



1684 W. HIBISCUS BLVD.

MELBOURNE FL, 32901

PHONE: 321-676-2353 (SCENTA) / 321-309-2806 (SCHB) FAX: 321-951-9267 / 321-308-4020

**PATIENT INFORMATION**

|   |  |  |
|---|--|--|
| <b>Last Name:</b><br>_____<br><br><b>First Name:</b><br>_____ <b>MI:</b> _____<br><br><b>Date of Birth:</b> _____<br><br><b>Social Security # :</b> _____ | <b>SEX:</b><br><br><input type="checkbox"/> MALE<br><input type="checkbox"/> FEMALE<br><br><b>ETHNICITY:</b><br><br><input type="checkbox"/> HISPANIC<br><input type="checkbox"/> NON - HISPANIC | <b>MARITAL STATUS:</b><br><br><input type="checkbox"/> SINGLE<br><input type="checkbox"/> MARRIED<br><input type="checkbox"/> DIVORCED<br><input type="checkbox"/> SEPERATED<br><input type="checkbox"/> WIDOWED |
| Is this your legal name? YES / NO<br><br>If No, what is your legal name? _____  | <b>PRIMARY CARE DOCTOR:</b><br>_____   |  |

**RACE:** A. Indian    Black/ African    American Native    Hawaiian/Pacific Islander    White

|  |   |
|--|---|
| <b>Street Address:</b><br>_____<br>_____<br><br><b>City:</b> _____ <b>State:</b> _____<br><br><b>Zip Code:</b> _____ | <b>Phone:</b><br>_____<br><br>CELL / HOME<br><br><b>Alternate phone?</b><br>_____ |
|--|---|

|  |   |
|--|---|
| <b>Pharmacy Information</b><br><br>NAME: _____<br><br>Address: _____<br><br>Phone: _____ | <b>EMAIL:</b><br>_____<br><br>Web enable for Patient Portal?<br><br>YES    NO |
|--|---|

**Electronic Prescribing**

\_\_\_\_\_ (Initials) SPACE COAST EAR, NOSE, AND THROAT ASSOCIATES is enrolled in an electronic prescribing program. This program is meant to help our providers with understanding what medications our patients are currently using and to provide the best possible treatment. I give SPACE COAST EAR, NOSE, AND THROAT ASSOCIATES permission to request and use my prescribing medication history from other healthcare providers.

Please give your photo ID and Insurance Card to the receptionist

| PRIMARY INSURANCE                                     |  |
|---|--|
| Insurance Name : _____                                |  |
| SECONDARY INSURANCE                                   |  |
| Insurance Name : _____                                |  |
| RESPONSIBLE PARTY INFO                                |  |
| Person responsible for bill: _____ Birth Date: _____  |  |
| Social Security: _____ <i>(insurance requirement)</i> |  |
| Address (if different): _____<br>_____                |  |
| Phone: _____ Relationship to patient: _____           |  |

**CONSENT FOR TREATMENT/ FINANCIAL RESPONSIBILITY (REQUIRED)**

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I authorize SPACE COAST EAR, NOSE, AND THROAT ASSOCIATES / SPACE COAST HEARING AND BALANCE or Insurance Company to release any information required to process my claims.

I hereby voluntarily consent to the rendering of care, including treatment, administration of anesthesia and performance of diagnostic and/ or surgical procedures.

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_

**RELEASE OF INFORMATION**

\_\_\_\_\_ **(Initials)** My physician and authorized staff may disclose all or part of the patient's records to any person or corporation which is or may be liable under a contract to the physician(s), the patient, family member, employer of the patient or physicians(s) charges, including but not limited to: insurance companies, workers' compensation carriers, auto insurance carriers, attorney or the patient's employer.



**PATIENT AGREEMENT**

This AGREEMENT confirms your responsibilities and informs you about our Practice Policies

**ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES – HIPAA**

\_\_\_\_\_ (Initials) I hereby acknowledge that I have access to a copy of the Notice of Privacy Practices of Space Coast Ear, Nose, and Throat Associates/ Space Coast Hearing and Balance which is available for me at this and subsequent visits to read and understand. I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) I have certain rights to privacy regarding my protected health information. I understand that information can and will be used to:

- Conduct, plan & direct my treatment and follow up among the multiple health providers involved in my treatment.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physical certifications.
- I understand that SPACE COAST EAR, NOSE, AND THROAT/ SPACE COAST HEARING AND BALANCE may need to reach me by phone.

