AUSTIN EAR CLINIC
12319 N Mopac Expy, Bldg C, Suite #300, Austin, Tx 78758-2403 (512) 454-0341

NEW PATIENT INFORMATION – ***PLEASE PRINT***

Name: Date:
First Middle Last

Address:
Street City State Zip

( ) ( ) ( ) / / - -
Home Telephone Cell# Work Telephone**:** **Patient Date of Birth** **AGE** Patient SSN

EmailAddress:

Male / Female Marital Status: S D M W **REFERRING DOCTOR**:

Patients Employer: Occupation:

Emergency Contact: Contact Phone: ( ) Relation to Patient:

PRIMARY Insurance Company: **Name of Policy Holder:**

Relation to Patient: **Date of Birth:** **Policy Holder's SSN:** - -

Group Number: **Policy ID Number:**

SECONDARY Insurance Company: **Name of Policy Holder:**

Relation to Patient: **Date of Birth:** **Policy Holder's SSN:** - -

Group Number: **Policy ID Number:**

MINOR PATIENTS:

MOTHER: Address:

Home Phone: Business Phone: Date of Birth: / / SSN: - -

Employer: Occupation:

FATHER: Address:

Home Phone: Business Phone: Date of Birth: / / SSN: - -

Employer: Occupation:

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Briefly state the reason for your visit today: _____

PAST SURGERIES: Please list any past surgeries and the date of the surgery.

Any Ear/Nose/Throat/Neck surgeries? Yes No Complications with anesthesia? Yes No

Surgery:	Date:	Surgery:	Date:	Surgery:	Date:

Medical History: (Examples: Hospitalizations, diseases, medical conditions, traumatic injuries.) Please list diagnosis and the date of the diagnosis below.

Diagnosis:	Date:	Diagnosis:	Date:	Diagnosis:	Date:

Family History: Check all that apply

☐ Heart Disease ☐ High Blood Pressure ☐ Strokes ☐ Diabetes ☐ Autoimmune
☐ Hearing Loss ☐ Cancer ☐ Aneurysms ☐ Environmental Allergies ☐ Meniere's Disease

Are you interested in Allergy Testing and/or Treatment at this time? Yes No

Social History: Do you smoke? Yes No If YES, how much per day? _____

Do you drink? Yes No If YES, how much per day? _____

Drug Allergies: Do you have any? If YES, What? _____

Antibiotics: In the last 3 months, have you been on any course of antibiotics? If YES, please list below:

_____

If you are *female*, is there a chance you might be pregnant? Yes No

MEDICATIONS: Please list medications you are currently taking, and their dosages.

Medication:	Dose :	Medication:	Dose:	Medication:	Dose:

What **Pharmacy** do you use? Name, Phone# and/or Address: _____

_____

Authorized signature: I authorize the release of any medical information necessary to process an insurance claim. I authorize payment of medical benefits to the Austin Ear Clinic and/or Dr. Patrick W. Slater.

_____

Patient signature, or authorized persons' signature **Date**

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Patient Name: _____ **Date:** _____

In the past few months/weeks have you felt any of the following conditions? Check **ALL** that apply.

Allergic/Immunologic:
- ☐ Trouble Breathing
- ☐ Seasonal Allergies
- ☐ Immune Deficiency
- ☐ Reaction to drugs

Constitutional Symptoms:
- ☐ Fever or chills
- ☐ Weight loss or gain
- ☐ Night sweats
- ☐ Headaches
- ☐ Fatigue

Cardiovascular:
- ☐ Chest pain
- ☐ Difficulty breathing on exertion
- ☐ Difficulty breathing when lying flat
- ☐ Palpitations
- ☐ Heart murmurs
- ☐ High blood pressure
- ☐ Edema
- ☐ Ankle swelling
- ☐ Coronary artery disease
- ☐ High cholesterol
- ☐ Stent placement
- ☐ Pacemaker

Head/Eyes:
- ☐ Head injury
- ☐ Double vision
- ☐ Vertigo
- ☐ Blind spots
- ☐ Eye Pain
- ☐ Cataracts
- ☐ Tearing

Blood:
- ☐ Easy Bruising
- ☐ History of blood clots
- ☐ Anemia
- ☐ Blood Transfusion
- ☐ History of swollen glands

Endocrine/Urinary:
- ☐ Increased thirst
- ☐ Heat or Cold intolerance
- ☐ Diabetes
- ☐ Masses
- ☐ Hernias
- ☐ Blood in urination
- ☐ Painful urination
- ☐ Hormone therapy
- ☐ Increased urine production

Ear, Nose, Throat:
- ☐ Hearing loss or ringing
- ☐ Bloody nose
- ☐ Nasal congestion
- ☐ Runny nose
- ☐ Sinus issues
- ☐ Sore Throat
- ☐ Hoarseness
- ☐ Speech changes
- ☐ Dentures
- ☐ Teeth issues
- ☐ Neck stiffness, Pain or Tenderness
- ☐ Thyroid mass

