VERO ENT ASSOCIATES

Date: _____

LEGAL Name : _____ Soc. Sec. # _____

Date of Birth: _____ Age: _____ Sex: _____ Marital Status: _____

E-mail Address: _____

Spouse or Parent/Guardian: _____

Mailing Address: _____ City: _____ State:____ Zip: _____

Seasonal Address: _____City: _____ State: ____ Zip: _____

Home Telephone: _____ Cell Telephone: _____

Employer: _____ Employer Telephone: _____

How did you hear about us? ___ Friend / Other Referral ___ Dr. Referral ___ Press Journal ___ FL Healthcare News
___ Internet ___ Phonebook ___ Radio Other: _____

Friend or relative <u>not living with you</u> that we may contact in case of emergency (REQUIRED):

Name: _____ Telephone: _____

Referring Physician : _____ City: _____ State:_____

Regular Physician : _____ City: _____ State: _____

Pharmacy: _____ Pharmacy Street Location: _____

WE WILL NEED TO COPY ALL OF YOUR CURRENT INSURANCE CARDS AND DRIVER'S LICENSE / ID FOR OUR RECORDS

<u>Policy Holder's Insurance Information is REQUIRED to file to Insurance</u>

Primary Insurance Company

Insurance Co Name: _____ ID # : _____

Secondary Insurance Company

Insurance Co Name: _____ ID # : _____

Please note that this office is compliant and regulated by the Board of Medicine Rule Chapter 64B8-9.009, F.A.C. Effective February 17, 2000

FINANCIAL POLICIES

The best medical care can be provided only on the basis of mutual understanding.
We encourage you to contact our billing office with any questions regarding filing of insurance and your financial obligation to Drs. Baggett, Yoon, Livingston.
Please be advised that this is not an all-inclusive list.

Please initial by each paragraph below indicating that you have read and agree to each.

***Initial*_____** If we participate with your insurance, we are contractually obligated to collect any deductible, coinsurance and / or co-pay at the time of service.

***Initial*_____** All doctors are participating providers for MEDICARE, CIGNA, CHAMPUS / TRICARE, BLUE CROSS / BLUE SHIELD (except HMO), BEECHSTREET COMPANIES, UNITED HEALTHCARE, SOUTHCARE PPO, ECN, and EMI and CMS Network. If you have insurance coverage that is different from these companies, we will file your insurance once as a courtesy, however, if they do not pay within 30 days, any balance due will be your responsibility. **If you have a co-pay stated on your insurance card, we will collect that at the time of your visit.**

***Initial*_____** I authorize release of information concerning healthcare, advice, treatment to my insurance company(s), other physicians' offices where I am a patient, a physician's office that I am being referred to or to a surgical facility in preparation for surgery.

***Initial*_____** I understand that it is my responsibility to notify the office if my medical or medication information changes.

I, the undersigned, authorize payment of medical benefits for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I agree to be responsible for any legal fees and / or court costs incurred as a result of my failure to pay for services rendered.

Please print Patient's name : _____ Date: _____

Patient's or Parent/Guardian signature:_____

MEDICAL AND SURGICAL HISTORY

Please help us serve you better by completing your medical history before you see the Doctor.
Your medical record is strictly confidential.

Name :_____ Date: _____

Date of Birth:_____ Age: _____ Height:_____ Weight:_____

Language: (please circle) English Spanish Other: _____

Race: (please circle) White/Caucasian American Indian Asian Black Native Hawaiian Unknown

Ethnicity: (please circle) Hispanic Origin Non-Hispanic Origin Unknown

Reason you are seeing the doctor today: _____

How long have you had this problem:_____

How many times have you been treated for this problem in the past year?_____

What medications or tests have you received for this problem in the past?_____
_____

Medical Information

Allergic to any medications? No_____ Yes_____ If yes, please indicate:_____
_____

List medications you are taking now:_____
_____

Do you take aspirin? No_____ Yes_____ How often?_____

List any food or environmental allergies you may have:_____
_____

List all previous medical problems:_____
_____
_____

List all previous surgeries:_____
_____
_____

Social History

Do you smoke tobacco? Never___ Past ___ Present ___ Heavy Smoker ___ Light Smoker ____
Average packs per day ____ Approx start date? _____ Approx quit date? _____
Do you use chewing tobacco or smoke cigars? No _____Yes _____ Amount per day? _____
Do you drink alcohol?_____ Amount per day?_____

Family History

Please list any illnesses which run in your family. Please indicate which family member for each illness
_____
_____

PLEASE CHECK "*YES*" TO CONDITIONS YOU ARE CURRENTLY EXPERIENCING

GENERAL YES
1. Fever ☐
2. Chills ☐
3. Weight loss ☐
4. Night sweats ☐
5. Other_____

EARS YES
1. Hearing loss - gradual ☐
2. Hearing loss - sudden ☐
3. Pain ☐
4. Ringing ☐
5. Dizziness or vertigo ☐
6. Frequent infections ☐
7. Other_____

