Foothills E.N.T.

Date:_____ FENT#_____

PLEASE PRINT

Patients Name:_____ Male___Female:___
(Last) (First) (Middle) (Preferred name)

MailingAddress:_____ City:_____
(Street name and Number)

State:_____ Zip Code :_____Home Phone:_____ Email address:_____

Street address (if different from above):_____

Age:_____ Date of Birth:_____SS#:_____Marital Status: M S D W

Employment: _____Work Phone:_____ Cell Phone:_____

Name of spouse:_____SS#:_____Birthdate:_____

Spouse's Employment_____ Phone: _____Ext:_____

IF PATIENT IS A CHILD/STUDENT:

Mother's Name:_____SS#:_____Birthdate:_____

Mothers Employment:_____ Bus. Phone:_____ Cell Phone:_____

Father's Name:_____SS#:_____ Birthdate: _____

Fathers Employment: _____Bus. Phone:_____ Cell phone:_____

School Currently Attending:_____ City & State:_____

OTHER INFORMATION:

Family Physician:_____ Phone #:_____ City & State:_____

Who referred you to our office? _____

Reason you are being seen to day? _____

Emergency contact (someone outside of your current residence): Name:_____

Relationship:_____ Phone Number:_____

Pharmacy you currently use:_____ City:_____ Phone #:_____

INSURANCE INFORMATION:

Primary Insurance: _____ Insured:_____ ID/Group #:_____

Secondary Insurance: _____ Insured:_____ ID/Group#:_____

I authorize Foothills E.N.T. to furnish my insurance company medical and any other information necessary to process insurance claims. I hereby assign payment of insurance benefits on services rendered. I understand that I am responsible for any health insurance co-payments, co-insurance, deductibles, non-covered services, or remaining charges. This authorization also gives my consent for treatment.

I am aware that if my account goes over 60 days with no payment, a collection process may begin. In the event an outside collection agency becomes necessary, my account may be charged a collection fee.

Signature:_____Date:_____
(Patient/Parent/Legal Representative)

FOOTHILLS EAR, NOSE & THROAT
PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Foothills ENT to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Foothills ENT Notice of Privacy Practice provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Foothills ENT reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Foothills ENT, Privacy Officer at 201 Richard St., Easley, SC 29640.

With this consent, Foothills ENT may call any phone number provided to the practices and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory and x-ray results among them.

With this consent, Foothills ENT may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment remainder cards and patient statements. I have the right to request that Foothills ENT restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Foothills ENT use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Foothills ENT may decline to provide treatment to me.

Signature of Patient or Legal Guardian	**Date**
Patient's Name	**Received/Declined Privacy Notice Signature of Patient or Legal Guardian**
Print Name of Patient or Legal Guardian	

FOOTHILLS EAR, NOSE & THROAT, PA

PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES

By signing this authorization, I authorize Foothills Ear, Nose & Throat to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below.

This authorization permits Foothills Ear, Nose & Throat to use or disclose to

Name:_____ Relationship to patient:_____

Name:_____ Relationship to patient:_____

the following individually identifiable health information (specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.)_____

_____

_____

_____

This authorization will expire on _____.

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Foothills Ear, Nose & Throat has acted in reliance upon this authorization. My written revocation must be submitted to Foothills Ear, Nose & Throat 201 Richard Street, Easley, SC 29640.

_____ _____

Signature of Patient or Legal Guardian **Relationship to Patient**

_____ _____

Patient's Name **Date**

_____

Print Name of Patient or Legal Guardian

Foothills ENT Medical and Social History Form

Patient Name:_____ Date: _____Chart No.: _____

Medication Allergy:_____

_____Latex Allergy __Yes ___ No

Reason for visit: _____

Past History/Family History:

Medications: _____

_____

Hospitalizations/Surgical/Illness/Injury History:_____

_____

_____

Family History (Parents, Siblings, and children) Include cause of death if applicable:

_____

_____

Referring Doctor:_____How long you have had this problem:_____

What medications or tests (x-rays, labs, etc) have you had for this problem? Where?_____

