PEDIATRIC PATIENT INFORMATION SHEET
ENT & AUDIOLOGY CENTER OF SOUTHLAKE
PHONE: (817) 416-9731 FAX: (817) 416-9751

PATIENT

PATIENT NAME (LAST, FIRST, MIDDLE)		DOB:	AGE:	SEX:
ADDRESS:	APT#:	CITY:		ZIP:
HOME PHONE:	CELL PHONE:	EMAIL:		
ANY OTHER FAMILY MEMBERS TREATED WITH US? ❒ YES ❒ NO IF YES, WHO? _____	WERE YOU REFERRED? ❒ NO ❒ YES, BY MY PCP ❒ YES, BY ANOTHER PHYSICIAN IF ANOTHR PHYSICIAN, WHO?			
PRIMARY CARE PHYSICIAN:	CITY:	PHONE:		
PHARMACY:	LOCATION:	PHONE:		

PARENT/GUARDIAN

PATIENT LIVES WITH: ❒ FATHER ❒ MOTHER ❒ OTHER NAME AND RELATIONSHIP, IF OTHER:		
FATHER 'S NAME (LAST, FIRST, MIDDLE):		DOB:
IS THE FATHER'S ADDRESS THE SAME AS THE PATIENT? Yes ☐ No ☐		
IF NO, FATHER'S ADDRESS:	CITY, STATE:	ZIP:
HOME PHONE:	MOBILE:	SSN:
EMPLOYER:	OCCUPATION:	WORK PHONE:
MOTHER'S NAME (LAST, FIRST, MIDDLE):		DOB:
IS THE MOTHER'S ADDRESS THE SAME AS THE PATIENT? Yes ☐ No ☐		
IF NO, MOTHER'S ADDRESS:	CITY, STATE:	ZIP:
HOME PHONE:	MOBILE:	SSN:
EMPLOYER:	OCCUPATION:	WORK PHONE:

INSURANCE

PRIMARY INSURANCE CO.:	ID/MEMBER#:	GROUP#:
POLICY HOLDER'S NAME:	DOB:	
DO YOU HAVE SECONDARY INSURANCE? YES / NO		
SECONDARY INSURANCE CO.:	ID/MEMBER#:	GROUP#:
POLICY HOLDER'S NAME:	DOB:	

I hereby authorize my treating 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 treating 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 the physicians at ENT & Audiology Center of Southlake as may be necessary in their 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. The foregoing consents remain in effect until retracted by written notice.

_____ _____
NAME OF PERSON COMPLETING FORM RELATIONSHIP TO PATIENT

_____ _____
SIGNATURE DATE

Revised 06/2017

ENT & Audiology Center of Southlake

Pediatric Medical History Form

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

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

Primary Care Physician: _____ Referring Physician: _____

Your relationship to the patient: ___Parent ___ Legal Guardian ___ Other_____

Current Medical Concern(s)

What is the reason for today's visit/current medical concerns?

_____

_____

How long has this problem existed? _____

Have you consulted any other providers about this problem? Yes / No

If yes, please give name of provider and date of consultation(s).

_____

_____

Current Living/Household Status

Does anyone in the household smoke? Yes / No

Does your child attend school? Yes / No If yes, what grade_____

Does your child attend daycare? Yes / No If yes, how many days/wk _____

Any pets in the home? Yes / No List: _____

List all people who live with the patient: _____

_____

Birth History

Name and City of Birth Hospital _____

Did your child pass their newborn hearing screening test? ____Yes ____No ____Unknown

___ Full Term ___ Premature How many weeks premature? _____

Did your child ever stay in the NICU? Yes / No If yes, how long? _____

Has your child ever required a breathing tube? Yes / No If yes, how long? _____

Any other significant birth history info: _____

Medication History

Does your child have any medication allergies? Yes / No:

If yes, list medication (s) and date and type of reaction: _____

_____

_____

Currently taking any medications? Yes / No

If yes, what medications? Include over the counter and all prescriptions:

Pharmacy_____ **Location**_____ **Phone#**_____

Patient Name: _____ Date: _____

Past Medical History

Does your child have, or ever had, any of the following?

