Buckland Ear, Nose & Throat, LLC

Medical History

Today's Date: _____

Patient Name: _____ Date of Birth: _____ Age: _____

Primary Care Doctor: _____ Referred by: _____

Local Pharmacy: _____ Mail-Away Pharmacy: _____
Name Street City/Town

1. Reason for visit: _____

2. Past Medical History: (Check all that apply)

__ high blood pressure	__ hepatitis A, B or C	__depression
__ heart disease	__ liver disease	__ anxiety
__ chest pain	__ kidney disease	__ psychiatric illness
__ irregular heart beat	__ cancer	__ drug addiction
__ rheumatic heart disease	__ tuberculosis	__ alcohol problem
__ diabetes	__ asthma	__ reflux/GERD
__ bleeding disorders	__ bronchitis, emphysema	__ hay fever
__ stroke	__ shortness of breath	__ food allergies
__ seizures	__ enlarged lymph nodes	__ blood disorder
__ thyroid problems	(neck, under arm, groin)	__ sleep apnea
__ AIDS/HIV	__ vertigo	__ high cholesterol
__ immune disorders	__ hearing loss	__ arthritis

__ other _____

3. Please list any ALLERGIES you have to medications (name of drug and reactions)

4. Do you smoke? Yes / No _____ packs per day for _____ years.
If not, have you ever smoked? Yes / No _____ packs per day for _____ years. I quit _____ years ago.

5. Do you have a history of alcohol use? Yes / No How much? _____

6. Previous surgery: Type Year
Ear, nose or throat:
All other surgeries:

7. Have you had any adverse reactions to surgery or anesthesia? Yes / No
Explain:

8. Family history of (circle all that apply):
diabetes heart disease cancer bleeding tendencies reaction to anesthesia

9. Are you pregnant? Yes / No

10. Have you had previous allergy testing? Yes / No Where: Date:

MEDICATION LIST

DATE: _____

NAME: _____DATE OF BIRTH: _____ NAME

	STRENGTH	DOSAGE
INCLUDE OVER THE COUNTER AND HERBAL MEDICATIONS		
Example: Calcium	**600 mg**	**one tablet 3 times a day**
***DO YOU TAKE ALL YOUR MEDICATIONS BY MOUTH? YES____NO____**		

Buckland Ear, Nose &Throat, LLC
Michael J. Franklin, M.D.
Vanessa Romero, PA-C

PLEASE FILL OUT ALL INFORMATION REQUESTED

PATIENT'S NAME: _____ SOC. SEC. NO: _____

ADDRESS: _____
STREET CITY STATE ZIP

PHONE: HOME: ( ) _____WORK: ( ) _____ CELL: ( ) _____

DATE OF BIRTH: _____ SEX: M___ F___ MARITAL STATUS: M___ S___ W___ D___

EMAIL ADDRESS: _____YOUR REGULAR DOCTOR: _____
NAME CITY

EMERGENCY CONTACT: _____
NAME ADDRESS PHONE RELATION

EMPLOYER: _____
NAME CITY

IF PATIENT IS A CHILD:

FATHER'S NAME: _____ MOTHER'S NAME: _____

ADDRESS: _____ ADDRESS: _____

PHONE NUMBER: H)_____C)_____ PHONE NO: H)_____C)_____

EMPLOYER: _____ EMPLOYER: _____
NAME PHONE NO. NAME PHONE NO.

PRIMARY INSURANCE

INS CO. NAME: _____

SUBSCRIBER'S NAME: _____

PT.'S RELATION TO SUBSCRIBER: _____

SUBSCRIBER'S SOC. SEC. NO: _____

SUBSCRIBER'S DATE OF BIRTH: _____

INS. ID NO: _____

GROUP NUMBER:_____

EMPLOYER: _____

SECONDARY INSURANCE

INS. CO. NAME: _____

SUBSCRIBER'S NAME: _____

PT.'S RELATION TO SUBSCRIBER: _____

SUBSCRIBER'S SOC. SEC. NO: _____

SUBSCRIBER'S DATE OF BIRTH: _____

INS. ID. NO: _____

GROUP NUMBER: _____

EMPLOYER: _____

DO YOU HAVE A THIRD INSURANCE: YES___ NO ___ IF YES, PLEASE LIST ON BACK OF THIS FORM

HOW DID YOU HEAR ABOUT US: YOUR PHYSICIAN___ OUR WEBSITE ___ YELLOW PAGES ___ OPG.COM ___ OTHER _____

I authorize the release of medical information necessary to process claims for medical benefits. I authorize payment of medical benefits to Buckland ENT for services rendered. I understand that I am financially responsible to the doctor for charges not covered by this assignment. I also understand even though I have insurance coverage, I am responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Today's Date: _____Patient's or Other Authorized Signature: _____

