

**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? <input type="checkbox"/> YES <input type="checkbox"/> NO		WERE YOU REFERRED? <input type="checkbox"/> NO <input type="checkbox"/> YES, BY MY PCP <input type="checkbox"/> YES, BY ANOTHER PHYSICIAN			
	IF YES, WHO?		IF ANOTHR PHYSICIAN, WHO?			
	PRIMARY CARE PHYSICIAN:		CITY:	PHONE:		
PHARMACY:		LOCATION:	PHONE:			
PARENT/GUARDIAN	PATIENT LIVES WITH: <input type="checkbox"/> FATHER <input type="checkbox"/> MOTHER <input type="checkbox"/> OTHER      NAME AND RELATIONSHIP, IF OTHER:					
	FATHER 'S NAME (LAST, FIRST, MIDDLE):			DOB:		
	IS THE FATHER'S ADDRESS THE SAME AS THE PATIENT?    Yes <input type="checkbox"/> No <input type="checkbox"/>					
	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 <input type="checkbox"/> No <input type="checkbox"/>					
	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:			
	<b><u>DO YOU HAVE SECONDARY INSURANCE?</u>      YES / NO</b>					
	SECONDARY INSURANCE CO.:		ID/MEMBER#:	GROUP#:		
	POLICY HOLDER'S NAME:		DOB:			

I hereby voluntarily consent to such healthcare encompassing diagnostic procedures and treatment by the providers at ENT & Audiology Center of Southlake as may be necessary in their judgment. I have relied on my provider 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

**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 processes.

**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 a minor, 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 exceed 40 pages, however, this fee may be higher. 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; \$25 for a 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. A collection fee (\$25 for balances less than \$75, and \$50 for balances over \$75) and all accrued statement fees will be added to the account balance when the account 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 (2020)

**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: \_\_\_\_\_



# 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

Revised 06/2017

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



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