advanced
EAR, NOSE & THROAT
head and neck surgery

| PATIENT INFORMATION | | | | | |
|---|---|---|---|---|---|
| LAST NAME | FIRST NAME | | MIDDLE INITIAL | SSN | |
| HOME PHONE | MOBILE PHONE | | AGE | DOB | GENDER |
| PATIENT ADDRESS | APT/UNIT # | CITY | STATE | ZIP CODE | |
| RACE | ETHNICITY | LANGUAGE SPOKEN | EMAIL ADDRESS | | |
| EMERGENCY CONTACT | EMERGENCY ADDRESS | | TELEPHONE | RELATIONSHIP | |

| RESPONSIBLE PARTY | | | |
|---|---|---|---|
| GUARANTOR NAME (LAST, FIRST, M.I.) | DOB | GENDER | SSN |
| GUARANTOR'S COMPLETE ADDRESS | TELEPHONE | | |
| REASON FOR VISIT | REFERRING PHYSICIAN | HOW DID YOU HEAR ABOUT OUR OFFICE? | |

| INSURANCE INFORMATION | | | |
|---|---|---|---|
| **(1)** PRIMARY INSURANCE COMPANY | TELEPHONE | | |
| POLICY HOLDER'S NAME | Relationship to patient | DOB | SSN |
| POLICY NUMBER | GROUP NUMBER | EFFECTIVE DATE | |
| **(2)** SECONDARY INSURANCE COMPANY | TELEPHONE | | |
| POLICY HOLDER'S NAME | Relationship to patient | DOB | SSN |
| POLICY NUMBER | GROUP NUMBER | EFFECTIVE DATE | |

| PHARMACY INFORMATION | | |
|---|---|---|
| PREFERRED PHARMACY | PHONE NUMBER | ADDRESS/ CROSS STREETS |

The above information is complete and correct. I hereby authorize release of information necessary to file a claim with my insurance company and I assign benefits otherwise payable to the doctor or group indicated on the claim. I understand that I am financially responsible for all charges for medical services rendered regardless of insurance coverage. A copy of the signature is valid as the original. (A $25.00 fee will be charged if I do not call 24 hours prior to canceling my appointment.

***PATIENT/GUARDIAN SIGNATURE*** _____ **DATE** _____

***GUARANTOR SIGNATURE*** _____ **DATE** _____

# Adult History

Please answer each question by filling in the appropriate circle fully.

Do you have any medical problems?

O Eye problems
O Vision changes
O Sinusitis
O Allergies in the past
O Ear problems
O Nose problems
O Throat/Neck problems
O High blood pressure
O Mitral valve prolapse
O Heart Attack in the past
O Asthma
O COPD
O Genitourinary problems
O Migraine headaches
O Seizures
O Anxiety/Depression
O Diabetes
O Thyroid problems
O Anemia
O Blood cancer
O Skin cancer
O Breast cancer
O Other, please list: _____
O None

Please List all Medications that you are currently taking: _____
_____

Please List all Allergies to Medications and the reaction you have to them:_____
_____
_____

Please List all Surgeries: _____
_____

Please answer each question by filling in the appropriate circle fully.

Does anyone in the family have any medical problems?

| | | | |
|---|---|---|---|
| Mother | O Yes O No | If yes, please list: | _____ |
| Father | O Yes O No | If yes, please list: | _____ |
| Children | O Yes O No | If yes, please list: | _____ |
| Maternal Grand Mother | O Yes O No | If yes, please list: | _____ |
| Maternal Grand Father | O Yes O No | If yes, please list: | _____ |
| Paternal Grand Mother | O Yes O No | If yes, please list: | _____ |
| Paternal Grand Father | O Yes O No | If yes, please list: | _____ |

Do you?

Drink Alcohol O Yes O No
If yes, amount: O 1 O 2 O 3 O 4 O per day O per week O per month

Smoke O Yes O No
If yes, amount: O 1 O 2 O 3
O packs/day O packs/week
For how long? O <5 yrs O 5-10yrs O 10-15 yrs O >15 yrs

Use Smokeless Tobacco O Yes O No
Use Recreational drugs O Yes O No
Are you around smoke O Yes O No
Are you Employed O Yes O No
Please List Occupation:_____

**Have you experienced any of the following in the last 6 months?**

| | |
|---|---|
| weight change | O Yes O No |
| fever | O Yes O No |
| chills | O Yes O No |
| fatigue (feeling run down) | O Yes O No |
| hearing loss | O Yes O No |
| sore throat | O Yes O No |
| nose bleeds | O Yes O No |
| change in voice | O Yes O No |
| ringing in ears | O Yes O No |
| dizziness | O Yes O No |
| allergies | O Yes O No |