BUCKLAND EAR, NOSE, & THROAT, LLC

Michael J. Franklin, M.D., D.D.S. Vanessa Romero, PA-C

PAYMENT POLICY

If you do not have insurance, payment will be expected on the day the service is provided.

If you arrive for your appointment without your insurance card, you may be asked to reschedule your appointment.

All co-payments must be paid when checking in with the receptionist.

As a courtesy to our patients, we will file an insurance claim for service provided only if you have provided us with **complete and correct subscriber insurance information** and that you have **signed the authorization section on your Patient Information Sheet.**

If you belong to a managed care insurance plan, you signed a contract that does not allow you to see a specialist without prior approval from your primary care physician (PCP). **You are responsible for obtaining this referral from your PCP.** If we do not have a documented referral from your primary care physician's office prior to your appointment, your visit **will not be covered by your insurance and you will be responsible for the payment on that date of service or your appointment can be rescheduled until the referral is obtained.** These are the guidelines set up by your insurance company and stated in your Insurance Policy Manual.

Within 30 days, you will receive a statement of your account. It will show the total amount due by your insurance and amount due by you. We will expect full payment on your account within 45 days of the date of service. If payment has not been received by that time, you will receive a **PAST DUE** letter as a warning. If payment is not made within 60 days, we will take further **collection action**.

In the event there is a duplicate payment on your account and it shows a credit balance, we will refund the amount immediately.

All checks returned for non-sufficient funds will be subject to a $20.00 additional charge.

If you have any questions, please feel free to call the office. We will be glad to help you anyway we can.

LATE FOR APPOINTMENT/NO SHOW POLICY

Buckland Ear, Nose, and Throat reserves the right to reschedule your appointment if you are 15 or more minutes late.

Buckland Ear, Nose, and Throat reserves the right to charge $25.00 or $100.00 (depending on appointment type) for appointments missed by the patient without a 24 hour notice of cancellation.

After two missed appointments without prior notification, your will receive a letter requesting you to find another physician.

****I HAVE READ AND UNDERSTAND THE ABOVE POLICIES.

Date: _____ **Signature:** _____

BUCKLAND EAR, NOSE, AND THROAT, LLC
PRIVACY NOTICE
Privacy Officer (860)645-6675

As a patient of Buckland Ear, Nose, and Throat, LLC, we want to provide you with the best possible care. We want you to feel free to make full disclosure of information to the physician(s) so that effective treatment can be provided. As required by the privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Buckland Ear, Nose, and Throat, LLC is providing you, the patient or the patient's legal representative, with a copy of our Privacy Notice. HIPAA regulations require us to provide this information to you and to obtain your signature or the signature of your legal representative as proof that you have received our Privacy Notice.

The policy of Buckland Ear, Nose, and Throat, LLC is to protect the confidentiality, integrity, and security of the protected health and personal information of our patients and to prevent unauthorized access to, or the use of such information. This policy applies to both current and former patients.

Protected Health Information (PHI) is individually identifiable health and personal information and includes any information obtained by Buckland Ear, Nose, and Throat, LLC in connection with providing healthcare treatment, obtaining payment and related healthcare operations. This relates to past, present or future information that Buckland Ear, Nose, and Throat, LLC receives from you as our patient.

We will use this information to provide caring and quality medical care to you. Examples of PHI include diagnosis, treatment, and communications, both oral and written and including answering machines, voice mail and e-mail, used for follow-up, appointment scheduling, reminders, and test results reporting. As part of our standard healthcare operations, we may share information with a facility such as a hospital, laboratory, diagnostic service or healthcare provider to coordinate your treatment plan in the most efficient manner. For insurance carriers, your information will be used for claims submission and to obtain payment for services provided. We will exchange data with your insurance carrier for activities such as confirming your eligibility with the plan, benefit and coverage determinations, and pre-certification/authorization and utilization review.