NOSE YES
1. Nose bleeds ☐
2. Injury ☐
3. Congestion ☐
4. Runny nose ☐
5. Mouth breather ☐
6. Other_____

THROAT YES
1. Frequent sore throats ☐
2. Difficulty swallowing ☐
3. Hoarseness ☐
4. Foreign body ☐
5. Thyroid problems ☐
6. Swollen tonsils ☐
7. Other_____

EYES YES
1. Cataracts ☐
2. Glaucoma ☐
3. Distorted vision ☐
4. Other_____

HEART YES
1. High blood pressure ☐
2. Chest pain ☐
3. Irregular heart beat ☐
4. Previous heart attack ☐
5. Other_____

LUNGS YES
1. Bronchitis/chronic cough ☐
2. Asthma/wheezing ☐
3. Congestion ☐
4. Other_____
5.

ALLERGY/ IMMUNE YES
1. Seasonal allergies ☐
2. Itchy eyes ☐
3. Runny Nose ☐
4. Allergy testing in past ☐
5. HIV or AIDS ☐

GASTROINTESTINAL YES
1. Indigestion or Heartburn ☐
2. Ulcers ☐
3. Diarrhea ☐
4. Diverticulitis ☐
5. Gall bladder trouble ☐
6. Nausea & vomiting ☐
7. Other_____

URINARY TRACT YES
1. Kidney problems ☐
2. Painful urination ☐
3. Bloody urination ☐
4. Prostate problems (men) ☐
5. Other_____

MUSCULOSKELETAL YES
1. Back pain ☐
2. Weakness of limbs ☐
3. Arthritis ☐
4. Other_____

NEURO/PYSCH YES
1. Numbness ☐
2. Migraine headaches ☐
3. Seizures ☐
4. Convulsions ☐
5. Stroke ☐
6. Depression ☐
7. Other_____

ENDOCRINE YES
1. Thyroid disorders ☐
2. Diabetes ☐
3. Menopause (women) ☐
4. Hormonal replacement ☐
5. Pregnant (women) ☐

BLOOD DISORDERS YES
1. Low blood counts ☐
2. Free bleeding ☐
3. Blood clots ☐
4. Blood disorders ☐
5. Hepatitis ☐
6. Other_____

Patient Name _____ Date _____

Patient Signature _____

Vero ENT Associates

Board Certified Otolaryngology
Head & Neck Surgery

Drs. Baggett, Yoon & Livingston Office Policies and Patient Responsibilities

If you are more than 20 minutes late for your appointment, you may be asked to reschedule.

Minors will not be seen without an accompanying parent or legal guardian, or a written notarized permission by the parent or legal guardian to see the patient.

Nursing home residents who have an assigned Power of Attorney (POA) will not be seen unless accompanied by their POA, or we get a written signed permission to see the patient and perform any necessary procedures.

Please notify the front desk receptionist of any change of address, phone number or insurance.

Medical records will be released within 10 business days or receipt of a signed, written request. One copy will be free of change. Any additional copies requested will be charged a fee per page.

Charge for returned checks is $50.

We understand your time is just as valuable as ours, and we do our best to stay on time. However, sometimes patient visits and surgical procedures take longer than expected which may result in some delays. We ask for your patience and understanding.

Circumstances under which a patient will be dismissed:

1. Failure to comply with Drs. Baggett, Yoon or Livingston's instructions.
2. Being disrespectful, or impolite to the doctor or staff.
3. Suboptimal patient-doctor relationship.
4. Failure to keep scheduled appointment of failure to cancel/reschedule one day (twenty four hours) prior to the appointment. Two violations will be tolerated prior to dismissal.
5. Overdue balance on account greater than 180 days.

Patient Signature:_____

Vero ENT Associates

Board Certified Otolaryngology
Head & Neck Surgery

NAME:_____ **Soc. Sec. #**_____

Date of Birth:_____ **Sex:**_____

Medicare Patients Only

I request that payment of authorized Medicare benefits be made on my behalf to Vero ENT Associates for any services rendered to me. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine if these benefits are payable for related services. The Medicare providers Dr. Kathleen Baggett, Dr. Alex Yoon, Dr. Jeffrey Livingston, Dr. Alfred Filosa and Dr. Alexis Riley agree to accept the charge determination of Medicare as the full charge and the patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Signed:_____ **Date:**_____

PATIENT PRIVACY QUESTIONAIRE
HIPAA ACKNOWLEDGEMENT
PRESCRIPTION MEDICATION REQUEST CONSENT

Name: _____ Date: _____

You may be contacted by us to remind you of appointments or discuss healthcare treatment options, results, or other health-related matters.

Please list any preferred phone numbers:

Home: _____ Cell: _____

Work: _____ Other: _____

Can we leave a message at the above numbers? ____ Yes ____ No

Are there any restrictions with regard to our office contacting you with medical information?