Gastrointestinal:
- ☐ Loss of Appetite
- ☐ Abdominal pain
- ☐ Nausea
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in stool
- ☐ Abnormal stools
- ☐ Heartburn
- ☐ Anorexia
- ☐ Jaundice

Musculoskeletal:
- ☐ Joint pain
- ☐ Stiffness\Swelling
- ☐ Night cramps
- ☐ Back pain
- ☐ Muscle pain/cramps
- ☐ Limited range of motion

Neurologic:
- ☐ Paralysis
- ☐ Seizures
- ☐ Tremors
- ☐ Stroke
- ☐ Difficulty with speech
- ☐ Light headed/dizzy

Psychiatric:
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ Bipolar disorder
- ☐ Memory loss
- ☐ Bulimia
- ☐ Hallucinations
- ☐ Suicidal thoughts

Respiratory:
- ☐ Dry Cough
- ☐ Productive Cough
- ☐ Shortness of breath
- ☐ Asthma/Wheezing
- ☐ Pain with Breath

Integumentary (skin and/or breast):
- ☐ Rash
- ☐ Itching
- ☐ Dry Skin
- ☐ Hair or nail changes
- ☐ Pain
- ☐ Masses
- ☐ Discharge

Please list below any surgeries or medical conditions:

_____

_____

_____

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Acknowledgement of Review of Notice of Privacy Practices (HIPAA)

TO OUR PATIENTS: We are required by all applicable federal and state law to maintain the privacy of your health information. We may use or disclose your health information to a physician or other healthcare provider that provides treatment to you.

We **may** use and disclose your health information to obtain payment from insurance companies or third parties for treatment and services we provide to you. **Unless at your request**, and in writing we **may not** disclose your health information to your insurance provider, so in this case you would be a self-paying-patient and would be paying for your claims as out-of-pocket.

Please initial and check how we will process your claims at the Austin Ear Clinic:

O **I choose TO use my *Insurance Provider* for processing of my claims.**
Initials: _____

O **I choose NOT to use my Insurance Provider, and the services rendered from the Austin Ear Clinic will be paid "*out-of-my pocket".***
Initials: _____

We **may** disclose your health information:

–To our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services.
–To oversight activities with include audits, investigation, inspections and licensure.
–For Data Breach Notification purposes to provide legally required notices of unauthorized access to your health information.
–Public health Risks.
–For lawsuits and disputes.
–Coroners, Medical Examiners and Funeral Directors as well as Law Enforcement
–Health oversight activities by law.
–National Security and Intelligence Activities.
–To the Protective Services for the President and Others.
–If you are an Inmate or individuals in Custody.

UNLESS YOU GIVE US WRITTEN AUTHORIZATION, WE CANNOT USE OR DISCLOSE YOUR HEALTH INFORMATION FOR ANY REASON EXCEPT THOSE REASONS DESCRIBED ABOVE.

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Acknowledgement of Review of Notice of Privacy Practices (HIPAA)

(Continued)

We **may not** disclose your health information without written authorization for the following:

1. Uses and disclosure of protected health information for Marketing Purposes.
By checking this box and signing below, I authorize Austin Ear Clinic to send me educational and/or marketing information on new products and service that may become available. Austin Ear Clinic may receive direct or indirect remuneration from another entity for participating in certain education and/or marketing events or promotions.

2. Disclosures that constitute a sale of your Protective health information.

Please initial and check how we may disclose your health information:

O I ALLOW my protective health information to be used for Marketing Purposes.

Initials: _____

O I DO NOT ALLOW my protected health information to be used for Marketing Purposes.

Initials: _____

A Signature (below) is required to acknowledge your understanding of Austin Ear Clinic's Privacy Practices.

_____ _____

Signature of Patient (or Patient's Representative) **Date of Signature**

_____ _____

Printed Name of Patient or Representative **Representative's authority to sign for Patient (Parent, Guardian, POA for Healthcare, or Executor)**

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FINANCIAL POLICY:

Thank you for choosing us as your health care provider. We are committed to the success of your treatment. Please understand that the payment of your bill is considered your responsibility. The following is a statement of our Financial Policy, which we require that you read and sign prior to receiving any treatment in our clinic. In addition, all patients must complete and sign the Patient Information Form before being seen at the Austin Ear clinic.

INSURANCE BILLING:

We file insurance claims for companies in which we are providers. If your insurance company has not paid the claim within 30 days of filing, we require that you make a payment to your account. Your insurance policy is a contract between you and your insurance company. The charges due on your account are your responsibility, regardless of whether your insurance company pays your claim in a timely manner.

Assignment Of Benefits:

I have been given the opportunity to pay my estimated deductible and co-insurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate prompt payment of the claim by my insurance company. I authorize the provider to initiate a complaint or file appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

Full payment is due at the time of service. We accept cash, checks, Visa, Master Card, Discover and American Express credit cards for payment.

