

Frisco Family ENT

Phone: 214-374-8264 Fax: 214-297-0073

Main Reason for today's visit: _____

Today's Date: / /		Primary Care Physician:		Referred to us by:	
Patient's Name:		Email:		Marital Status (circle answer): Married/Single/Divorced Separated/widowed	
Birth Date: / /		Sex:		Social Security #:	
Street Address:			City:		State: Zip Code:
Employer:	Work#:	Home#:		Cell#:	
Occupation:					
Emergency Contact:		Relationship to Patient:		Phone#	
Name of Primary Insurance		Policy Holder :		Relationship to Patient	
		Birth Date: / /		Self/Spouse/Child	
		SS#: -- --			
Name Secondary Insurance		Policy Holder :		Relationship to Patient	
		Birth Date: / /		Self/Spouse/Child	
		SS#: -- --			
Pharmacy Name & Location (Please name the cross streets and city of your most frequented pharmacy)					
Personal Health History					
Please list any medical diagnoses received from other healthcare providers:					
Drug Allergies & Nature of Allergic Reaction:					
Medications (Rx and Non-Rx):			Surgeries/Hospital Admissions & Dates:		
Notes for Rx filled in by Dr. Huang:					

New Patient Information

Health Habits							
Exercise	<ul style="list-style-type: none"> <input type="radio"/> Sedentary (no exercise) <input type="radio"/> Mild Exercise (i.e. climb stairs, walk 3 blocks, golf) <input type="radio"/> Occasional vigorous exercise (i.e. less than 4x/week for 30 min) <input type="radio"/> Regular vigorous exercise (i.e. 4x/week for 30 min) 						
Caffeine	Circle all that apply:	None	Coffee	Tea	Soda	Other Source:	
	# of cups or cans per day:						
Tobacco	Do you use tobacco?	Yes/No	Cigarettes	Chew	Pipe	Cigars	Other Source:
History of Drug Use		No	Previously			Currently	
Alcohol Consumption		None	Occasionally			2 or more drinks a day	
Family Medical History							
(Please specify where illness has occurred in your family)							
Allergies		Mother	Father	Both	Neither	Other:	
Anesthesia Complications		Mother	Father	Both	Neither	Other:	
Asthma		Mother	Father	Both	Neither	Other:	
Arthritis		Mother	Father	Both	Neither	Other:	
Cancer		Mother	Father	Both	Neither	Other:	
Cardiovascular Issues: Hypertension and/or Stroke		Mother	Father	Both	Neither	Other:	
Diabetes		Mother	Father	Both	Neither	Other:	
Hearing Loss		Mother	Father	Both	Neither	Other:	
Mental Illness		Mother	Father	Both	Neither	Other:	
Obesity		Mother	Father	Both	Neither	Other:	
Osteoporosis		Mother	Father	Both	Neither	Other:	
Current Symptoms							
(Please circle any current symptoms you are having and/or mark through those you are not experiencing)							
Allergy	Runny Nose	Scratchy Throat		Ear fullness	Stuffy Nose		
	Sinus Congestion	Itchy Eyes					
Cardiology	Chest Pain	Heart Murmur		Shortness of Breath	Elevated Blood Pressure		
Ears	Ear drainage	Ringing		Balance Problems	Hearing Problems		
Eyes	Blurry Vision	Double Vision		Spotted Vision			
Gastrointestinal	Vomiting	Nausea		Constipation	Blood in Stool		
	Diarrhea	Heartburn					
Musculoskeletal	Joint Pain	Stiffness		Chronic soreness			
Neurologic	Headache	Tingling/Numbness		Seizures	Migraine		
Nose	Excessive Sneezing	Nasal itching		Watery eyes	Nasal Obstruction		
	Loss of smell	Snoring					
Psychiatric	Depression	Anxiety		Panic Attacks			
Respiratory	Wheezing	Coughing		Chest congestion	Recent Bronchitis		
Throat	Difficult or painful swallowing	Sore throat		Hoarseness			

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We ask for your insurance information when we schedule your first appointment, and we make every effort to verify your coverage and benefits. While we do our best to verify that our doctors are contracted and in-network with your insurance plan, it is ultimately your responsibility to ensure that this is the case. We call your insurance company and ask for specific benefits for procedures that are common in our ENT practice. Based upon information provided to us by your insurance company, we will expect payment according to the benefits quoted. Upon check-in, we will expect payment of the full amount of your co-payment. After you see one of our providers, we will expect payment of any deductible and co-insurance amounts based on the services rendered. We will then file your insurance claim with your insurance company for that visit. When they process your claim, they will mail both you and our office an Explanation of Benefits (EOB). When we receive the EOB, we will adjust any contracted discounts off of your account for that visit. We will post any payments received for the insurance company to your account for that visit. All outstanding balances are due in full upon receipt of statement.

Many insurance plans have a requirement that patients must provide additional information to them **before** they will pay your claim. When this is the case, your insurance company will inform us that they have “pended” your claim for additional information. If that happens, the **full balance** due on your visit becomes your responsibility to pay. Once an insurance company “pends” a claim, there is **nothing** that our office can do to get the claim paid; it is completely up to the patient to contact their insurance company, provide the needed information, and ensure that the insurance company pays the claim within thirty days. Additionally, if your insurance plan, group number or policy number changes, you must notify us at the time of service. Failure to provide us with current valid insurance information will result in the entire balance becoming your responsibility. This is because health care providers only have a certain amount of time in which to file your insurance claim; this timely-filing deadline varies with each insurance company. Also, visits that have been filed in a timely fashion and go unpaid by you insurance company for 60 days will be transferred to your financial responsibility. **Please remember that our office files on your insurance as a courtesy to you and is not legally required to do so.** It is important to remember that your insurance policy is a contract **between you and the insurance company.** We will do everything possible to assist you in getting your claim paid, however all charges incurred for your medical care are your sole financial responsibility.

