NEW PATIENT PACKET

Date:_____

Patient Name:_____ DOB:_____ Sex: (circle one) Male Female

Social Security No:_____ Marital Status: (circle one) Single Married Divorced Widowed

Address:_____

City:_____ State:_____ Zip:_____

Northern Address (If applicable):_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Email Address:_____

Employer:_____

Were you referred to our office? YES NO If Yes, by whom?_____

Primary Care Physician:_____

Pharmacy:_____ Phone No:_____

Preferred Language:_____ Race:_____ Ethnicity:_____

INSURANCE POLICY	**INSURANCE POLICY HOLDER INFORMATION**
INS COMPANY:	NAME:
ID NO:	DOB:
GROUP NO:	SOCIAL SEC NO:
ARE YOU THE PRIMARY ON PLAN? YES NO	PHONE NO:
(IF NO- PLEASE FILL OUT POLICY HOLDER INFO)	RELATIONSHIP TO PATIENT:

Insurance Information: I acknowledge that the physicians of Cape Coral ENT may not be a part of the provider network for my insurance plan. I understand it is my responsibility to verify this information with my insurance company.

In order to keep our charges as low as possible, we expect payment for services, deductible, co-insurance and co-pay at the time of service unless arrangements have been made in advance with the business manager.
I will pay my services today by: (circle one) Check Cash Credit Card

I hereby authorize the physicians of CCENT to furnish the necessary information concerning my illness and treatment to my insurance company, and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependants. I understand I am responsible for any amount not covered by my insurance.

Signature:_____Date:_____

HEALTH HISTORY

Welcome to our practice. As a new patient, please fill out the information below to the best of your ability.

Patient Name:_____DOB:_____ AGE:_____

Height:_____ Weight:_____

History of Present Illness:

Chief Complaint:_____

Location:_____ Symptoms:_____
(Where is the pain/problem)

Past Medical History:

Cardiac:
____ High Blood Pressure
____ Heart Attack
____ Pacemaker or Defibrillator
____ Heart Surgery
____ Other (specify) _____

Respiratory:
____ Asthma/Wheezing
____ Lung Cancer
____ COPD
____ Tuberculosis

Eyes:
____ Glaucoma
____ Other (specify)_____

Urinary:
____ Kidney Problems
____ Other (specify)_____

Neurological:
____ Headache/Migraine
____ Dizzy/Vertigo
____ Stroke
____ Neuralgia/Shingles
____ Seizures

Gastrointestinal:
____ Acid Reflux
____ Hiatal Hernia
____ Stomach Ulcer
____ Liver Problems
____ Other (specify)_____

Blood:
____ Hepatitis
____ HIV/AIDS
____ Bleeding Problems
____ Blood Thinners
____ Other (specify)_____

Endocrine:
____ Thyroid
____ Diabetes
____ Pituitary

Cancer:
____ Specify:_____

Other:_____

Past Surgeries:_____

Medications:_____
_____

Allergies:_____

Patient Social History:
Use of alcohol: ____ Never ____Rarely ____ Moderately ____ Daily
Use of tobacco: ____Never ____Former Smoker ____Current Daily Smoker (How many packs/day_____)

Family History: (Mother/Father/Sibling)_____
_____

FINANCIAL RESPONSIBILITY

A **deductible** is a specified portion of your bill that a patient must pay before an insurance company will pay the claim. While generally a co-payment is required for some insurance plans for an office visit, some services and all procedures performed in the office will require the patient to meet the deductible before any benefits will be paid by insurance. If your deductible has not been met, you will be responsible for full or partial payment, depending on your insurance contract. Procedures performed in the office may be considered the same as surgery by your insurance and are billed as such. It is your responsibility to understand your insurance contract and what they will cover for you.

Additionally, your office visit today may include the use of the following for diagnostic purposes: Ear wax removal, Mastoid debridement, Fiberoptic nasal or throat examination with a scope, biopsy, or office surgery. These procedures may be considered as a SURGICAL PROCEDURE to your insurance company. Depending on your particular policy, your insurance company will pay all, part, or none of the costs. **It is your responsibility to be aware of the terms and conditions of your policy prior to procedures being performed**. Any charges not covered by the insurance carrier will be the responsibility of the patient.

YOU HAVE THE RIGHT TO REFUSE THIS DIAGNOSTIC PROCEDURE. By signing this consent form, you are acknowledging these terms.

Signature:_____Date:_____

APPOINTMENT CANCELLATION POLICY

As a courtesy, we agree to confirm your appointment the day before your scheduled appointment. You will at that time have the opportunity to confirm or cancel the scheduled appointment. If you have scheduled your appointment within 24 hours, you will not receive a confirmation call.

Please call us at 239-574-4600 by 4:00 p.m. on the day prior to your scheduled appointment to notify us of any changes or cancellations. If prior notification is not given, and results in a NO SHOW to your appointment, **YOU WILL BE CHARGED $40 for the missed appointment**. After three (3) NO SHOW appointments, you will be dismissed from the practice. There is also a NO SHOW policy for office surgeries, hearing tests, and scoping procedures in the office, resulting in a charge of $80. Please call our office 24 hours in advance of scheduled appointment to avoid being charged.

I hereby acknowledge that I am aware and accept the financial responsibility for fees assessed to my account for failing to provide the required cancellation notice of any scheduled appointments at CCENT. I understand that this fee is not reimbursable by my insurance carrier.

Signature:_____Date:_____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

_____

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature:_____Date:_____

Witness:_____Date:_____