure, or the procedure may be rescheduled. You may receive an additional bill from this office after the claim is processed. Our physicians may refer you to a facility where they have a financial interest. You have the option, at your discretion and without repercussions, to choose another facility for your procedure, assuming your specific medical needs can be met at another facility. Dr. Bryan has an interest in Texas Pediatric Surgery Center, Harris Methodist Southlake, and Forest Park Medical Center. Dr. Mettman has a financial interest in Harris Methodist Southlake and Forest Park Medical Center. Staff members can provide you with names of appropriate alternative facilities for your procedure.

Returned Checks: There is a $30.00 fee for each returned check. Unpaid checks will be prosecuted.

Collections: An unpaid account may be turned over to a third party collection agency that will report the information to all three major credit reporting agencies. All collection expenses and taxes, and all accrued statement fees will be added to the account balance when it is transferred to an outside collection agency.

Refunds: Refunds for deposits made with a credit card on an electively cancelled surgery/procedure will be issued by check , less a 5% processing fee from the refunded amount. Refunds for services delivered are made only after your insurance company has fully processed the claim. Refund checks will be issued to the party who paid the overage (payer), not necessarily the guarantor on the account, unless written instructions from the original payer are received before the refund check is issued.

Complaints: Billing complaints may be made to the practice manager, preferably in writing, who will make every attempt to promptly resolve the issue in accordance with the policies stated herein.

I have reviewed these policies and agree to the terms as stated above. A copy is available upon my request.

_____	_____	_____
Print Patient Name	Signature of Responsible Party	Date

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ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS

By signing below, you acknowledge that you have received this *Notice of Privacy Practices* prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

_____

_____

_____

_____

_____

Patient Name: _____
(Please Print Name)

Patient Date of Birth: _____

SIGNATURES:

Patient/Legal Representative: _____ Date:_____

If Legal Representative, relationship to the patient: _____

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Consent and Authorization

I hereby authorize my physician, _____, to release any information acquired in the course of my treatment to my insurance company, employer, or third party payer as required for claims filed, quality assurance, health plan administration, or complaints/grievances. I understand that the specific information to be released may include, but is not limited to history, diagnosis and/or treatment of all related illnesses including HIV virus and Acquired Immune Deficiency Syndrome (AIDS).

I authorize direct payment to be made to my physician for any and all medical or surgical services rendered. I understand that if any services or charges are not covered, or if the office is unable to verify eligibility, that I am responsible for all charges incurred for services rendered.

I hereby voluntarily consent to such healthcare encompassing diagnostic procedures and treatment by my physician as may be necessary in his/her judgment. Specialized procedures may require an additional consent form. I have relied on my physician for information in this regard and acknowledge that no warranty or guarantee has been made to me as a result or cure. This form has been fully explained to me, and I certify that I understand its contents.

This consent is valid for each visit I make to ENT & Audiology Center of Southlake unless revoked by me in writing.

I am over the age of 18 years and therefore have the legal right to consent to this treatment.

Patient Signature: _____ Date:_____

If patient is a Minor (under age 18, unmarried, not financially independent, not in the armed forces on active duty), parent or legal guardian MUST SIGN BEFORE patient is examined.

Patient's Name: _____ Date: _____

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CONSENT TO DISCLOSE PROTECTED HEALTHCARE INFORMATION

Patient Name: _____

Date of Birth: _____

I, _____, give my consent for the physicians and staff at Southlake ENT to disclose my private healthcare information to the following people. This consent will be valid until revoked in writing by the patient.

Name: _____

Relationship to Patient: _____

Telephone: _____

Name: _____

Relationship to Patient: _____

Telephone: _____

Name: _____

Relationship to Patient: _____

Telephone: _____

_____ _____
Patient Signature Date

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