Patient Information

Date: 9/23/19 Home Phone: _____ Cell Phone: _____

Last Name: _____First: _____ Middle In: _____
Sex: ☐ M or ☐ F

Age: _____ Date of Birth: _____ SSN (required unless under 18): _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Race: _____ Language: _____ Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Minor ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐

Full Time Student ☐ Part Time Student ☐

May we contact you by email? Yes ☐ No ☐

E-mail Address: _____

How were you referred? Internet ☐ Another Patient ☐ Other _____

Physician ☐ Dr:_____

Primary Care Physician: _____

Employment Information

Retired: ☐

Employed By: _____ Phone Number: _____

If Married: (Required if policy holder for insurance) Spouse's Name: _____

Employed By: _____ Phone Number: _____

Birth Date: _____ Social Security #: _____

If Patient is a minor: (Required) Father's Name: _____

Employed By: _____ Phone Number: _____

Birth Date: _____ Social Security #: _____

If Patient is a minor: (Required) Mother's Name: _____

Employed By: _____ Phone Number: _____

Birth Date: _____ Social Security #: _____

In case of an emergency, who should we notify?

Name: _____ Relationship: _____ Phone Number: _____

Insurance Information

Do you have medical insurance? Yes ☐ No ☐

Insurance Company Name: _____

Policy Holder Name: _____ ID#: _____ Group #: _____

If you have Medicare, please read and sign below:

I request that payment of authorized Medicare benefits be made on my behalf to South Lake Hearing and Tinnitus Center for any services furnished to me by their physician(s). I authorize any holder of medical information about me to be released to the HCFA and it's agents if any information is needed to determine these benefits or the benefits payable fore related services. I understand y signature request that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 pf the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and deductible are based upon the charge determination of the Medicare carrier.

Medicare Policy Holder Signature _____ Date: _____

ALL PATIENTS:

FINANCIAL ARRANGEMENTS & BILLING POLICIES

For your convenience, we will be happy to file your insurance when provided with the proper information. Deductibles, co-payments, co-insurance and non-covered services/products are to be paid in full at the time services are rendered, unless otherwise arranged.

A list of the insurance plans we participate with is posted by the reception desk. Also, please keep in mind that the co-pay listed on the card may only apply to primary care doctors. In many cases, benefits for specialist office visits and/or services are subject to a deductible. It is ultimately your responsibility to know your network providers and benefits. You are also responsible for procuring a referral from your PCP if required by your plan. (If you are unsure if your plan requires a referral, please contact your insurance carrier as a lack of referral may result in denial of your claim and you will be responsible for the entire amount).

*** Please let us know immediately, if there has been a change in your name, address, phone number, as well as any changes in your insurance coverage. Per North Carolina law, providers have 90 days in which to file a claim. Delays in informing us of coverage charges could result in denial of your claim and you will be responsible for the charges incurred.

Our policy requires that all balances be paid in full within 30 days of treatment. All returned checks are subject to a $20.00 charge.

Patient dismissal and what it means: Our practice reserves the right to dismiss a patient at any time and usually occurs when there are outstanding balances, patient/family are verbally abusive towards staff, patient is continually seeking narcotics, or any other issue that the MD sees fit. A dismissed patient will no longer be able to receive services from any provider at our practice. This included office visits, prescription refills, RX samples, or medical advice. A 30 day notice would be given for patient to find another physician.

Patient/Guardian's Signature:_____ Date: _____

South Lake Hearing and Tinnitus Center Medical History

Patient Name: _____ **Date of Birth:** _____

Past Medical History: Have you ever had the following? (Check "Yes" or "No", Leave blank if uncertain)

	Yes	No
Eye trouble (other than glasses)	☐	☐
Hypertension	☐	☐
Heart Disease	☐	☐
Stroke	☐	☐
Gastrointestinal	☐	☐
Diabetes	☐	☐
Thyroid Disease	☐	☐
Hepatitis	☐	☐
HIV/AIDS	☐	☐
Neurological	☐	☐
Muscular/Skeletal	☐	☐

	Yes	No
Trouble with Ears or Nose	☐	☐
Blood or Plasma Transfusion	☐	☐
Bleeding Tendency	☐	☐
Respiratory	☐	☐
Prostate Disorder	☐	☐
Kidney Disease	☐	☐
Mitral Valve Prolapse	☐	☐
Cancer	☐	☐
Anemia	☐	☐
Allergic/Immunologic	☐	☐
Trouble with Mouth or Throat	☐	☐

Any other disease, please list: _____

Past Surgical History	**When**	**Hospital**

Physician History: Please list doctors seen in the last 5 years

Doctor: _____ City/State: _____
Doctor: _____ City/State: _____
Doctor: _____ City/State: _____

