WEST TENNESSEE ENT CLINIC, PA

STUDTMANN_____ GALLIMORE_____

PATIENT PROFILE AND INFORMATION SHEET

PLEASE PRINT

ACCT. # _____

PATIENT NAME_____ AGE _____ BIRTH DATE _____

ADDRESS_____ CELL # _____

CITY _____ STATE_____ ZIP_____ PHONE_____

PATIENT SOCIAL SECURITY #_____SEX: M _____F _____

PATIENT MARITAL STATUS: MARRIED_____ SINGLE_____ DIVORCED_____WIDOWED_____

PATIENT EMPLOYER _____ PHONE _____

EMPLOYER ADDRESS_____ CITY_____ STATE _____

HOW DID YOU FIND OUT ABOUT OUR PHYSICIANS AND/OR CLINIC?

___ 1) REFERRING PHYSICIAN, PLEASE NAME: _____

___ 2) FRIEND/RELATIVE ___ 3) INSURANCE PLAN ___ 4) YELLOW PAGE AD

___ 5) NEWSPAPER AD ___ 6) TELEVISION AD / INTERVIEW ___ 7) RADIO AD / INTERVIEW

___ 8) OTHER, PLEASE DECSCRIBE: _____

HUSBAND OR FATHER	WIFE OR MOTHER
NAME _____	NAME _____
ADDRESS _____	ADDRESS _____
CITY_____ STATE_____ ZIP_____	CITY_____ STATE_____ ZIP_____
EMPLOYER _____	EMPLOYER _____
EMP. ADDRESS_____	EMP. ADDRESS_____
EMP. PHONE _____ EXT_____	EMP. PHONE _____ EXT_____
BIRTH DATE_____ SS#_____	BIRTH DATE_____ SS#_____

NAME AND PHONE NUMBER OF PERSON OTHER THAN LISTED ABOVE TO CONTACT FOR EMERGENCIES:

NAME _____PHONE _____

AUTHORIZATION: I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE WEST TENNESSEE ENT CLINIC, PA. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY NONCOVERED CHARGES INCLUDING ATTORNEY'S FEES, COURT COSTS, AND COLLECTION AGENCY FEES, SHOULD MY ACCOUNT BE PLACED FOR COLLECTION. I HEREBY AUTHORIZE THE RELEASE OF PERTINENT MEDICAL INFORMATION TO INSURANCE CARRIERS.

RESPONSIBLE PARTY SIGNATURE_____**DATE** _____

YOUR RELATIONSHIP TO PATIENT: SELF_____SPOUSE ____ PARENT____ OTHER _____

WEST TENNESSEE ENT CLINIC - PATIENT INFORMATION FORM

PLEASE PRINT

Patient's Name _____ Date _____

Referred By Doctor? Yes___ No___ If Yes, Name of Doctor _____

List Any Drug Allergies: _____

_____

Have you ever had or do you now have trouble with any of the following? (Check Yes or No)

	Yes	No
1. Eyes or ears w/ hospital care	❑	❑
2. Nose, throat or sinus w/ hospital care	❑	❑
3. Frequent headaches	❑	❑
4. Dizziness or fainting	❑	❑
5. Convulsion or fits	❑	❑
6. Speech defect	❑	❑
7. Paralysis or stroke	❑	❑
8. Shortness of breath	❑	❑
9. Chronic cough	❑	❑
10. Persistent hoarseness	❑	❑
11. Blood spitting	❑	❑
12. Breathing difficulty	❑	❑
13. Night sweats	❑	❑
14. Pneumonia	❑	❑
15. Emphysema	❑	❑
16. Tuberculosis	❑	❑
17. Other lung disease	❑	❑
18. Chest pains	❑	❑
19. Swelling of ankles	❑	❑
20. Rheumatic fever	❑	❑
21. Heart problems	❑	❑
22. Heart murmur	❑	❑
23. High blood pressure	❑	❑
24. Jaundice	❑	❑
25. Intestinal bleeding	❑	❑
26. Stomach or ulcer	❑	❑
27. Bowel trouble (or any change in bowel habits)	❑	❑
28. Hemorrhoids	❑	❑
29. Disease of colon	❑	❑
30. Liver or Gall bladder	❑	❑
31. Rupture or hernia	❑	❑
32. Difficulty in urination	❑	❑
33. Kidney disease	❑	❑
34. Diabetes	❑	❑
35. Thyroid trouble	❑	❑
36. Back trouble	❑	❑
37. Joint trouble	❑	❑
38. Asthma	❑	❑
39. Other allergies	❑	❑
40. Drug abuse	❑	❑
41. Alcohol abuse	❑	❑
42. Prostate trouble	❑	❑
43. Female problems	❑	❑
44. Treatment for nervous or emotional problems	❑	❑
45. HIV Testing	❑	❑
46. Hepatitis	❑	❑
47. Any other illness, injury or surgery?	❑	❑
48. Have you ever been hospitalized?	❑	❑

If you answered yes to any of the questions above, please explain:

Please list any medications you are presently taking:

Are you under the care of a doctor for any chronic illness? Yes___ No___ If yes, please explain:

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.

USES AND DISCLOSURES

Treatment Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations Your health information may be used as necessary to support the day-to-day activities and management of West Tennessee ENT Clinic, P.A. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

ADDITIONAL USES OF INFORMATION

Appointment reminders Your health information may be used by our staff to provide you with appointment reminders (such as postcards, voicemail messages, or letters).

Information about treatment Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition.. We may also send you information describing other health-related products and services that we believe may interest you.

INDIVIDUAL RIGHTS

You have certain rights under the federal privacy standards. These include:

- the right to request restrictions on the use and disclosure of your protected health information
- the right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and copy your protected health information
- the right to amend or submit corrections to your protected health information
- the right to receive an accounting of how and to whom your protected health information has been disclosed
- the right to receive a printed copy of this notice

WEST TENNESSEE ENT CLINIC, P.A.'S DUTIES

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

RIGHT TO REVISE PRIVACY PRACTICES

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

REQUESTS TO INSPECT PROTECTED HEALTH INFORMATION

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Receptionist or the Privacy Officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

COMMENTS OR COMPLAINTS

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to the contact person set forth below. Additionally, if you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

CONTACT PERSON

The name and address of the person you can contact for further information concerning our privacy practices is:

Privacy Officer
West Tennessee ENT Clinic, P.A.
619 Skyline Drive
Jackson, TN 38301
731-424-3682

EFFECTIVE DATE

This Notice is effective on or after April 14, 2003.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices for West Tennessee ENT Clinic, P.A.. This notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the notice by calling 731-424-3682 or by requesting one at this office.

_____

Name of Patient (Print or Type)

_____

Signature of Patient

_____

Date

_____

Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

_____

Relationship of Patient Representative to Patient

DISCLOSURE FORM

The West Tennessee ENT Clinic, P.A. may disclose personal health information about you to your family, close personal friends, or another person that you identify *as long as the information disclosed to those individuals is relevant to their involvement in your care, or the payment for your care.* This Practice also may notify a family member, or another person who is responsible for your care, of your location and general health condition. This form provides you with the opportunity to choose not to have your health information disclosed to individuals involved in your care.

Please initial one of the following to indicate your choice regarding such disclosures:

_____ **I do not object** to my personal health information being disclosed to a family member, friend, or another individual involved in my care.

_____ **Only** disclose my personal health information to the following person(s):

_____

_____

_____

_____ **I object** to my personal health information being disclosed to a family member, friend, or another individual involved in my care.

_____

Patient name (please print)

_____ _____

Signature of patient or patient representative Date

_____

Relationship of patient representative to patient