Allergies	Yes / No	Diagnosed by Allergist	Yes / No
Asthma or breathing problems	Yes / No	Anesthesia Difficulties	Yes / No
Bleeding Disorders	Yes / No	Cancer	Yes / No
Diabetes or Endocrine Problems	Yes / No	Gastrointestinal Disorders	Yes / No
Hearing Problems	Yes / No	Heart Problems	Yes / No
Immunization Up to Date	Yes / No	Seizure Disorder	Yes/ No
Neurological Disorder	Yes / No	Syndrome	Yes / No
Other	Yes / No		

Please Describe all Yes Answers, and explain if immunizations are not up to date:

_____
_____
_____
_____
_____

Past Surgical History

Please list all surgical procedures your child has had. If none, state "None."

Procedure	Date	Surgeon/Location

Family History

Does any direct relative in the child's family have a history of any of the following?

Anesthesia Difficulties	Yes / No	Bleeding Disorders	Yes / No
Ear Surgery	Yes / No	Head or Neck Cancer	Yes / No
Hearing Loss	Yes / No	Other	Yes / No

If you answered yes, what is family relationship to your child and what is the history?

_____
_____
_____

Name of Person Completing Form _____ Signature_____

ENT & AUDIOLOGY CENTER OF SOUTHLAKE
FINANCIAL AND BILLING POLICY

Patients with Insurance: Deductibles, co-insurance, and co-pays 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.

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 with a $5.00 charge assessed to each statement after the first statement. These monthly late fees may be charged collectively for unpaid balances. Balances are due before further services will be provided. Payments are applied to the oldest balances. Failure to pay an outstanding balance may result in termination of the physician/patient relationship.

Medical Record Copies: 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. Electronic copies are available for $20/set records if faxed (less than 30 pp only); $25 for set of records if copied to CD. There is a $10.00 fee for mailing 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 3% 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 Methodist Southlake Hospital. Dr. Mettman has a financial interest in Harris Methodist Southlake and Methodist Southlake Hospital. We can provide you with names of appropriate alternative facilities for your procedure.

Returned Checks: There is a $40.00 fee for each returned check. Unpaid checks will be prosecuted with the DA.

Stop Payment Fees: If you lose a refund check from Dr. Bryan or Dr. Mettman, a stop payment fee of $45.00 will be subtracted from the replacement check.

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 or payments made with a credit card on an electively cancelled surgery/procedure/hearing aid will be issued by check, less a 3% 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

ENT & Audiology Center of Southlake

Notice of Privacy Practices Signature Page

VII. 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. This notice, in its entirety, may be viewed on our website or in our office.
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: _____

660 W. Southlake Blvd, # 100
Southlake, TX 76092

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Fax: 817-416-9751

ENT & Audiology Center of Southlake

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 by the patient.

Name: _____ Name: _____

Relationship to Patient: _____ Relationship to Patient: _____

Telephone: _____ Telephone: _____

Name: _____ Name: _____

Relationship to Patient: _____ Relationship to Patient: _____

Telephone: _____ Telephone: _____

You may leave messages regarding protected health information at the following numbers:

Home: Yes ☐ No ☐ Type of accepted message: Brief ☐ Detailed ☐ Number: _____
Cell: Yes ☐ No ☐ Type of accepted message: Brief ☐ Detailed ☐ Number: _____
Work: Yes ☐ No ☐ Type of accepted message: Brief ☐ Detailed ☐ Number: _____

E-mail: Yes ☐ No ☐ Confirm e-mail address: _____

Messages regarding appointments will be left at all available numbers unless expressly excluded on this consent.

_____ _____
Patient/Parent/Guardian signature Date

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