Advanced Otolaryngology Associates, P. A.

Date: _____/_____/_____

Last Name: _____ First Name: _____ Middle Initial: ____

Date of Birth: _____ /_____ /_____ Age: _____ Sex: M___ F___ SS# _____-_____-_____

Marital Status: Single____ Married ____ Divorced ____ Widowed _____Civil Union _____ Domestic Partnership _____

Race: _____ Ethnicity: _____ Religion: _____

Hispanic: Yes____ No_____ Declined_____ Email Address: _____

Street Address: _____ Apt/Suite: _____

City: _____ State: _____ Zip: _____

Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____ Work Phone: _____-_____-_____

Primary number to contact you: _____-_____-_____

Emergency Contact Name: _____ Phone Number: _____-_____-_____

Pharmacy Name: _____ Address: _____

Pharmacy Phone: _____-_____-_____

Employer Name: _____ Occupation: _____

Primary Doctor Name: _____ Address: _____

Primary Doctor Phone: _____-_____-_____

Referring Doctor Name: _____ Address: _____

Name of Person Financially Responsible for This Account: _____

Primary Insurance Name: _____ID# _____

Group# _____ Policy Holder's Name: _____

Date of Birth: ____/_____/_____ SS# _____-_____-_____ Home Phone: _____-_____-_____

Street Address: _____ City: _____ State: _____ Zip:_____

Relationship to Patient: _____

Policy Holder's Employer Name: _____ Address: _____

Secondary Insurance Name: _____ ID#: _____

Group#: _____ Policy Holder's Name: _____

Advanced Otolaryngology Associates, P. A.

Office Policy and Financial Agreement

We are committed to providing our patients with the best possible care and are pleased to discuss our professional charges and office policies at any time. In order to avoid any misunderstanding, we ask that you read and sign the following:

CO-PAYMENTS: We are required to collect co-payments at the time of service. Please be prepared to pay your co-pay at each visit.

APPOINTMENTS: Our office requires notice of a cancellation within 24 hours of your appointment. If you do not provide notification, then a $25 charge will occur. Exceptions will be made in the event of an emergency.

REFERRALS: If your insurance requires a referral from a primary care physician, it is your responsibility to provide this office with a copy prior to your appointment. It is also your responsibility to keep record of the remaining visits and expiration date. If a referral is not provided prior to your appointment, we may reschedule your appointment until a valid referral is available. Should you choose to be seen without a referral, payment is expected in full at the time of service and a claim will not be filed with your insurance company.

MEDICARE: We do not accept assignment of benefits with Medicare. This means that when services are rendered, you are billed at the Medicare limiting fee and are responsible for payment at that time. We will submit all necessary paperwork for you so that you will be reimbursed directly. We can never guarantee 100% reimbursement.

INSURANCE PLANS: After a claim is processed by your insurance company, you will be billed for any balance due to this office such as deductibles, co-payments or co-insurance. If you chose to neglect such payment or refuse to make financial arrangements, your account will then be submitted to a collection agency.

OUT OF NETWORK PLANS: If we do not participate with your insurance company, you are responsible for payment in full at the time of service. We may also choose to submit a claim to your insurance without taking payment at the time of service, leaving you responsible for any balance after the claim is processed.

SECONDARY INSURANCE: We do not submit to secondary insurance. You will be responsible to pay your out of pocket costs then submit to your secondary for reimbursement directly.

Your signature below indicates that you understand and accept this policy/agreement. Furthermore, your signature authorizes this office to release medical information necessary to process your insurance claims and allows the use of "signature on file" in lieu of your signature. You herein authorize payment of medical benefits to Advanced Otolaryngology Associates, P. A.

Print Name of Patient: _____

Signature of Patient/Legal Guardian: _____

Date: _____/_____/_____

Advanced Otolaryngology Associates, P.A.

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It is effective April 14, 2003, and applies to all protected health information contained in your health records maintained by us. We have the following duties regarding the maintenance, use and disclosure of your health records:

(1) We are required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of our legal duties and privacy practices with respect to that information.
(2) We are required to abide by the terms of this Notice currently in effect.
(3) We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

There are a number of **situations in which we may use or disclose** to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

Treatment: We will use your health information to make decisions about the provision, coordination or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your care. [If there are other such disclosures that you might make, list them here.] These are only examples of uses and disclosures of medical information for treatment purposes that may or may not be necessary in your case.

Payment: We may need to use or disclose information in your health record to obtain reimbursement from you, from your health-insurance carrier, or from another insurer for our services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system.
Operations: Your health records may be used in our business planning and development operations, including improvements in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions.

