

WELCOME TO EAST ALABAMA EAR, NOSE AND THROAT, P.C.

- If you are **more than 15 minutes late** to your appointment, you will be seen, but on a work-in basis as the schedule allows or you may choose to reschedule to next available appointment time.
- If you are here for complaints of **loss of hearing, dizziness, ear pain**, etc., you will be seeing our **audiologists for evaluation and testing prior** to being seen by your doctor. This may cause an additional wait time prior to seeing the doctor. These types of tests may be applied to your insurance plan's Major Medical Deductible.
- If you have not updated your patient information sheet and/or health history form within the past year, you will be asked to update your sheets. ALL sections will need to be completed (including emergency contact information and insurance information) and signed.
- Submit all insurance cards and driver license for us to scan into our computer system, when asked by the front staff. We participate with Medicare, Blue Cross Blue Shield, Alabama Medicaid, United Healthcare, and a few others. If you are unsure, please ask if we participate with your plan. We will file your insurance; however, you will be responsible for any amount not covered by your insurance plan.
- **Because our physicians are specialists, your visit may consist of diagnostic procedures not covered under your regular office copay and will be applied to your Insurance's Major Medical Deductible.** If this is the case, you will receive a statement for any balance due after insurance has cleared. Balances are due within 30 days.
- If you have **Medicare**, please note that there is an **annual deductible** which your supplement may not cover. This amount may change each year.
- Medicaid, Tricare Prime, some Blue Cross Blue Shield Plans, Student Health plans, and some others require a primary care physician referral. **It is the patient's responsibility to ensure that we have received the proper referral, from their assigned doctor, by the time of the appointment.** If the appropriate referral has not been received in our office by the time of your visit, you will be asked to reschedule your appointment or to make payment for the visit at check-in.
- **Copay, deductible or balance amounts** will be asked for during your check-in process. this amount needs to be paid at that time of service. There will be no billing of copays. If you are unable to pay your required amount before being seen, our office staff will check with your doctor to see if your appointment needs to be rescheduled.
- If you are a self-pay patient, you will be asked to pay at least \$50, if you cannot pay in full, towards today's visit. We will then bill you for any remainder. I
- Our doctors try to see every patient in a timely manner, but since we are specialists situations do arise that cause our doctors to fall behind. Please be patient and we will update you when and if there will be a longer than expected wait for your appointment.

Thank you and feel free to contact us, if you need any additional questions.

**EAST ALABAMA EAR, NOSE AND THROAT, PC
PATIENT INFORMATION SHEET**

Patient Name: _____ **Sex:** M F
Last First Middle

Date of Birth: ____ / ____ / ____ **Social Security Number:** ____ - ____ - ____

Mailing Address: _____
Street Address

City State Zip

Home Phone Number: _____ **Cell Phone Number:** _____

Email Address(es): _____

Employer: _____ **Work Number:** _____

Marital Status: S M Other **Spouse's Name:** _____

Person Responsible for Bill: _____ **Relationship:** _____
If different than patient, NOT an insurance company

Responsible Person Address: _____
Street Address City State Zip

Phone Number: _____ **Cell Phone Number:** _____

Employer: _____ **Work Phone Number:** _____

Emergency Contact Person: (*someone not living with you*) _____

Phone Number: _____ **Relationship to Patient:** _____

Which Physician referred you for today's visit? _____

Who is your Primary Care Physician? _____

Which Pharmacy do you use? _____

City: _____ **Phone Number:** _____

PLEASE PROVIDE YOUR INSURANCE INFORMATION
(We will also need to scan your insurance card)

Primary Insurance: _____ **Contract ID #:** _____

Name of Cardholder: _____ **Group #:** _____

Cardholder's DOB: ____ / ____ / ____ **SSN:** _____

Relationship to Patient: _____ **Sex:** M F

Secondary Insurance: _____ **Contract ID #:** _____

Name of Cardholder: _____ **Group #:** _____

Cardholder's DOB: ____ / ____ / ____ **SSN:** _____

Relationship to Patient: _____ **Sex:** M F

I certify that the above information is true and correct to the best of my knowledge. I understand that I am financially responsible for all charges, regardless of insurance coverage.

Patient or Authorized Person's Signature: _____ **Date:** _____

EAST ALABAMA EAR, NOSE AND THROAT, PC ADULT PATIENT HEALTH HISTORY

TODAY'S DATE: ____ / ____ / ____ **YOUR PRIMARY CARE PHYSICIAN:** _____

NAME: _____

AGE: _____ **DATE OF BIRTH:** _____ / _____ / _____
First Middle Last

GENDER: Female Male **HEIGHT:** _____ **WEIGHT:** _____

WHO REFERRED YOU TO US?

