Patient #________________

BURLINGTON EAR, NOSE AND THROAT CLINIC, P.C. PATIENT INFORMATION

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: ____

Employer: ____________________________ **Work Phone Number**: ____________________

(This information is required by CMS)

Preferred Way to be Contacted: ____Declined ____Mail ____Phone

Primary Language Spoken: ______________________________

Race: ____American Indian/Alaska Native ____Asian ____Black/African American ____Declined ____Native Hawaiian/Pacific Islander ____Other Race ____White

Ethnicity: ____Declined ____Hispanic or Latino ____Not Hispanic or Latino

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

Person Responsible for Bill: __________________________ **Relationship to Patient**: ____________
If different than the patient

Responsible Person Address: ____
Street Address

Responsible Person DOB: ______/_____/______ **SSN**: __________-__________-__________

Phone Number: ________________________ **Cell Phone Number**: ____________________

Employer: ____________________________ **Work Phone Number**: ____________________

Emergency Contact Person: (*Someone not living with you*) ______________________________

Phone Number: ____________________ **Relationship to Patient**: ____________________

Family Physician: ______________________ **Referring Physician**: ____________________

Which Pharmacy do you use: ________________________ **Pharmacy Phone Number**: __________

PLEASE PROVIDE YOUR INSURANCE INFORMATION

(We will also need to scan your insurance card and photo ID)

Primary Insurance:______________________ Name of Cardholder**:** ________________________

Cardholder's DOB**:** ______________________Cardholder's SSN**:** __________/_____/__________

Secondary Insurance: ____________________Name of Cardholder**:** ________________________

Cardholder's DOB**:** ______________________Cardholder's SSN**:** __________/_____/__________

I certify that the above information is true and correct to the best of my knowledge. I have been presented with Burlington Ear, Nose and Throat Clinic's Financial Policy. I understand that I am financially responsible for all charges, regardless of insurance coverage.

Patient or Authorized Person's Signature:______________________________ **Date:** ________________

Financial Policy

Burlington Ear, Nose & Throat Clinic, P.C.
Dr. Douglas E. Henrich, M.D.
Dr. Jennifer K. Berge, M.D.

1225 South Gear Ave, Ste 255
West Burlington, IA 52655
(319) 752-2725

This is an agreement between Burlington Ear, Nose & Throat Clinic, P.C., as a creditor, and the Patient/Debtor named on this form.

By executing this agreement, I, ______________________________ agree to pay for all services that are received.

- I acknowledge that all information given is true and correct and that it has been furnished to this office with the full knowledge that the patient is liable for all said services rendered and that he/she is contractually bound to pay for said services, including all costs of collection and reasonable attorney fees should collection become necessary. I hereby authorize and request that payments under my insurance plans be made directly to Burlington Ear, Nose & Throat Clinic, P.C. for any services furnished to me.

- I hereby consent to the administration and performance of all diagnostic procedures and/or treatments which in the judgment of Burlington Ear, Nose & Throat Clinic, P.C. may be considered necessary and advisable. I am entitled to a full explanation prior to any testing, procedure or referral that I have the option to decline such treatment or seek further information.

- I also authorize the release of any information required to process insurance claims including any information relating to alcohol, drug abuse, and /or AIDS. I authorize the release of my personal health information to: billing agencies, laboratories, diagnostic testing facilities, referring physicians and others involved in the medical and/or financial aspects of my care.

- **Payment Options If You Have Insurance:**
  1. Co-pay, deductible and any out-of-pocket expenses are due at the time of service payable by cash, check or credit card. No exceptions.
  2. You will be charged a 1.5% interest monthly (18% annually) on balances 30 days and older.

- **Payment Options If You Do Not Have Insurance:**
  1. You may choose to pay by cash, check or credit card at the time the treatment is rendered. No exceptions.
  2. On extensive treatment, you may prefer to secure a bank, credit union or other third party financing for the entire amount and make payments to the lending institution or speak to our office manager/billing specialist about payment arrangements.

- **Payments:** Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is considered past due if not paid by the end of the month.