( ) I **DO** authorize SPACE COAST EAR, NOSE, AND THROAT ASSOCIATES / SPACE COAST HEARING AND BALANCE to leave messages on my telephone regarding appointments, lab/imaging results, biopsy results, billing information.

Home Phone       Cell Phone

( ) I **DO NOT** authorize SPACE COAST EAR, NOSE, AND THROAT ASSOCIATES / SPACE COAST HEARING AND BALANCE to leave a message on my telephone regarding any type of testing results and/or billing information. I will accept the responsibility of making an appointment with the physician to obtain the results.

Please list all relatives and/or friends, in which we may discuss your information with:

**Check box for  
EMERGENCY CONTACT/HIPAA**

NAME: \_\_\_\_\_ RELATION: \_\_\_\_\_ PHONE: \_\_\_\_\_

NAME: \_\_\_\_\_ RELATION: \_\_\_\_\_ PHONE: \_\_\_\_\_

NAME: \_\_\_\_\_ RELATION: \_\_\_\_\_ PHONE: \_\_\_\_\_





## **FINANCIAL POLICY**

We have established the following policies to improve communication regarding appointments, medical records, and your financial responsibility at the time of service or prior to any scheduled surgery.

**YOUR INSURANCE POLICY:** At this time, our office is a participating provider for most insurance plans and most of the major insurance networks. If we are not a participating provider for your insurance plan, we can attempt to file an insurance claim as a courtesy to you. However, if your insurance denies coverage then you will be responsible for the visit charges.

If you are enrolled in an insurance plan requiring a referral and/or authorization, it is patient's responsibility to obtain this from your primary care provider before your office visit. We will assist you in this process if applicable. Please be aware that without a required referral or authorization, your appointment may have to be rescheduled.

Any fees we charge are for our services only. Any service provided outside our office will be billed separately by the rendering provider. This would include laboratory, diagnostic imaging (CT/MRI), and surgery performed at the hospital or ambulatory surgery center. Please speak directly to the provider regarding their fees.

Federal law prohibits our office from writing off any balances due after insurance. Patients who are experiencing financial difficulties should speak to the office manager prior their office visit.

**COPAY/COINSURANCE/DEDUCTIBLE:** It is the policy of Space Coast Ear, Nose & Throat Associates and Space Coast Hearing & Balance to collect any applicable co-payment and/or deductible at the time of service. Please be aware that your insurance may require a higher copayment for a specialist office visit. If you are unable to pay, we will need to reschedule your appointment.

**SELF PAY POLICY:** If you do not have health insurance, we do offer discounted (Medicare) rates. You will responsible for paying the full amount due at the time services are rendered.

**ACCOUNT INFO:** You will be mailed a statement on a monthly basis for any balance due. We request that you pay upon receipt of the statement. Please do not hesitate to call with any questions regards the status of your account. Billing is handled outside our office, so please call 321-368-3862. If your balance is not paid we will need to collect the full amount at your next office visit. Your account must be current prior any scheduled services. For you convenience we accept, cash, checks, and most major credit cards. There will be a \$25 charge for returned checks.

**REFUNDS:** Overpayments will be refunded upon request to the responsible party within 30 days. Please be aware that an overpayment from your insurance company is not a credit to you and cannot be refunded to you personally.

**PAST DUE ACCOUNTS:** Accounts older than 60 days or those failing to honor agreed-upon payment plans will be sent to a collection agency. We will not schedule further appointments until the account is brought into good standing. Failure to resolve balance due can result in dismissal from the practice for financial matters and will have to seek healthcare elsewhere.

**AUDIO & FOLLOW UP APPOINTMENTS:** If you are having a hearing test and then following up with an ENT provider, your insurance may charge you two co-pays because the two appointments are actually with two different offices. Space Coast Ear, Nose, & Throat Associates and Space Coast Hearing & Balance are two separate businesses in the same clinic.

**MISSED APPOINTMENTS/LATE CANCELLATIONS:** Broken appointments represent a cost to our business, to you, and other patients who could have been seen in the time set aside for you. Therefore, cancellations are requested a minimum of 24 hours prior to your scheduled appointment for an office visit. We reserve the right to charge \$25 for missed and late cancellations and \$50 for missed and late cancellations of scheduled office procedures. This fee is not covered by your insurance company. Excessive abuse of schedule appointments may result in discharge for the practice. Our staff understands that emergencies do arise, and will be handled on a case by case basis as needed.