- Primary care physician
 Other physician(s) Name: _____
 Friend/family

MAIN REASON FOR VISIT:

Describe briefly: _____

How long have symptom(s) been present? _____

What makes it better or worse? _____

Have you seen other physicians about this problem? Yes No If Yes, when? _____

Have you taken any medications for this condition? Yes No If Yes, what kind? _____

Have you had any tests performed so far? Yes No If Yes, when? _____

What treatments/surgeries have you already had for this problem? _____

Do you have any of the following?

| | YES | NO |
|-----------------------|--------------------------|--------------------------|
| Sinus problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Post nasal drip | <input type="checkbox"/> | <input type="checkbox"/> |
| Decreased smell/taste | <input type="checkbox"/> | <input type="checkbox"/> |
| Nose congestion | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequent sore throat | <input type="checkbox"/> | <input type="checkbox"/> |
| Change in voice | <input type="checkbox"/> | <input type="checkbox"/> |

| | YES | NO |
|-------------------------|--------------------------|--------------------------|
| Decreased hearing | <input type="checkbox"/> | <input type="checkbox"/> |
| Ear infection | <input type="checkbox"/> | <input type="checkbox"/> |
| Dizziness | <input type="checkbox"/> | <input type="checkbox"/> |
| Ringing ears (tinnitus) | <input type="checkbox"/> | <input type="checkbox"/> |
| Snoring | <input type="checkbox"/> | <input type="checkbox"/> |
| Lump in neck | <input type="checkbox"/> | <input type="checkbox"/> |

MEDICATION:

Do you take the following? **YES NO**

| | YES | NO |
|------------------------|--------------------------|--------------------------|
| Coumadin/warfarin | <input type="checkbox"/> | <input type="checkbox"/> |
| Aspirin/BC powder | <input type="checkbox"/> | <input type="checkbox"/> |
| Plavix | <input type="checkbox"/> | <input type="checkbox"/> |
| Ibuprofen/Advil/Motrin | <input type="checkbox"/> | <input type="checkbox"/> |
| Aleve/Naprosyn | <input type="checkbox"/> | <input type="checkbox"/> |
| Ginkgo biloba | <input type="checkbox"/> | <input type="checkbox"/> |
| Vitamin E | <input type="checkbox"/> | <input type="checkbox"/> |

List all other medication(s) you currently take including over the counter and herbal supplements (you may provide a separate sheet if not enough space):

| Name | Dose | Name | Dose |
|------|------|------|------|
| | | | |
| | | | |
| | | | |
| | | | |

ALLERGIES:

YES NO

| | | |
|----------------------------------|--------------------------|--------------------------|
| Are you allergic to latex? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you allergic to tape? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you allergic to iodine? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you allergic to IV contrast? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had allergy testing? | <input type="checkbox"/> | <input type="checkbox"/> |

List all medications you are allergic to and their reaction(s):

| Name | Reaction(s) | Name | Reaction(s) |
|------|-------------|------|-------------|
| | | | |
| | | | |
| | | | |
| | | | |

PREVIOUS SURGERIES:

| SURGERY (check if applies to you) | DATE(S) | OTHER SURGERY (please list below) | DATE(S) |
|--|---------|-----------------------------------|---------|
| <input type="checkbox"/> Tonsillectomy | | | |
| <input type="checkbox"/> Adenoidectomy | | | |
| <input type="checkbox"/> Ear tubes | | | |
| <input type="checkbox"/> Nasal Surgery (septoplasty) | | | |
| <input type="checkbox"/> Sinus Surgery | | | |
| <input type="checkbox"/> Mastoid Surgery | | | |
| <input type="checkbox"/> Palate Surgery | | | |
| <input type="checkbox"/> Pacemaker placement | | | |
| <input type="checkbox"/> Heart bypass surgery | | | |

PAST MEDICAL HISTORY:

Please check if you are currently being treated or been diagnosed for any of the following conditions:

| | YES | NO | | YES | NO |
|-----------------------------|--------------------------|--------------------------|----------------------------|--------------------------|--------------------------|
| High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes – diet controlled | <input type="checkbox"/> | <input type="checkbox"/> |
| Past heart attack | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes – oral medication | <input type="checkbox"/> | <input type="checkbox"/> |
| Blocked heart arteries | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes – insulin shots | <input type="checkbox"/> | <input type="checkbox"/> |
| Mitral valve prolapse | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| Heartbeat irregularity | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid nodule | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart failure | <input type="checkbox"/> | <input type="checkbox"/> | Overactive thyroid | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Low thyroid | <input type="checkbox"/> | <input type="checkbox"/> |
| Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | Skin cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| COPD (chronic lung disease) | <input type="checkbox"/> | <input type="checkbox"/> | Sleep apnea | <input type="checkbox"/> | <input type="checkbox"/> |
| Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | Allergic rhinitis | <input type="checkbox"/> | <input type="checkbox"/> |
| Acid reflux | <input type="checkbox"/> | <input type="checkbox"/> | Food allergy | <input type="checkbox"/> | <input type="checkbox"/> |
| Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> | Bleeding disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| Hiatal hernia | <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> |
| Past stroke | <input type="checkbox"/> | <input type="checkbox"/> | Depression | <input type="checkbox"/> | <input type="checkbox"/> |
| Seizures | <input type="checkbox"/> | <input type="checkbox"/> | HIV positive | <input type="checkbox"/> | <input type="checkbox"/> |
| Neurological disease | <input type="checkbox"/> | <input type="checkbox"/> | Migraine headaches | <input type="checkbox"/> | <input type="checkbox"/> |
| Fibromyalgia | <input type="checkbox"/> | <input type="checkbox"/> | Kidney disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Gout | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Cataract | <input type="checkbox"/> | <input type="checkbox"/> |
| Lupus | <input type="checkbox"/> | <input type="checkbox"/> | TMJ | <input type="checkbox"/> | <input type="checkbox"/> |
| High cholesterol | <input type="checkbox"/> | <input type="checkbox"/> | | | |

If you are female, are you currently pregnant? YES NO

Other unlisted disease(s): _____

If you have been treated for any type of cancer, please give details: _____

REVIEW OF SYSTEMS:

| | YES | NO | | YES | NO | | YES | NO |
|-----------------------|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|-----------------------|--------------------------|--------------------------|
| Unplanned weight loss | <input type="checkbox"/> | <input type="checkbox"/> | Light bothers eyes | <input type="checkbox"/> | <input type="checkbox"/> | Blood in urine | <input type="checkbox"/> | <input type="checkbox"/> |
| Recent fevers/chills | <input type="checkbox"/> | <input type="checkbox"/> | Vision changes | <input type="checkbox"/> | <input type="checkbox"/> | Painful urination | <input type="checkbox"/> | <input type="checkbox"/> |
| Facial rashes | <input type="checkbox"/> | <input type="checkbox"/> | Itchy/watery eyes | <input type="checkbox"/> | <input type="checkbox"/> | Easy bruising | <input type="checkbox"/> | <input type="checkbox"/> |
| Itchy skin | <input type="checkbox"/> | <input type="checkbox"/> | Recurrent headaches | <input type="checkbox"/> | <input type="checkbox"/> | Prolonged bleeding | <input type="checkbox"/> | <input type="checkbox"/> |
| Shortness of breath | <input type="checkbox"/> | <input type="checkbox"/> | Facial numbness | <input type="checkbox"/> | <input type="checkbox"/> | High stress | <input type="checkbox"/> | <input type="checkbox"/> |
| Chronic cough | <input type="checkbox"/> | <input type="checkbox"/> | Shaking/tremors | <input type="checkbox"/> | <input type="checkbox"/> | Anxiety | <input type="checkbox"/> | <input type="checkbox"/> |
| Wheezing | <input type="checkbox"/> | <input type="checkbox"/> | Stomach pain | <input type="checkbox"/> | <input type="checkbox"/> | Daytime sleepiness | <input type="checkbox"/> | <input type="checkbox"/> |
| Coughing blood | <input type="checkbox"/> | <input type="checkbox"/> | Heartburn | <input type="checkbox"/> | <input type="checkbox"/> | Trouble sleeping | <input type="checkbox"/> | <input type="checkbox"/> |
| Chest pain | <input type="checkbox"/> | <input type="checkbox"/> | Nausea/vomiting | <input type="checkbox"/> | <input type="checkbox"/> | Trouble concentrating | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart murmur | <input type="checkbox"/> | <input type="checkbox"/> | Cold intolerance | <input type="checkbox"/> | <input type="checkbox"/> | Irregular heartbeat | <input type="checkbox"/> | <input type="checkbox"/> |
| Heat intolerance | <input type="checkbox"/> | <input type="checkbox"/> | Foot/ankle swelling | <input type="checkbox"/> | <input type="checkbox"/> | Frequent thirst | <input type="checkbox"/> | <input type="checkbox"/> |

FAMILY HISTORY:

Check box(es) if any of the following affects your immediate blood relatives (parents, siblings, children):

- Heart disease Bleeding problem High blood pressure Stroke
- Cancer Allergies Hearing loss Asthma
- Thyroid problem Diabetes Sickle cell Other: _____

If you checked any of the boxes above, please give more detail if known: _____

SOCIAL HISTORY:

Please check box and provide details when indicated for the following questions:

- Do you smoke tobacco? **YES** **NO**
- How many packs per day? _____
- How many years have you smoked? _____
- Did you smoke in the past? YES NO
- If yes, how long? _____
- If yes, when did you quit? _____
- If yes, how many packs per day? _____
- Do you drink alcohol? **YES** **NO**
- How often? _____
- How much? _____
- Use in the past? YES NO
- If yes, when did you quit? _____

Have you been or currently exposed to loud noises (firearms, machines, etc)? YES NO

Do you regularly sing, scream, or yell? YES NO

Do you drink more than one serving of a caffeinated beverage a day? YES NO

Have you used chewing tobacco in the present or past? YES NO

Have you used illicit drugs in the past year? YES NO

I believe that the above information is completed to the best of my knowledge:

Patient signature: _____

Physician signature: _____

HIPAA NOTICE OF PRIVACY PRACTICES
East Alabama Ear, Nose and Throat, P.C.
1965 First Avenue
Opelika, AL 36801
334-705-0012

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

TREATMENT: We will use and disclose your protected health information to provide and coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

PAYMENT: Your protected health information will be used, as needed, to obtain payment from your insurance company for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

HEALTHCARE OPERATIONS: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use, or disclose your protected health information, as necessary, to contact you to remind you of your appointment, such as leaving a message on a recorded answering system.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases; Health Oversight, Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates, Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirement so of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES: Will be made only with your consent, authorization, or opportunity to object unless required by law. You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information.

YOU HAVE THE RIGHT TO INSPECT AND COPY YOUR PROTECTED HEALTH INFORMATION: Under federal law, however, you may not inspect and copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

YOU HAVE THE RIGHT TO REQUEST A RESTRICTION ON YOUR PROTECTED HEALTH INFORMATION: This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state specific restrictions requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another health care professional.

YOU HAVE THE RIGHT TO REQUEST TO RECEIVE CONFIDENTIAL COMMUNICATIONS FROM US BY ALTERNATIVE MEANS OR AT AN ALTERNATIVE LOCATION. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e., via email or other electronic method.

YOU MAY HAVE THE RIGHT TO HAVE YOUR PHYSICIAN AMEND YOUR PROTECTED HEALTH INFORMATION. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.

YOU HAVE THE RIGHT TO RECEIVE AN ACCOUNTING OF CERTAIN DISCLOSURES WE HAVE MADE, IF ANY, OF YOUR PROTECTED HEALTH INFORMATION.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

COMPLAINTS: You may complain to us or to the Secretary of Health and Human Services at 200 Independence Avenue SE, Washington, DC 20201, if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy officer, Kathy Skinner, at 334-705-0012, or by fax at 334-705-0378. **We will not retaliate against you for filing a complaint.**

This notice was published and became effective on **April 14, 2003.**

EAST ALABAMA EAR, NOSE & THROAT, P.C.

1965 FIRST AVENUE
OPELIKA, AL 36801
(334) 705-0012
FAX: (334) 705-0378

BY SIGNING BELOW, I HEREBY ACKNOWLEDGE RECEIPT OF THIS PRIVACY NOTICE

Printed Name of Patient

Date

Signature of Patient or Patient's Representative

Printed Name of Patient's Representative (If applicable)

Representative's Relationship to Patient (If applicable)

.....
DISCLOSURE

I authorize the following persons to have access to my health information:

Patient or Patient Representative's Signature

Date

To be completed by Health Care Provider

After a good faith attempt to obtain Acknowledgement of Receipt, the patient or representative refused or was unable to sign the Privacy Notice for the following reasons:

Signature of East Alabama ENT Representative

EAST ALABAMA EAR, NOSE & THROAT, P.C.

1965 FIRST AVENUE

OPELIKA, AL 36801

(334) 705-0012

FAX: (334) 705-0378

Warren A. Stiles, MD

William R. Blythe, MD

W. Stites Whatley, MD

**PAYMENT OF NON-COVERED SERVICES FORM AND INSURANCE
AUTHORIZATION, SIGNATURE ON FILE**

PAYMENT OF NON-COVERED SERVICES

I understand that East Alabama Ear, Nose and Throat, P.C. is a specialty practice.

I understand that my physician may need to do an Endoscopy at my visit to help him diagnose any nasal, throat or voice box conditions that I may have. He may also order a Sinus CT or Audiology test(s) in order to further diagnose and evaluate my condition. These types of procedures and other medically necessary services, may not be included with my office visit co-pay and, therefore, be applied to my major medical deductible.

I will be personally responsible for payment in full of any balance due for services not covered by my insurance plan.

RELEASE OF INFORMATION

I authorize the release of any medical record information necessary to process my insurance claims to request payment of benefits to East Alabama Ear, Nose and Throat, P.C.

By signing below, I certify that I have read and understand the above.

Signed: _____
(Patient or authorized person)

Date: _____