(over)

- **Contracted Insurance:** If we are contracted with your insurance company, we must follow our contract, and their requirements. If you have co-pay, you must pay that at the time of service. If your insurance requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and /or preauthorization may result in a lower payment from the insurance company.

- **Divorce:** In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for that account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent and not the responsibility of Burlington Ear, Nose & Throat Clinic, P.C.

- **Workers Compensation:** We require written approval/authorization by your employer and/or workers compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for the payment in full.

- **Personal Injury:** If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury.

- Patients may be charged directly for additional fees for the following: Prescription Renewals $20.00, Completing Disability/Medical Leave /Insurance forms $20.00, Completing Sport/Camp/School Physical Forms $15.00, Copies of Medical Records 1to 20 pages $20.00 with each additional page at $0.75 and postage for mailing.

- There is a fee of $30.00 for any checks returned by the bank.

I HAVE READ AND UNDERSTAND THE TERMS AND CONDITIONS OF THE FINANCIAL POLICY OF BURLINGTON EAR, NOSE AND THROAT CLINIC, P.C.

Patient's Name:____

Signature:____Date:________________

(Parent/Guardian signature if patient is a minor)

Relationship to patient:____

Burlington Ear, Nose & Throat Clinic, P.C.

NAME______________________________ **AGE**__________ **DATE**______________

This form is to help give you better health care. It is completely confidential and will be part of your medical record. If you have any questions regarding your answers, please wait and ask the doctor.

REASON FOR TODAY'S VISIT______________________________

PERSONAL MEDICAL HISTORY

Allergies	Yes____	HIV/AIDS	Yes____
Anemia	Yes____	Indigestion	Yes____
Arthritis/Joint Pain	Yes____	Irregular Heart	Yes____
Asthma	Yes____	Jaundice	Yes____
Bleeding Disorder	Yes____	Kidney Disease	Yes____
Chest Pain	Yes____	Night Sweats	Yes____
Convulsion	Yes____	Nosebleeds	Yes____
COPD/Emphysema	Yes____	Pacemaker	Yes____
Cough	Yes____	Shortness of Breath	Yes____
Coughing Blood	Yes____	Sinusitis	Yes____
Diabetes	Yes____	Skin Cancer	Yes____
Difficulty Swallowing	Yes____	Stroke	Yes____
Dizziness	Yes____	Thyroid Disease	Yes____
Epilepsy	Yes____	Tonsillitis	Yes____
Glaucoma	Yes____	Tuberculosis	Yes____
Hearing Loss	Yes____	Ulcer	Yes____
Heart Disease	Yes____	Vision Changes (other than glasses)	Yes____
Hepatitis	Yes____	Weight Loss	Yes____
High Blood Pressure	Yes____	Other	Yes____

SURGICAL HISTORY

____Appendix ____D&C ____Ear Surgery ____Eye Surgery ____Gallbladder

____Heart Surgery ____Heart Stents ____Hysterectomy ____Joint Replacement ____Nasal Surgery

____Prostate ____Thyroidectomy ____Tonsil/Adenoid

____Other______________________________

____No Prior Surgery

Complications with anesthesia?______________________________

CURRENT MEDICATIONS

Do you take aspirin daily? Yes____ No____ Occasionally? Yes____ No____

List all medications you are currently taking. Include over-the-counter, herbal and medications that you take only occasionally.______

____

____

Are you allergic to any medications? Yes____ No____

If so, what?______________________________

PHSYCOSOCIAL HISTORY **Pediatric Only:** Are immunizations up to date? Yes____ No____

Adult: Are you married?__________ Do you consume alcohol?__________ If yes how much/often?__________

Tobacco Use: Currently/Formerly/Never If yes: Smoke or chewing tobacco?

Age started:__________Age stopped:__________ How much and how often:__________

Do you take recreational drugs (cocaine, marijuana, etc.)?______________________________

Are you Pregnant? Yes_____ No_____

FAMILY HISTORY

Do you know of any inherited diseases or bleeding disorders in your family?______________________________

What kind of work do you do?______________________________

PATIENT SIGNATURE______________________________ **DATE**__________

READ AND REVIEWED WITH THE PATIENT______________________________ **DATE**__________

Douglas E. Henrich, M.D.

