VERO ENT ASSOCIATES

Date: _____

LEGAL Name: _____ Soc. Sec. # _____

Date of Birth: _____ Age: _____ Sex: _____ Marital Status: _____

E-mail Address: _____

Spouse or Parent/Guardian: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Seasonal Address: _____ City: _____ State: _____ Zip: _____

Home Telephone: _____ Cell Telephone: _____

Employer: _____ Employer Telephone: _____

How did you hear about us?

_____Friend / Other Referral _____Dr. Referral _____Newspaper _____Internet _____Phonebook Other:_____

Friend or relative <u>not living with you</u> that we may contact in case of emergency (REQUIRED):

Name: _____ Telephone: _____

Referring Physician: _____ City: _____ State: _____

Regular Physician: _____ City: _____ State: _____

WE WILL NEED TO COPY ALL CURRENT INSURANCE CARDS AND DRIVER'S LICENSE / ID FOR OUR RECORDS

Primary Insurance Company

Insurance Co Name: _____ ID #: _____

Policy Holder name (if different from patient): _____

Policy Holder Date of Birth: _____ Relationship to Patient: _____

Policy Holder address: _____

Secondary Insurance Company

Insurance Co Name: _____ ID #: _____

Please note that this office is compliant and regulated by the Board of Medicine Rule Chapter 64B8-9.009, F.A.C. Effective February 17, 2000

MEDICAL AND SURGICAL HISTORY

Please help us serve you better by completing your medical history before you see the Doctor.
Your medical record is strictly confidential.

Name: _____ Date: _____
Date of Birth: _____ Age: _____ Height: _____ Weight: _____
Language: (please circle) English Spanish Other: _____
Race: (please circle) White/Caucasian American Indian Asian Black Native Hawaiian Unknown
Ethnicity: (please circle) Hispanic Origin Non-Hispanic Origin Unknown
Reason you are seeing the doctor today: _____
How long have you had this problem: _____
How many times have you been treated for this problem in the past year? _____
What medications or tests have you received for this problem in the past? _____

Medical Information

Allergic to any medications? No_____ Yes_____ If yes, please indicate: _____

List medications you are taking now: _____

Pharmacy: _____ Pharmacy Street Location: _____
Primary Care Physician: _____
Do you take aspirin? No_____ Yes_____ How often? _____
List any food or environmental allergies you may have: _____

List all previous medical problems: _____

List all previous surgeries: _____

Social History

Do you smoke tobacco? Never_____ Past_____ Present_____ Heavy Smoker_____ Light Smoker_____
Average packs per day_____ Approx start date?_____ Approx quit date?_____
Do you use chewing tobacco or smoke cigars? No_____ Yes_____ Amount per day?_____
Do you drink alcohol?_____ Amount per day?_____

Family History

Please list any illnesses which run in your family (list specific family members) including any bleeding disorders or bad reactions to anesthesia during surgeries.

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Head & Neck Surgery

PLEASE CHECK *"YES"* TO CONDITIONS YOU ARE CURRENTLY EXPERIENCING

GENERAL	YES
1. Fever	☐
2. Weight loss	☐
EYES	YES
1. Cataracts	☐
2. Glaucoma	☐
EARS	YES
1. Hearing loss	☐
2. Dizziness	☐
NOSE	YES
1. Nose bleeds	☐
2. Congestion	☐
THROAT	YES
1. Difficulty swallowing	☐
2. Hoarseness	☐
NEURO/PYSCH	YES
1. Stroke	☐
2. Depression	☐
HEART	YES
1. High blood pressure	☐
2. Previous heart attack	☐
LUNGS	YES
1. Bronchitis/chronic cough	☐
2. Asthma/wheezing	☐
GASTROINTESTINAL	YES
1. Diarrhea	☐
2. Nausea & vomiting	☐
HEMATOLOGIC / LYMPHATIC	YES
1. Excessive bleeding	☐
2. HIV	☐
MUSCULOSKELETAL	YES
1. Back pain	☐
2. Arthritis	☐
ENDOCRINE	YES
1. Thyroid disorders	☐
2. Diabetes	☐
OTHER	YES
Pregnant	☐
GENITOURINARY	YES
Difficulty Urinating	☐

Patient Name _____ Date _____

Patient Signature _____

FINANCIAL POLICIES

The best medical care can be provided only on the basis of mutual understanding. We encourage you to contact our billing office with any questions regarding filing of insurance and your financial obligation to Drs. Baggett, Yoon, Livingston, NP Tatiana Beir, APRN Kristina Fahmie and MSN APRN Summer Monroe.

Please be advised that this is not an all-inclusive list.

Please initial by each paragraph below indicating that you have read and agree to each.

Initial_____ If we participate with your insurance, we are contractually obligated to collect any deductible, coinsurance and / or co-pay at the time of service.

Initial_____

Initial_____ All doctors are participating providers for:**SEE LIST. If you have a co-pay stated on your insurance card, we will collect that at the time of your visit as well as any co-insurance and/or deductible that may apply.** If you have insurance coverage that is different from the list, we will file your insurance a courtesy for your reimbursement. **PAYMENT IS DUE AT THE TIME OF SERVICE.**

Initial_____ I authorize release of information concerning healthcare, advice, treatment to my insurance company(s), other physicians' offices where I am a patient, a physician's office that I am being referred to or to a surgical facility in preparation for surgery.