Credit Card On File Authorization:

We provide secured methods of accepting your payment at the time of treatment and also for keeping your credit card on file to handle any remaining balance after insurance company reimbursement.

USUAL AND CUSTOMARY CHARGES:

Our practice is committed to providing the best treatment possible for our patients and we charge what is considered usual and customary for Otological and Neurotolological specialties.

MINOR PATIENTS:

The adult accompanying a minor patient and/or the parents (or guardians) are responsible for full payment of the minor's treatment charges. An unaccompanied minor patient requiring non-emergency treatment will not be seen by our staff, unless the minor patient has written permission for treatment and charges have been pre-authorized by a deposit placed upon a valid credit card or check at the time of service.

Please let us know if you have any questions or concerns regarding our financial policy. We appreciate your understanding that we have instituted this financial policy in order to continue to provide quality patient care to all of the patients of the Austin Ear Clinic.

ACKNOWLEDGMENT:

I have read the Financial Policy above and agree to be seen as a patient of the Austin Ear Clinic, and therefore, accept the terms of said Financial Policy.

Printed Patient Name	**Printed Parent or Guardian Name**
Signature of Responsible Party	**Date of Signature**

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Credit Card On File Authorization

We understand that convenience is not often associated with today's Healthcare environment. Our Practice not only focuses on excellent healthcare service but also how to provide service as cost and time effective as possible. We have found that collecting all known liability at the time of service is not only beneficial for the practice, but the experience has proven that our patients appreciate knowing they will not have to worry about delayed billing or payments.

We provide secured methods of accepting your payment at the time of treatment and also for keeping your credit card on file to handle any remaining balance after insurance company reimbursement.

We will work with you in establishing a payment schedule if necessary using this credit card authorization form.

I , _____ AUTHORIZE The Austin Ear Clinic/ Patrick Slater, M.D.
(GUARANTOR NAME)
to keep my signature and credit card information on file and to charge my account for balances that remain unpaid sixty (60) days following the service not to exceed $200 per month (or frequency as outline in our agreement). **If the amount is over $200 we will contact you to verify the amount we are charging your credit card.**

I understand the provider is offering this as a courtesy and I will pay my Copay's, estimated deductible and co-insurance at the time of service and may pay my balance in full at any time and cancel this agreement. I am authorizing the use of this card for:

Patient Name: _____

Card Holder Name: _____

Card Holder Address: _____

Type of Credit Card: Visa____ MC_____ AMEX _____ DISC_____

#_____

EXPIRATION DATE: _____ SECURITY CODE: _____

_____ _____

Signature of Responsible Party **Date of Signature**

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Authorization for Release of Medical Records

TO OUR PATIENTS: We are required by all applicable Federal and State law to maintain the privacy of your Personal Health Information (PHI).

PATIENT IDENTIFICATION	Patient _____ Date of Birth: _____ Telephone Number: _____

DESIGNATED APPOINTEE(s)

You may list a person(s) whom Austin Ear Clinic will authorize to sign and pick up your medical records as well as communicate verbally about your medical records and your treatment.

Name: _____

Telephone Number: _____

RELEASE of RECORDS TO PRIMARY CARE PHYSICIAN

It is possible for Austin Ear Clinic to send updates of significant healthcare milestones to your Primary Care Physician (PCP) as appropriate. Please indicate if you would like to release your medical records to your PCP so that they can receive your medical updates.

Would you like your PCP to receive updates from Austin Ear Clinic? **YES** ☐ **NO** ☐

Primary Care Physician (First & Last Name): _____

RELEASE OF PRINTED RECORDS

Please indicate the type of medical records you wish to have released: _____

☐ SELF- PERSONAL USE _____
Fax Number

☐ PHYSICIAN

_____
Physician's Full Name **Telephone Number**

_____
Physician's Full Address **Fax Number**

1. **I understand that Austin Ear Clinic now has permission to release and discuss my records to the person(s) stated on this form, and that I can change at any time to allow/disallow another person to receive my information if so desired, but must be restated in writing. If no one is listed above, records will be released to no one but the patient.**
2. **I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Austin Ear Clinic. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.**
3. **In addition, I understand that my medical records may contain copies of information received from other healthcare facilities and due to Federal Regulations, those records must be released from the original medical facility and not from Austin Ear Clinic.**
4. **FEES FOR PRINTED RECORD REQUESTS: The fee for record request is as follows: $25.00 for the first 20 pages and $.50 for each page after. Fees are subject to change without notice.**
5. **Records will be faxed approximately 7-10 business days after payment is received.**

_____ _____
Signature of Patient or Patient's Representative **Date of Signature**

_____ _____
Printed Name of Patient or Representative **Representative's authority to sign for Patient (Parent, Guardian, POA for Healthcare, or Executor)**