Jennifer K. Berge, M.D.

REVIEW OF SYSTEMS:

PLEASE PUT AN "X" ON THE LINE IN THE TO INDICATE WHETHER YOU PRESENTLY HAVE ANY OF THE FOLLOWING SYMPTOMS.

		YES		YES
GENERAL	Fatigue	___	Weight Gain	___
	Daytime Sleepiness	___	Fever	___
	Chills	___	Weight Loss	___
EYES	Eye Pain	___	Watery/Itchy Eyes	___
ENT	Change in Voice	___	Hoarseness	___
	Difficulty Swallowing	___	Ear Pain	___
	Hearing Loss	___	Nasal Congestion	___
	Ringing/Sounds in Ears	___	Sinus Pain/Pressure	___
	Sleep Apnea	___	Snoring	___
	Sore Throat	___		
CARDIAC	Chest Pain	___	Rapid Heart Rate	___
	Irregular Heart Beat	___	Leg Swelling	___
RESPIRATORY	Shortness of Breath	___	Cough	___
	Wheezing	___	Coughing Blood	___
GI	Heartburn	___	Difficulty Swallowing	___
GU	Frequent Urination	___	Painful Urination	___
SKIN	Rash	___	Pigmentation Changes	___
	Hair Growth Changes	___	Hives	___
	Itching	___		
NEURO	Seizures	___	Headache	___
	Passing Out	___	Dizziness	___
MSK	Joint Pain	___	Muscle Pain	___
ENDO	Feel Cooler Than Others	___	Feel Warmer Than Others	___
PSYCHE	Depression	___	Mental Health Problems	___
HEME/LYMPH	Night Sweats	___	Bleeding Problems	___
	Easy Bruising	___	Swollen Glands	___
ALLERGY	Sneezing	___	Throat Dryness/Itching	___
	Environmental Allergy	___	Post Nasal Drip	___

CHECK HERE IF NONE OF THE ABOVE ___

PLEASE LIST MORE DETAILS ABOUT YOUR EAR, NOSE AND THROAT PROBLEMS BELOW: ____

____
____
____
____
____
____

NOTICE OF PRIVACY POLICIES FOR BURLINGTON ENT CLINIC, P.C.

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

INTRODUCTION

At BURLINGTON ENT CLINIC, P.C., we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit BURLINGTON ENT CLINIC, P.C., a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment.
Understanding what is in your record and how your health information is used helps to ensure its accuracy, better understand who, what, when, where and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Federal law grants you certain right with respect to your Protected Information. Specifically you have the right to:

- Receive notice of our policies and procedures used to protect your Protected Information.
- Request that certain uses and disclosures of your Protected Information be restricted, provided however, we have the right to refuse your request.
- Access to your Protected Information, provided however, the request must be in writing and may be denied in certain limited situations.
- Request that your Protected Information be amended.
- Obtain an accounting of certain disclosures by us of your Protected Information for the past six years.
- Revoke in writing any prior authorization for use or disclosure of Protected Information, except to the extent that action has already been taken.
- Request communications of Protected Information are done by reasonable alternative means or at alternative locations.

Our Responsibilities

Federal law also imposes certain obligations and duties upon us with respect to your Protected Information. Specifically, BURLINGTON ENT CLINIC, P.C., is required to:

- Provide you with notice of our legal duties and our facility's policies regarding the use and disclosure of your Protected Information.
- Maintain the confidentiality of your Protected Information.
- Review your requested restrictions regarding the use and disclosure of your Protected Information and inform you if these restrictions will be used.
- Allow you to inspect and copy your Protected Information during our regular business hours with a scheduled appointment pursuant to any legal restrictions. Please contact our Privacy Officer for fess and/or an explanation of our fee structure for copies, staff time charges and postage.
- Act on your request to amend Protected Information within sixty (60) days and notify you of any delay which would require us to extend the deadline by the permitted thirty (30) day extension. Although this does not guarantee that amendment is appropriate.
- Accommodate reasonable requests to communicate Protected Information by alternative means or methods.
- Abide by the terms of this notice.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain.
We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received written revocation of the authorization according to the procedures included in the authorization.