Initial_____ I understand that it is my responsibility to notify the office if my medical or medication information changes.

I, the undersigned, authorize payment of medical benefits for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I agree to be responsible for any legal fees and / or court costs incurred as a result of my failure to pay for services rendered.

PLEASE PRINT PATIENT'S NAME:_____ **DATE:** _____

Patient's or Parent/Guardian signature:_____

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Office Policies and Patient Responsibilities

If you are more than 15 minutes late for your appointment, you may be asked to reschedule.

Minors will not be seen without an accompanying parent or legal guardian, or a written notarized permission by the parent or legal guardian to see the patient.

Nursing home residents who have an assigned Power of Attorney (POA) will not be seen unless accompanied by their POA, or we get a written signed permission to see the patient and perform any necessary procedures.

Please notify the front desk receptionist of any change of address, phone number or insurance.

Medical records will be released within 10 business days or receipt of a signed, written request. One copy will be free of charge. Any additional copies requested will be charged a fee per page.

We understand your time is just as valuable as ours, and we do our best to stay on time. However, sometimes patient visits and surgical procedures take longer than expected which may result in some delays. We ask for your patience and understanding.

If you are unable to make your appointment we ask that you please call and cancel the appointment, any appointment not cancelled will be charged a $ **$50 NO SHOW FEE.**

Circumstances under which a patient will be dismissed:

1. Failure to comply with Drs. Baggett, Yoon, Livingston, NP Tatiana Beir, APRN Kristina Fahmie and MSN APRN Summer Monroe's instructions.
2. Being disrespectful, or impolite to the doctor or staff.
3. Suboptimal patient-doctor relationship.
4. Failure to keep scheduled appointment of failure to cancel/reschedule one day (twenty four hours) prior to the appointment. Two violations will be tolerated prior to dismissal.
5. Overdue balance on account greater than 180 days.

Patient Signature: _____

PATIENT PRIVACY QUESTIONAIRE

HIPAA ACKNOWLEDGEMENT

PRESCRIPTION MEDICATION REQUEST CONSENT

Name: _____

You may be contacted by us to remind you of appointments or discuss healthcare treatment options, results, or other health-related matters.

Please list any preferred phone numbers:

Home: _____ Cell: _____

Work: _____ Other: _____

Can we leave a message at the above numbers? ____ Yes ____ No

I agree to receive appointment reminders via TEXT MESSAGE at this number: _____

Are there any restrictions with regard to our office contacting you with medical information?

_____

Would you like to authorize an individual(s) as your personal representative? This person would have the authority to schedule, confirm or change appointments only. ____ Yes ____ No ____ N/A

If yes, please list full names:

_____ _____

I agree that my prescription medication history may be requested from other healthcare providers or third party pharmacy benefit payors and used for treatment purposes.

_____ _____

Patient or Personal Representative Signature Date

Some of the providers at Vero ENT Associates may use a remote "live scribe" transcription service during office visit to assist in accurate medical documentation. All privacy standards outlined in HIPAA regulations are employed with this service. Vero ENT Associates has offered me a copy of my rights as a patient under the HIPAA act. I have been provided the opportunity to read and understand my rights and ask questions regarding my rights and receive answers to my satisfaction.

_____ _____

Patient or Personal Representative Signature Date

Vero ENT Associates

Board Certified Otolaryngology
Head & Neck Surgery

NAME: _____ **Soc. Sec. #** _____

Date of Birth: _____ **Sex:** _____

Medicare Patients Only

I request that payment of authorized Medicare benefits be made on my behalf to Vero ENT Associates for any services rendered to me. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine if these benefits are payable for related services. The Medicare providers Dr. Kathleen Baggett, Dr. Alex Yoon, Dr. Jeffrey Livingston, NP Tatiana Beir, APRN Kristina Fahmie, MSN APRN Summer Monroe, Dr. Marietta Mathis and Dr. Brooke Nadeau agree to accept the charge determination of Medicare as the full charge and the patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Signed: _____ **Date:** _____

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General Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Patient Name: _____ Date of Birth: _____
Address: _____ Zip: _____
Phone: _____ SSN #: _____

I authorize the custodian of records of Vero ENT Associates, LLC to disclose / release the following information* (check all that apply):

___ All Records
___ Billing Records
___ Pharmacy / Prescription
___ Laboratory / Pathology Records
___ Imaging Records
___ Other (describe specifically): _____

*NOTE: If these records contain any information from previous providers or information about HIV / AIDS, cancer diagnosis, substance abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

Release Records from: _____
Name, Telephone & Fax #

Please send records indicated above to: _____
Name, Telephone, fax number and address if needed

Call for patient pick up: _____
Telephone number

This authorization shall expire 365 days from the date of signing and may not be valid for greater than one year from the date of signature. I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. By signing below, I represent and warrant that I have authority to sig this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____
Signature of patient or patient's representative

_____
Date

_____
Printed name of patient's representative

_____
Representative's relationship to patient
(e.g. parent, guardian, power of attorney for healthcare)

1325 36th Street Suite A Vero Beach, FL 32960

Phone: (772) 563-0015 Fax: (772) 770-0799