**Have you experienced any of the following in the last 6 months?**

| | | |
|---|---|---|
| chest pain | O Yes | O No |
| irregular heart rhythm | O Yes | O No |
| take Coumadin/blood thinners | O Yes | O No |
| nausea | O Yes | O No |
| vomiting | O Yes | O No |
| diarrhea | O Yes | O No |
| difficulty swallowing | O Yes | O No |
| heartburn | O Yes | O No |
| diabetes | O Yes | O No |
| thyroid disease | O Yes | O No |
| cold intolerance | O Yes | O No |
| heat intolerance | O Yes | O No |
| headache | O Yes | O No |
| memory loss | O Yes | O No |
| difficulty walking | O Yes | O No |
| blurring of vision | O Yes | O No |
| cough | O Yes | O No |
| wheezing | O Yes | O No |
| shortness of breath | O Yes | O No |
| runny nose | O Yes | O No |
| itchy eyes | O Yes | O No |
| stuffy nose | O Yes | O No |
| easy bruising | O Yes | O No |
| anemia | O Yes | O No |
| skin rashes | O Yes | O No |
| skin lesions | O Yes | O No |
| rheumatoid arthritis | O Yes | O No |
| lupus | O Yes | O No |

# PATIENT NOTIFICATION FOR PAYER PAYMENT POLICIES FOR CERTAIN IN-OFFICE PROCEDURE

Patient Name: _____

Please be aware that certain procedures performed in our office are not included in the standard office visit. These procedures will be billed separately and in addition to the office visit charges. We have become aware that some insurance carriers are classifying these procedures as "Surgery" and applying the charges to a higher deductible amount. The result may be insurance payment for an office visit but not a procedure. In such cases, payment for the procedure will be due from the patient. Be assured that we are following accepted billing and coding guidelines and that all procedures are performed in the best interest of patient care.

Examples of in-office procedures include:

**Flexible laryngoscopy**: This procedure involves passing a long thin flexible fiber optic scope through the nasal cavity and into the throat. The fiber optic scope enables the physician to visualize areas of the throat not readily seen using the laryngeal mirrors.

**Nasal endoscopy**: This procedure uses the flexible or rigid scope attached to a light source to view areas of the nasal cavities that cannot be viewed by the physician using the standard nasal speculum and head mirror.

**Nasal endoscopy with debridement or biopsy**: This is the same procedure as above with removal of crusting or tissue.

Please speak with our nurse or clinical assistants if you have any questions.

**Patient/Guardian Signature** _____ **Date** _____

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# Financial Policy

Dear patient,

Thank you for choosing us as your healthcare provider. The following is our office financial policy. Our main concern is that you received the proper and optimal treatments needed to restore your health. Therefore, if you have any questions or concerns about our payment policies please do not hesitate to ask.

We ask that all patients read and sign our financial policy and fill out the patient information for prior to seeing the doctor.

Cash patients please remember that payment for services is due at the time services are rendered. Our office may offer you a cash discount and a payment plan if necessary.

For your convenience we accept Cash Check, MasterCard, Visa, Discover Cared or American Express.

**All co-pays and deductibles are due at the time of service. If your financial responsibility is not paid, a $25.00 charge will be added to your bill. Please initial_____.**

If the insurance company does not pay your balance in full within 30 days, we ask that you contact the carrier to help process your outstanding claim(s). Please remember that your insurance requires us to collect all co-pays and deductibles prior to services being rendered. This is our contract obligation and your obligation to your insurance company.

All insured patients are required to sign the assignment of benefits for payment from the insurance company.

All returned checks will be subject to a $35.00 NSF fee.

Delinquent accounts will be turned over to an attorney and/or collection agency without notice. All accounts will be considered delinquent if unpaid after 90 days. In the vent your account is turned over to a collection agency, you will be responsible for the collection agency and court costs up to 50% of the outstanding balance at the time the account is considered delinquent.

Again, we thank you for choosing us as your healthcare provider. We appreciate your trust in us and we appreciate the opportunity to serve you.

**Patient/Guardian Signature: _____ Date: _____**

**ASSIGNMENT OF BENEFITS**

I hereby guarantee the payment of all charges incurred at the office of Dr. Randall S. Lomax, DO. I hereby assign and direct to pay any and all benefits for medical services under this claim directly to Randall S. Lomax DO, PLLC. I hereby authorize the release of any medical information requested by the insurance companies with the above assignment.

**Patient/Guardian Signature: _____ Date: _____**

# HIPAA Notice of Privacy Practices

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

## Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other uses required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities included, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law; Public Health issues as required by law; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners; Funeral Directors, and Organ Donors; Research ; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

**Other Permitted and Required Uses and Disclosures** will be made only with your consent, authorization or opportunity to object unless required by law.

**You may revoke this authorization,** at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

## Your Rights

Following is a statement of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information.** Under Federal Law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is now subject to law that prohibits access to protected health information.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location.**

**You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice alternatively i.e.., electronically.

**You may have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

**Complaints**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at (702) 360-3838

Signature below is only an acknowledgement that you have received this Notice of Privacy Practices:

**PRINT NAME:** _____**SIGNATURE:** _____**DATE:** _____

Permission to release health information to_____, Relationship_____

Permission to release health information to_____, Relationship_____

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# Request for Records

Patients: Please list any previous providers so we may retain medical records.

Date: _____

Physician: _____

Specialty: _____

Phone: _____Fax:_____

☐ Copies of Blood work in the last _____months

☐ Medical Records in the last _____ months

☐ All radiology reports in the last _____ months

I, _____ hereby authorize you to release all of the above records to Dr. Randall S. Lomax. This request expires 12 months from date signed.

_____ _____

**Print Patient Name** **Date of Birth**

_____ _____

**Patient or Guardian Signature** **Relationship to Patient**

*****FAX RECORDS TO (702)834-5752*****