Patient Social History

Use of Tobacco? Never ☐ Daily ☐ Packs per day_____ How long? _____ years
Use of Alcohol? Never ☐ Rarely ☐ Moderate ☐ Daily ☐
# of drinks per day? _____
Use of Drugs? Type: _____
Never ☐ Rarely ☐ Moderate ☐ Daily ☐
Excessive Exposure at Home or work to:
Fumes ☐ Dust ☐ Air-Borne Particles ☐ Noise ☐ Solvents ☐

Family Medical History

	Age	Diseases	If Deceased, Cause of Death
Father			
Mother			
Siblings			

I certify that the above information is correct to the best of my knowledge. I will not hold my Doctor or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Parent or Legal Guardian:_____ **Date:** _____

Patient Name: _____ **DOB:** _____

Please list all Medications	Dosage

Allergies

Please list any allergies or adverse reactions you have had:

Medication or Substance which caused the reaction?	What kind of reaction did you experience?	When did this reaction first occur?

Patient Acknowledgement and Consent

I have been given a copy of South Lake Hearing and Tinnitus Center's Notice of Privacy Practices, version effective October 1, 2013. I consent to the uses and disclosures of my health information as outlined in the Notice.

Signature of Patient or Representative: _____ Date: _____

Print Name: _____ Relationship to Patient: _____

Please describe the Representative's authority to act on behalf of Patient:

_____

_____

_____

_____

For South Lake Hearing and Tinnitus Center **USE ONLY**

If Acknowledgment of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain acknowledgement and the reason you could not obtain it:

_____

_____

_____

_____

CONSENT FOR RELEASE OF
PROTECTED HEALTH INFORMATION TO FAMILY

I consent to disclosure of the following protected health information about me to the following family member(s) or person(s) involved in my care or payment for my care:

_____

Check all that may apply:

- ☐ All my medical information
- ☐ Information necessary to schedule appointments for me
- ☐ Lab or test results
- ☐ Information necessary to provide, call in or pick up prescriptions for me
- ☐ Information necessary to help my family member(s) take care of me
- ☐ Information necessary to allow my family member(s) to pick up or arrange for medical equipment to be provided for me
- ☐ Information necessary to bill for or submit claims for care provided to me to government or private insurance payors

My consent will remain in effect, as long as I am a patient of South Lake Hearing and Tinnitus Center, unless and until I notify South Lake Hearing and Tinnitus Center in writing of any changes.

Signature of Patient or Representative: _____ Date: _____

Print Name: _____ Relationship to Patient: _____

Although allowed under HIPAA, North Carolina law does not permit release of PHI outside of the Hospital unless required by law, pursuant to a court order or patient authorization, or for treatment, payment, or health care operations purposes as defined and limited by HIPAA. There is no exception for family members except for residents of a nursing home. The North Carolina physician-patient privilege statute, N.C.G.S. § 8-53. and HIPAA allow verbal authorization or consent for release, respectively, of information to family members. However, the better practice is to document the patient's consent in order to have clear evidence of the patient's intent. The package does not include a consent or authorization to release PH1 to other providers or to insurance companies or others since most providers already have such forms. The contents of this form can be combined with such existing consent forms.

South Lake Hearing and Tinnitus Center
South Lake Ears Nose and Throat

Stan Phillips, M.D.
Molly Koester, Au.D.
Brian Slater, Au.D.
9710 Sam Furr Rd,Huntersville NC
704-896-1909

1. I have had a diagnostic hearing test: ☐ YES ☐ NO

2. If YES, when was your last hearing test? _____
   Where was it completed? _____

3. What is your hearing device experience?
   - ☐ I have a hearing device and use it regularly on the: _____ right ear _____ left ear
   - ☐ I have a hearing device, but don't use it or only use it occasionally
   - ☐ I have tried a hearing device, but returned it
   - ☐ I have inquired about hearing devices at another office, but did not purchase at that time
   - ☐ I have never used a hearing device

4. For current hearing device users:
   Type/style of hearing device: ☐ Behind-The-Ear ☐ In-The-Ear
   Brand: _____
   Date Purchased: _____
   Place Purchased: _____
   Is the Device under warranty? ☐ YES ☐ NO ☐ UNSURE
   If YES, warranty expiration: _____

5. What motivated you to come in today?

   _____

   _____

6. How did you hear about South Lake Hearing and Tinnitus Center?
   - ☐ Google
   - ☐ Facebook
   - ☐ Doctor
   - ☐ Radio/Print Ad
   - ☐ Friend/Family
   - ☐ Other: _____

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7. Do you currently experience, or have any history of the following?
   - ☐ Ear Infection or Surgery
   - ☐ Head, neck, or jaw injuries/pain
   - ☐ Regular use of Aspirin, Motrin, or Meloxicam
   - ☐ Headaches/Migraines
   - ☐ Stress
   - ☐ Traumatic Brain Injury (TBI)
   - ☐ IV Antibiotics
   - ☐ Cancer medications/chemotherapy/radiation treatment
   - ☐ Sinus and/or allergy difficulty
   - ☐ Disorders of the heart or blood vessels