Your information is maintained in our office in our practice management information system. We also maintain information about you in your medical chart. Buckland Ear, Nose, and Throat, LLC limits access to your PHI to those employees and business associates who need to know this information and we restrict the types and amount of information provided to that which is "minimally necessary" in order to carry out their work.

We do not disclose PHI to third parties for purposes other than treatment, payment or health care operations unless the following exceptions occur:

- We receive a signed authorization from you to release your individually identifiable information. Buckland Ear, Nose, and Throat, LLC will provide you with an Authorization Form that will need to be signed by you, the patient, or in the case of a minor, his/her guardian. This authorization will be for a defined period of time and may be cancelled by you, the patient, or in the case of a minor, by his/her guardian at any time.
- Federal, state or other applicable law requires us to share PHI.
- Workers' Compensation purposes.

You have the right to request a review of your PHI, to amend your records, and request restrictions on how your PHI is used. You may request an accounting of how your PHI has been disclosed. Any requests for amendments or restrictions to the use of your PHI must be in writing. You have a right to request a copy of your medical records. Buckland Ear, Nose, and Throat, LLC will make every effort to provide you with your records within a reasonable amount of time and subject to normal copying charges.

I acknowledge that I have received the above Buckland Ear, Nose, and Throat, LLC Privacy Notice.

_____ _____
Patient Name (Print) DOB

_____ _____

BUCKLAND EAR, NOSE, AND THROAT, LLC
PERMISSION TO COMMUNICATE WITH FAMILY MEMBERS AND/OR OTHER INDIVIDUALS

I authorize Buckland Ear, Nose, and Throat, LLC's **USE AND DISCLOSURE** of all individual identifiable personal, health, financial and demographic information (known as Protected Health Information, or PHI) for:

___myself (DOB____/____/_____)

___my minor child:

Child's name _____ DOB ____/____/_____

For the purpose of:

- Providing medical treatment
- Obtaining payment and reimbursement
- Obtaining authorizations from my insurance for testing (when required)
- Requesting health care services from other providers
- Coordinating with other providers in my medical care
- Fulfilling requests for information when specifically authorized by me
- In addition, doing all other things directly related to providing health care to me

I also authorize any physician or health care facility to provide upon request any PHI to Buckland Ear, Nose, and Throat, LLC when needed for the purpose of treatment, payment and other health care options.

I consent to Buckland Ear, Nose, and Throat, LLC **DISCUSSING** any or all of my medical care including my evaluation, treatment and diagnosis, even if related to psychiatric or psychosocial impairments, substance abuse, acquired immunodeficiency virus (HIV), or HIV-related opportunistic infections or pregnancy with the **following person(s).**

Name:	Phone Number:	Relationship (circle one):
_____	(____)_____-_____	Spouse/Parent/Grandparent/Child/Friend/Other_____
_____	(____)_____-_____	Spouse/Parent/Grandparent/Child/Friend/Other_____
_____	(____)_____-_____	Spouse/Parent/Grandparent/Child/Friend/Other_____
_____	(____)_____-_____	Spouse/Parent/Grandparent/Child/Friend/Other_____

I consent to Buckland Ear, Nose, and Throat, LLC leaving messages on my answering machine/voicemail at the provided phone number(s):
(____)_____-_____ (____)_____-_____

I have been given the opportunity to review Buckland Ear, Nose, and Throat, LLC's Privacy Notice.
I understand my rights to restrict the use and disclosure of PHI and to revoke this consent at any time in writing.
I understand that should I choose not to consent to the terms and conditions of Buckland Ear, Nose, and Throat, LLC's Privacy Notice, the practice has the right to and will withhold treatment except where required by law.

_____ _____
Patient Name (Print) DOB

_____ _____
Patient/Legal Representative's Signature Date

The Health Insurance Portability and Accountability Act of 1996 prohibits the use and disclosure of protected health information for treatments, payments, and other health care operations without a signed consent and prohibits the use and disclosure of protected health information for non health care related activities without specific and explicit authorization.