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# **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

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

Office Use Only

Patient Name:

Patient DOB:

12319 North Mopac Expressway Building C, Suite 300, Austin, TX 78758 (512) 454-0341

Office Policy

Patient Identification: To enhance identity protection in compliance with the Federal Trade Commission's "Red Flag" rule, which mandates healthcare providers establish anti-identity theft programs, our office has implemented a patient identification policy. Our office will require valid photo identification from all patients upon check-in.

Treatment Authorization: I hereby authorize Austin Ear Clinic to examine, diagnose, and treat me. I authorize Austin Ear Clinic consent to submit specimens (blood, urine, tissue, etc.) to the laboratory for analysis and study, and to include diagnosis for submission for payment to the insurance carrier for the named patient. I hereby voluntarily consent to the rendering of such care and treatment as my providers, in their professional judgment, deem necessary for my health and well-being. My consent shall cover medical examinations and diagnostic testing, including but not limited to, minor surgical procedures, audiogram testing, and CT Scans.

Assignment of Benefits and Authorization to Release Medical Information: I hereby certify that the insurance information I have provided is accurate, complete, and current, and that I have no other insurance coverage. I assign my right to receive payment of authorized benefits under Medicare, Medicaid, and/or any of my insurance carriers to the provider or supplier of my services furnished to me by that provider or supplier. I authorize my provider to file an appeal on my behalf for any denial of payments and/or adverse benefit determination related to services and care provided. If my health insurance plan does not pay my provider directly, I agree to forward to my provider all health insurance payments which I receive for the services rendered by my provider and its health care providers. I authorize my provider or any holder of medical information about me or the patient named below to release to my health insurance plan such information needed to determine these benefits or the benefits payable for related services. I understand that if my provider does not participate in my insurance plan's network, or if I am a self-pay patient, this assignment of benefits may not apply

Consent to Call, Email & Text: I understand and agree that my provider may contact me through calling, emailing, or text messaging sent to my landline and/or mobile device. These communications may notify me of appointment reminders, results, outstanding balances, or any other communications from my provider. I understand that I may opt out of receiving such communications from my provider by notifying my provider's staff. By providing a telephone number and signing this form, I am consenting to be contacted by SMS text message. You can reply STOP to opt-out of further messaging.

Prescription Benefits and Medication History: I hereby authoize Austin Ear Clinic to download my prescription benefits and medication history information from Surescripts pharmacy clearinghouse.

Marketing Communications: I acknowledge and consent to receive marketing text/emails including information regarding goods/services/events/promotions etc. that we believe may be of interest to you. You may opt out of these messages at any time. Your care will not be affected if you choose to opt out of marketing communications. You will continue to receive healthcare related messages.

Acknowledgment of Review of Privacy Practices: I have reviewed this office's Notice of Privacy Practices, outlined on our clinic's website under Privacy Policy or by request from the front desk, which explains how my medical information will be used and disclosed. I acknowledge that I have received a copy of Austin Ear Clinic's "Notices of Privacy Practices."

Interpreter Services: Austin Ear Clinic provides free aids and services to people with disabilities to communicate effectively with us and free language services to people whose primary language is not English, such as qualified language interpreters or written information in other formats. Please inform the front desk no later than 72 hours before your appointment if you will be needing interpreting services.

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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 by Dr. Slater.

PRICING AND FEES:

Austin Ear Clinic works diligently with insurance companies to check patient's benefits and Dr. Slater's network status. Austin Ear Clinic will do our best to inform you of your benefits and our network status with your insurance before you see Dr. Slater. If we are out of network with your insurance, we are operating on an out of pocket system and would like to be as upfront and straightforward as possible in regards to our fees. Our fees are broken down below. If you have any questions, please ask the front office before seeking treatment by Dr. Slater. If you are here to only have your ears cleaned, there is no initial office visit charge. If you would like to file out of network benefits with your insurance company to receive reimbursement, please let the front desk know when you check out.

Initial Office Visit: **$400**
Follow Up Visit: **$100-$260**
Ear Cleaning: **$200**
Nasal Endoscopy: **$100-$300**
Steroid Injection of the Ear: **$200/ear**
CT Scan of Sinuses: **$200**
CT Scan of Temporal Bones: **$300**
Audiogram: **$65**
Sinus Ointment Placement: **$750**

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

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 Otology and Neurotology 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 care to all of our patients at Austin Ear Clinic.

Acknowledgment: I have read and agree to all sections under Austin Ear Clinic's Office and Financial Policy. I agree to Austin Ear Clinic's Notice of Privacy Practices. I agree that this form applies and extends to subsequent visits and appointments with any Austin Ear Clinic's providers.

Patient Name _____ Patient Signature _____

Legal Guardian (*if applicable*) _____ Legal Guardian Signature (*if applicable*) _____

Date _____

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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)**