How Your Protected Information May Be Used and Disclosed

Generally your Protected Information may be used and disclosed for treatment, payment or operations as required by law. This includes a variety of areas:

We will use your health information for treatment.
We may use or disclose your Protected Information for treatment purposes, including continuing care and case or care management. During your care at our office, it may be necessary for various personnel, including but not limited to, physicians, nurses, or other members of your health care team involved in your care to access to your Protected Information in order to provide you quality care.

We will also provide your physician and or a subsequent health care provider outside of our office with copies of various reports that should assist him or her in treating you with your current or future care.

We will use your health information for payment.
Your Protected Information may also be used or disclosed for payment purposes. It is necessary for us to use or disclose Protected Information so that treatment and services provided by us may be billed and collected from you, your insurance company or other third party payers. Bills requesting payment will usually include information which identifies you, your diagnosis and any procedures or supplies used. It may also be necessary to release Protected Information to obtain prior approval for treatment from your health insurance.

We will use your health information for regular health operations.
Your Protected Information may be used for facility operations which are necessary to ensure our office provided the highest quality of care. For example, your Protected Information may be used for learning or quality assurance purposes. We may also remove information which could identify you from your record so as to prevent others from learning who the specific patients are.

Emergency Use:
In an emergency situation exists and providing you with this notice is not practicable, we may use or disclose Protected Information to the extent necessary during the emergency.

Notification:
Unless you have informed us otherwise, your Protected Information may be used or disclosed by us to notify or assist in notifying you, a family member, or other person responsible for your care. This may include, but not limited to, voicemail messages, postcards or letters. In most cases Protected Information disclosed for notification purposes will be limited to your name, location and general condition.

Research:
Your Protected Information may be used or disclosed for research purposes. All research projects which use Protected Information are subject to a special approval process which will, among other things, evaluate the precautions used to protect patient medical information. In some cases, information which identifies you as the patient will be removed.

Special Circumstances
The law specifically requires us to use or disclose Protected Information in the following special circumstances:

Public Health:
As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Health Care Oversights:
Your Protected Information may be used or disclosed to a health oversight agency for activities authorized by law. Examples of health oversight activities include audits, investigations, inspections or judicial/administrative proceedings which you are not the subject of. In most cases, the oversight activity will be for the purpose of overseeing the care rendered by our office or our office's compliance with certain laws and regulations.

Judicial and Administrative Procedures
If you are involved in a lawsuit or other administrative proceedings, we may release Protected Information in response to a court or administrative order requesting the release. In some instances, we may also release Protected Information pursuant to a subpoena or discovery request but only if efforts have been made by the requestor to provide you with notice of the request and you have failed to object or the objection was resolved in a favor of disclosure, or in the alternative, the requestor has obtained a protective order protecting the requested information.

Victims of Abuse or Neglect:
We may disclose your Protected Information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. This Protected Information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others. If you are incapacitated and unable to agree to such a disclosure, we may release your Protected Information for this purpose but only if failure to release it would materially and adversely affect a law enforcement activity and the information will not be used, in any way, against you.

Law Enforcement:
We may disclose health information for law enforcement purposes as required by law or in response to a valid court order, warrant, subpoena/summons or administrative request.

Communication With Family:
Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, your Protected Information relevant to that person's involvement in your care or payment related to your care, only if you agree that we may do so.

Coroner, Medical Examiners, Funeral Directors:

We may disclose Protected Information to a coroner, medical examiner and to funeral directors consistent with applicable law to carry out their duties.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICY

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign the acknowledgement if you wish.

I acknowledge that I have received a copy of Burlington Ear, Nose and Throat Clinic, PC's Privacy Practices.

____

Please print your name here

____

Signature

____

Date

DISCLOSURE

I authorize the following persons to have access to my health and/or account information.

___________________________________ ___________________________________

___________________________________ ___________________________________

___________________________________ ____________________

Patient or Parent/Guardian's Signature Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

___ The patient refused to sign
___ Due to an emergency situation it was not possible to obtain acknowledgement.
___ We weren't able to communicate with the patient.
___ Other (Please provide specific details)

____

____
____

______________________________ __________

Employee Signature Date