Medically Necessary Services-

Insurance regulations require that in order to collect payment for services rendered, your doctor informs you in advance when a service may not be deemed “medically necessary” by Medicare guidelines, even though the doctor believes these services are required in order to provide you with the best quality of care you are owed. Based on past occurrences, the following service might not be paid by your insurance:

<i>Hearing Examinations</i>	<i>Pathologic Examinations</i>	<i>Fiberoptic Laryngoscopy</i>	<i>Nasal Endoscopy</i>	<i>Cerumen Removal</i>	<i>Surgical Procedures</i>
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By signing this statement, you are agreeing to pay for these services yourself even if they are determined by your insurance to not be “medically necessary.”

Non-Covered Services-

A non-covered service is any service that is denied by your insurance carrier due to benefit descriptions or limitations, policy exclusions, or pre-existing waiting periods. Non-covered services will be the responsibility of the patient and payment is due at the time of service. Please contact your insurance carrier and inquire about any service that may be non-covered. If you receive a service that is considered non-covered by your insurance plan, you will be expected to make payment in full.

Referrals/Authorizations-

Should your insurance company require a referral or authorization, it is your responsibility to obtain or request one prior to your appointment.

Returned Payment-

Payment is accepted in the form of cash, check (expect for new patients and surgery), credit card (expect American Express), and debit. Should a payment be returned for any reason, including but not limited to, insufficient funds, stop payment, or closed account, the patient will be liable for the original amount plus any associated NSF fees. Our current NSF fee is \$25.00.

Medical Records-

- 1) I understand the Texas State Board of Medical Examiners allows 2 weeks for the processing of my records.
- 2) I understand that if I request medical records there is a fee which must be paid prior to the records being copied.
According to the Texas State Board of Medical Examiners, the allowable fee is \$25.00 for the first twenty pages and \$.50 for each additional page.
- 3) I understand that there will be a \$ 35 fee for any FMLA Paperwork completed (Surgery patients)

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Your co-Payment is due at check-in, prior to seeing the doctor. Any deductibles and co-insurance portions must be paid at check-out for services rendered at that visit. If you are unable to pay your portions at the time of service, we ask that you reschedule your appointment or make prior financial arrangements with our billing department.

I, _____, do hereby affirm that I have read and understand the above financial policies. I understand that I am financially responsible for all medical fees incurred during my treatment regardless of insurance coverage of benefits,

(Print Name)

(Signature of Patient/Guardian)

(Date)

Consent for Treatment, Missed Follow –Up Appointments, and Returned Checks Policies

I hereby give authorization to the physician and medical staff of Dr. Patti C. Huang M.D., PA to provide medical treatment and care. I understand that no guarantees have been made with regards to treatment successes and that there may be complications associated with either my condition or with its proposed treatment.

I understand that failure to appear on a scheduled follow-up appointment may result in a delay in the diagnosis or treatment of a potentially serious condition. This office will call in advance to remind the patients of their upcoming appointments and will try to reschedule if the appointment cannot be kept. However, this office will not be held responsible for complications arising from missed appointments due to the patient's non-compliance. **We reserve the right to charge \$25 for missed appointments. A \$25 fee will also be assessed for all checks returned unpaid. Payment is expected at the time of service upon check-in unless prior arrangements have been made.**

Signature of PATIENT/Patient's Parent or Guardian _____

PATIENT'S Name Printed _____

Date _____

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Consent to Release Protected Health Information (PHI)

I understand that in order to disclose my PHI, Frisco Family ENT, must have my consent, therefore, I authorize Frisco Family ENT to disclose my PHI as described in the HIPAA Notice of Privacy Practices, to the recipients listed below:
Description of the information to be disclosed (**CHECK ALL THAT APPLY**):

All Information Test Results Appointments Surgeries Billing/Account Information Other

I specifically authorize Frisco Family ENT to use and disclose verbally, or fax the following types of super-confidential information as stated in the NOPP (**CHECK ALL THAT APPLY**):

HIV records (Including HIV test results) and sexually transmissible diseases

Alcohol and substance abuse diagnosis and treatment records

Psychotherapy records

Not Applicable

May we discuss the above information with your Primary Care Physician Yes No

If so please list the name of your Primary Care Physician: _____

Name(s) of other people authorized to obtain the above-mentioned information.

(E.g. family members, and other specified person/persons, Physician (other than your primary care physician))

Name: _____	Relationship: _____	Tel: _____
Name: _____	Relationship: _____	Tel: _____
Name: _____	Relationship: _____	Tel: _____
Name: _____	Relationship: _____	Tel: _____

Contact Information:

***Please list the **BEST** phone number that our office may contact you regarding appointment reminders and all other medical correspondence: _____

May we leave a detailed message on your answering machine or voicemail? Yes No

I approve being contacted about **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of Frisco Family ENT
 Yes No

In signing this HIPAA Patient Acknowledgement form, you acknowledge and authorize, that you hold harmless the Healthcare Facility, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring from this authorization. I understand that my records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law; that this authorization remains effective until this federal and state law has expired and the records have been destroyed; that I have the right to revoke this authorization at any time, provided I do so in writing; that I have been given the opportunity to ask question; that I have received a copy of the signed authorization; that I may inspect a copy of my PHI to be used or treatment of me upon receipt of this signed authorization; and that I may refuse to sign this authorization. A copy of this signed, dated Authorization shall be as effective as the original.

Patient or Representative: _____ Relationship: _____

Office Witness: _____ Date: _____