There are certain circumstances under which we may use or disclose your health information **without first obtaining your Acknowledgement or Authorization**. Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. [Delete if inapplicable:] You should be aware that we utilize an "open adjusting room" in which several people may be adjusted at the same time and in close proximity. We will try to speak quietly to you in a manner reasonably calculated to avoid disclosing your health information to others; however, complete privacy may not be possible in this setting. If you would prefer to be adjusted in a private room, please let us know and we will do our best to accommodate your wishes.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general

condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

Communication Barriers and Emergencies: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without you written authorization.

You have certain **rights regarding your health record information**, as follows:

(1) You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.

(2) You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.

(3) You have the right to inspect, copy and request amendments to you health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information.

(4) All requests for inspection, copying and/or amending information in your health records, and all requests related to your rights under this Notice, must be made in writing and addressed to the Privacy Officer at our address. We will respond to your request in a timely fashion.

(5) You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment and healthcare operations, disclosures that require an Authorization, disclosure incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period.

(6) If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice and to take one home with you if you wish.

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's web site, http://www.hhs.gov/ocr/hipaa.

All questions concerning this Notice or requests made pursuant to it should be addressed to:

SECURITY OFFICER
ADVANCED OTOLARYNGOLOGY ASSOCIATES, P.A.
557 CRANBURY ROAD, SUITE 3
EAST BRUNSWICK, NJ 08816

Advanced Otolaryngology Associates, P.A.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I have been given the opportunity to review the notice of privacy practices of Advanced Otolaryngology Associates, P.A.

☐ YES, I would like a copy

☐ NO, I do not want a copy

You may speak to the following people regarding my care:

NAME	PHONE NUMBER	RELATIONSHIP
_____	_____-_____-_____	_____
_____	_____-_____-_____	_____
_____	_____-_____-_____	_____

Print Name of Patient: _____

Signature of Patient/Legal Guardian: _____

Date: _____/_____/_____

Advanced Otolaryngology Associates, P.A.

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: ____/____/____ Primary Doctor: _____ Referring Doctor: _____

Chief Complaint: _____

PAST MEDICAL HISTORY: Please list all diagnosed illnesses.

_____
_____
_____

PAST SURGICAL HISTORY: Please list all surgeries and date performed.

Surgery	Date	Surgery	Date	Surgery	Date
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

MEDICATIONS: Please list all medications or provide list on separate paper. Please include over the counter medications.

Medication	Dosage	Reason	Medication	Dosage	Reason
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

ALLERGIES: Please list all allergies to medications and foods and what type of reaction you had:

Allergy	Reaction	Allergy	Reaction
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FAMILY MEDICAL HISTORY: Please list all illnesses in your immediate family and their relationship to you.

Diagnosis	Relationship	Diagnosis	Relationship	Diagnosis	Relationship
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

SOCIAL HISTORY: Check all that applies.

Tobacco: ☐ Never ☐ Current everyday: Amount per day: _____ ☐ Current some days

☐ Former: Year quit: _____

Alcohol: ☐ Never ☐ Current everyday: Amount per day: _____ ☐ Current some days

☐ Former: Year quit: _____

REVIEW OF SYSTEMS: Check active symptoms.

Constitutional: ☐ Fatigue ☐ Fever ☐ Chills ☐ Night sweats ☐ Body aches

Eyes: ☐ Redness ☐ Eye discomfort ☐ Dryness ☐ Blurred vision

ENT: ☐ Ear pain ☐ Ear fullness ☐ Hearing loss ☐ Ringing in ears ☐ Ear discharge ☐ Pressure sensation in ear ☐ Itching in ear ☐ Headaches ☐ Vertigo ☐ Sinus pain ☐ Nasal congestion ☐ Nasal bleeding ☐ Postnasal drip ☐ Nasal obstruction ☐ Decreased sense of smell ☐ Neck Mass ☐ Thyroid Mass ☐ Frequent throat clearing ☐ Snoring ☐ Sore throat ☐ Enlarged tonsils ☐ Swollen glands ☐ Lump in throat sensation

Cardiovascular: ☐ Chest pain ☐ Irregular heartbeats ☐ Rapid heart rate

Respiratory: ☐ Shortness of Breath ☐ Wheezing ☐ Cough ☐ Coughing up blood (hemoptysis)

Gastrointestinal: ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Difficulty swallowing (dysphagia) ☐ Heartburn ☐ Hoarseness

Integument: ☐ Skin dryness ☐ Rash ☐ Itchy ☐ New skin lesions

Neurologic: ☐ Loss of balance ☐ Speech difficulties ☐ Incoordination

Musculoskeletal: ☐ Joint pain ☐ Muscular weakness ☐ Joint swelling

Endocrine: ☐ Weight loss ☐ Weight gain

Psychiatric: ☐ Anxiety ☐ Depression ☐ Difficulty sleeping

Hematologic: ☐ Easy Bleeding ☐ Easy Bruising