_____

Was Problem related to accident: _____If so, date of accident? _____

Social History:

Do you smoke or use smokeless tobacco: _____Packs/day:_____Number of years:_____

If the patient is a child.... Does the caregivers smoke?_____ Is the child in daycare/school? _____

Alcoholic drinks:_____Number of drinks per week:_____

Recreational drugs:_____

Patient Name: _____ DOB: _____

Foothills ENT Review of Systems

Ears	YES	NO	
Hearing loss- gradual			
Hearing loss- sudden			
Pain			
Ringing			
Dizziness			
Foreign body			
Recurrent Ear infections			
Other			

Nose			
Nose bleeds			
Injury			
Congestion			
Runny nose			
Mouth Breather			
Other			

Throat			
Recurring sore throat			
Difficulty Swallowing			
Hoarseness			
Foreign body			
Swollen tonsils			
Other			

Eyes			
Cataracts			
Glaucoma			
Distorted vision			
Other			

Heart			
Hypertension			
Congestive Heart Failure			
Coronary Artery Disease			
Irregular heartbeat			
History of heart attack			

Lungs			
Bronchitis			
Asthma			
Congestion			
COPD			
Emphysema			

General			
Fever			
Changes in Weight			

Gastrointestinal	YES	NO	
Indigestion			
Ulcers			
Diarrhea			
Nausea/Vomiting			
Diverticulitis			
Gall bladder problems			
IBS			
other			

Renal			
Kidney Problems			
History kidney stones			
Prostate Problems			
Recurrent UTIs			
Other			

Musculoskeletal			
Back Pain			
Weakness of limbs			
Arthritis			
Other			

Neurological			
Numbness			
History of stroke			
Migraines			
Seizures			
Psychiatric Disorders			

Endocrine			
Thyroid problems			
Diabetes			
Hormone replacement			
Prostate			
Other			

Bleeding Disorders			
Low blood count			
Free bleeding			
Blood clots			
Hepatitis			
Other			

Immune Disorders/ Cancer/Other			
HIV/AIDs			
Cancer			
Skin disorders			

Patients Signature:_____ Physician Signature:_____ Date:_____

Foothills ENT

PATIENT FIRST CARE

10 Enterprise Blvd, Suite 201, Greenville, SC 29615
201 Richard Street, Easley, SC 29640

FINANCIAL/OFFICE POLICY

Payment is required at time of service. Co-pays are collected at check in. Co-insurance is collected at check out

We will file with your insurance for services provided. If we are contracted with your insurance we will bill you the contractual rate. If we are not contracted we will bill you for the balance due on the account.

If your insurance requires an authorization we require that you make sure we have received that from your primary care physician. If we do not have an authorization we will either reschedule your visit or you can be self pay and pay in full at time of visit.

If you are self pay we will give you a 25% discount for paying your balance in full at time of service. Payment arrangements have to be made prior to being seen by the physician. We do not make payment arrangements for first visit.

We do not accept Medicaid secondary for commercial insurance. You will be asks to pay your co-payment and/or co-insurance at time of visit.

If you are scheduled for surgery we will get your benefits information from your insurance company so we can give you an estimate of the cost of surgery. We require you to pay your portion of the surgery in advance no later than your per-op (before surgery) appointment for all non-emergent surgeries. For emergency surgeries we ask that you pay your portion of the surgery within 45 days of having the surgery.

A $35.00 charge will be added to all returned check. Check need to be picked up and paid with cash within 15 days of receiving notice of NSF. Checks over $50.00 will be turned over to the magistrates' office for collections and you will be required to pay all associated fees.

If your account is past due over 45 days we will require payment in full before a return appointment is schedule.
If we have to turn your account over to a collection agency a 25% fee will be added to the balance due for the cost of the agency.

We will fill out 1 (one) FMLA form for any patient having surgery. Additional FMLA forms and any other disability form will be filled out for a fee of $15.00-25.00 depending on the form.

I have read and understand the Financial Policy of Foothills ENT.

Patients Name (Print) _____Chart #_____

Patient/Guardian's Signature: _____Date _____