



PLEASE PRINT

Patient Name _____ Date of Birth _____ Age _____ M ___ F ___

Address _____ Email _____

Home Phone _____ Cell Phone _____ SSN _____

Mailing Address (If different than above) _____

Employment _____ Work Phone _____ Marital Status S M D W

Name of Spouse _____ DOB _____ Phone _____

INSURANCE INFORMATION

Primary Insurance _____ ID# _____ Grp# _____

Subscriber Name _____ DOB _____ SSN _____

Employer _____ Phone _____

Secondary Insurance _____ ID# _____ Grp# _____

Subscriber Name _____ DOB _____ SSN _____

Employer _____ Phone _____

IF PATIENT IS A CHILD / STUDENT

Mother's Name _____ DOB _____ SSN _____

Employer _____ Work # _____ Ext _____

Father's Name _____ DOB _____ SSN _____

Employer _____ Work # _____ Ext _____

School Attending _____ City / State _____

EMERGENCY CONTACT (outside of your current residence)

Name _____ Relationship _____

Phone Number _____ Alternative# _____

FAMILY DOCTOR / PCP _____ Phone# _____

REFERRING PROVIDER _____ Phone# _____

PHARMACY

Local Pharmacy _____ City _____ Phone # _____

- I authorize Foothills ENT to furnish my insurance company with medical and any other information to process during insurance claims, I hereby assign payment of insurance benefits of services rendered, I understand I am responsible for any health insurance co-pays, co-insurance, deductibles, non-covered services, or remaining charges.

- I am aware that if my account goes over 45 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 Representation)



Consent To Treat

1. I, _____ give permission to Foothills ENT to provide me medical treatment.
2. I allow Foothills ENT to file my insurance benefits to pay for the care I receive.

I understand that:

- Foothills ENT will have to send my medical record information to my insurance company.
- I must pay for the cost of these services if my insurance does not pay or if I don't have insurance.

3. I understand:

- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my clinician.

Patient Signature

Date



Foothills ENT
2 Roper Corners Circle, Greenville SC 29615
Phone (864) 234 -7815 Fax (864) 234- 7846

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, patients who do not show up for their appointment without a call to cancel at least 24 hours before the appointment time will be considered a NO SHOW. Foothills ENT has the right to charge a fee of \$25.00 for all missed appointments (“no-shows”). Foothills ENT understands that emergencies occur, however a call to cancel is appreciated. “No Show” fees will be billed to the patient. These fees are not covered by insurance and must be paid in full before your next appointment.

Thank you for your understanding and cooperation as we strive to serve the needs of all our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

Signature

Date

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

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

This authorization permits Foothills Ear, Nose, and 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.)

When my information is under or disclosed under 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 ENT has acted in reliance upon this authorization. My written revocation must be submitted to Foothills ENT, 2 Roper Corners Circle, Greenville, SC 29615.

Signature

Date





**Foothills ENT 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, before signing this consent, Foothills ENT reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Foothills ENT, Privacy Officer at 2 Roper Corners Circle, Greenville, SC 29615.

With this consent, Foothills ENT may call any phone number provided to the practice and leave a message on voicemail or in person about any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls about 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 reminders, cards, and patient statements, I have the right to request that Foothills ENT restricts 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 to use and disclose 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 prior consent. If I do not sign this consent, or later revoke it, Foothills ENT may decline to provide treatment to me.

Signature

Relationship to Patient

Patient's Name or Legal Guardian

Date



Financial Office Policy

Payment is required at the time of service. Co-pay and Co-insurance are collected at check-out.

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

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

If you are scheduled for surgery, we will get your benefit 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 7 days prior. For emergency surgeries, we ask that you pay your portion of the surgery within 45 days of having the surgery.

A \$85.00 charge will be added to all returned checks. Checks need to be picked up and paid within 15 days of receiving notice of NSF. Checks over \$50.00 will be returned to the magistrates' office for collection 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 scheduled. If we must turn your account over to a collection agency, a 25% fee will be added to the balance due for the cost.

We will fill out FMLA forms for surgery for a fee of \$25.00-\$50.00 depending on the form.

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

Signature

Relationship to Patient

Patient's Name

Date

Print Name of Patient or Legal Guardian



Medical and Social History Form

Patient Name _____ DOB _____

Reason for Visit _____

Medication Allergies _____

Latex Allergy _____ YES _____ NO

MEDICAL HISTORY/FAMILY HISTORY

Medications _____

Surgery/Illness:

Family History (Parents, Siblings, and Children) include cause of death if applicable:

REFERRING DOCTOR _____ PHONE _____

How long have you had this problem? _____

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

Was the problem related to an accident? _____ Yes _____ No If yes, date of accident/ _____

SOCIAL HISTORY

Do you smoke or chew tobacco? _____ Yes _____ No Pack/Day _____ Number of years _____

If the patient is a child, does the caregiver smoke? _____ Yes _____ No

Is the kid in school/daycare? _____ Yes _____ No

Alcoholic Drinks _____ Yes _____ No Number of drinks per week _____

Recreational Drugs _____

Foothills ENT Review of Systems

Ears	Yes	No	
Hearing Loss Gradual			
Hearing Loss Sudden			
Pain			
ringing			
Dizziness			
Foreign Body			
Recurrent Ear Infection.			
Other			
Nose	Yes	No	
Nose Bleeds			
Injury			
Congestion			
Runny Nose			
Mouth Breather			
Other			
Throat	Yes	No	
Recurring Sore Throat			
Difficulty Swallowing			
Hoarseness			
Foreign Body			
Swollen Tonsils			
Other			
Eyes	Yes	No	
Cataracts			
Glaucoma			
Distorted Vision			
Other			
Heart	Yes	No	
Hypertension			
Congestive Heart Fail.			
Coronary Artery Dise.			
Irregular Heartbeat			
History of Heart Attack			
Lungs	Yes	No	
Bronchitis			
Asthma			
Congestion			
COPD			
Emphysema			
Other			
Other			
General	Yes	No	
Fever			
Changes in Weight			
Gastrointestinal			
Indigestion			
Ulcers			
Diarrhea			
Nausea/Vomiting			
Diverticulitis			
Gall Bladder Problems			
ISS			
Other			
Renal	Yes	No	
Kidney Problems			
History Kidney Stones			
Prostate Problems			
Recurrent UTI's			
Other			
Musculoskeletal	Yes	No	
Back Pain			
Weakness of Limbs			
Arthritis			
Other			
Neurological	Yes	No	
Numbness			
History of Stroke			
Migraines			
Seizures			
Psychiatric Disorders			
Endocrine	Yes	No	
Thyroid Problems			
Diabetes			
Hormone Replace.			
Prostate			
Other			
Bleeding disorders			
Low Blood Count			
Free Bleeding			
Blood Clots			
Hepatitis			
HIV/AIDS			
Cancer			