_____

_____

Would you like to authorize an individual(s) as your personal representative? This person would have the authority to schedule, confirm or change appointments only. ____ Yes ____ No ____ N/A

If yes, please list full names:

_____ _____

I agree that my prescription medication history may be requested from other healthcare providers or third party pharmacy benefit payors and used for treatment purposes.

_____ _____

Patient or Personal Representative Signature Date

Vero ENT Associates has offered me a copy of my rights as a patient under the HIPAA act. I have been provided the opportunity to read and understand my rights and ask questions regarding my rights and receive answers to my satisfaction.

_____ _____

Patient or Personal Representative Signature Date

VERO ENT ASSOCIATES
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act (HIPAA; "Act") of 1996, revised in 2013, requires us as your health care provider to maintain the privacy of your protected health information, to provide you with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We are required to maintain these records of your health care and to maintain confidentiality of these records.

The Act also allows us to use your information for treatment, payment, and certain health operations unless otherwise prohibited by law and without your authorization.

- Treatment: We may disclose your protected health information to you and to our staff or to other health care providers in order to get you the care you need. This includes information that may go to the pharmacy to get your prescription filled, to a diagnostic center to assist with your diagnosis, or to the hospital should you need to be admitted. If necessary to ensure that you get this care, we may also discuss the minimum necessary with friends or family members involved in your care unless you request otherwise.
- Payment: We may send information to you or to your health plan in order to receive payment for the service or item we delivered. We may discuss the minimum necessary with friends or family members involved in your payment unless you request otherwise.
- Health operations: We are allowed to use or disclose your protected health information to train new health care workers, to evaluate the health care delivered, to improve our business development, or for other internal needs.
- We are required to disclose information as required by law, such as public health regulations, health care oversight activities, certain law suits and law enforcement.

Certain ways that your protected health information could be used disclosed require an authorization from you: disclosure of psychotherapy notes, use or disclosure of your information for marketing, disclosures or uses that constitute a sale of protected health information, and any uses or disclosures not described in this NPP. We cannot disclose your protected health information to your employer or to your school without your authorization unless required by law. You will receive a copy of your authorization and may revoke the authorization in writing. We will honor that revocation beginning the date we receive the written signed revocation.

You have several rights concerning your protected health information. When you wish to use one of these rights, please inform our office so that we may give you the correct form for documenting your request.

- You have the right to access your records and/or to receive a copy of your records, with the exception of psychotherapy notes. Your request must be in writing, and we must verify your identity before allowing the requested access. We are required to allow the access or provide the copy within 30 days of your request. We may provide the copy to you or to your designee in an electronic format acceptable to you or as a hard copy. We may charge you our cost for making and providing the copy. If your request is denied, you may request a review of this denial by a licensed health care provider.
- You have the right to request restrictions on how your protected health information is used for treatment, payment, and health operations. For example, you may request that a certain friend or family member not have access to this information. We are not required to agree to this request, but if we agree to your request, we are obligated to fulfill the request, except in an emergency

where this restriction might interfere with your care. We may terminate these restrictions if necessary to fulfill treatment and payment.

- We are required to grant your request for restriction if the requested restriction applies only to information that would be submitted to a health plan for payment for a health care service or item for which you have paid in full out-of-pocket, and if the restriction is not otherwise forbidden by law. For example, we are required to submit information to federal health plans and managed care organizations even if you request a restriction. We must have your restriction documented prior to initiating the service. Some exceptions may apply, so ask for a form to request the restriction and to get additional information. We are not required to inform other covered entities of this request, but we are not allowed to use or disclose information that has been restricted to business associates that may disclose the information to the health plan.
- You have the right to request confidential communications. For example, you may prefer that we call your cell phone number rather than your home phone. These requests must be in writing, may be revoked in writing, and must give us an effective means of communication for us to comply. If the alternate means of communications incurs additional cost, that cost will be passed on to you.
- Your medical records are legal documents that provide crucial information regarding your care. You have the right to request an amendment to your medical records, but you must make this request in writing and understand that we are not required to grant this request.
- You have the right to an accounting of disclosures. This will tell you how we have used or disclosed your protected health information. We are required to inform you of a breach that may have affected your protected health information.
- You have the right to receive a copy of this notice, either electronic or paper or both.
- You have the right to opt out of fund raising communications.

If you have any questions about our privacy practices, please contact our Privacy Officer at the number below.

You have the right to file a complaint with us or with the Office for Civil Rights. We will not discriminate or retaliate in any way for this action. To file a complaint, please contact the applicable party:

Suzette Nolen - Privacy Officer

Phone number: 772-563-0015

Fax number: 772-770-0799

Office for Civil Rights
http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

We are required to abide by the policies stated in this Notice of Privacy Practices, which became

effective on September 23, 2013.