**MEDICAL RECORDS:** Upon your request, we will provide you a copy of your medical records. Please allow 3 business days for this request.

**PATIENT CALLS/MESSAGES:** This practice maintains an automated attendant with voicemail. We make every effort to answer patient calls as they come in, however, if you are asked to leave a voice mail message please do so. It is not necessary to leave several messages. Patient calls are returned in order of priority within 48 hours. If you are experiencing a medical emergency and unable to reach a staff member, please go to the nearest emergency room for prompt treatment.

**HURRICANE POLICY:** Our clinic follows the Brevard County Schools for closures in the event of inclement weather. Most likely cause for our region is hurricanes. Our office will be closed and open as advised by the school board.

**PATIENT DISMISSAL:** Failure to observe these policies, demonstration of unacceptable behavior or medical non compliance can result in dismissal from the practice.

I hereby understand and agree to follow the financial policies of Space Coast Ear, Nose, & Throat, Associates/ Space Coast Hearing and Balance.

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**PATIENT OR GUARDIAN SIGNATURE**

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**DATE**



**STEVEN HO, MD**

**MEGAN FULLEN, PA-C**

**MAIJA SWEENEY, Au.D.**

**LINETTE LUNA, Au.D.**

1684 W. Hibiscus Blvd. Melbourne, FL 32901

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**AUTHORIZATION TO RELEASE OR REQUEST  
MEDICAL RECORDS**

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

I authorize **SPACE COAST EAR NOSE AND THROAT, ASSOCIATES/ SPACE COAST HEARING AND BALANCE** to disclose or request the following information in my medical record:

- My health information related to Ear, Nose, and Throat conditions, including:
  - Audiogram(s) Diagnostic Imaging Lab/Pathology Reports Progress Notes
- Other: \_\_\_\_\_

The above party may request or disclose this health information from/to the following party:

**NAME/ORGANIZATION:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**PHONE:** \_\_\_\_\_ **FAX:** \_\_\_\_\_

**I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party. I understand that uses and disclosures already made based upon my original permission cannot be taken back. I understand that it is possible that information used or disclosed with my permission may be redisclosed by the recipient and is no longer protected by the HIPAA Privacy Standards. I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization. I can receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.**

\_\_\_\_\_  
PATIENT NAME PRINTED

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PATIENT SIGNATURE (see reverse if unable to sign)

If the patient is a minor or unable to sign, please complete to following:

- Patient is a minor: \_\_\_\_\_ years of age
- Patient is unable to sign because: \_\_\_\_\_

Signature of Authorized Representative: \_\_\_\_\_

\_\_\_\_\_

Printed Name

Date:

Authority of representative to sign on behalf of patient:

Parent      Legal Guardian      Court Order      Other: \_\_\_\_\_



NAME: \_\_\_\_\_

DOB \_\_\_\_\_

Reason for today's visit:

\_\_\_\_\_

**MEDICAL HISTORY** Please indicate, with check or x, if you have, or have been treated, for any of the following conditions:

|                        |  |                              |  |  |  |
|------------------------|--|------------------------------|--|--|--|
| Auto-immune disorder:  |  | Bleeding /clotting disorder: |  | Cancer, Type:                            |  |
| Allergies              |  | Hepatitis C                  |  | Chemo / Radiation                        |  |
| Asthma                 |  | HIV/AIDS                     |  | Snoring                                  |  |
| COPD                   |  | High Blood Pressure          |  | Substance Abuse                          |  |
| Diabetes               |  | High cholesterol             |  | Stroke                                   |  |
| Depression / Anxiety   |  | Kidney disease               |  | Sinusitis                                |  |
| Headaches              |  | Meniere's Disease            |  | Sleep Apnea - If yes, C - Pap or Bi- Pap |  |
| Heart Disease          |  | Mental Illness               |  | Thyroid Disorder                         |  |
| Heartburn/ Acid Reflux |  | Liver Disease                |  | Chronic pain disorder                    |  |
| Hearing Loss           |  | Organ Transplant:            |  | Vertigo                                  |  |

Are you currently under the care of another specialist? If yes type/ Dr. \_\_\_\_\_

**CURRENT MEDICATIONS**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**ALLERGIES**

Are you allergic to any drugs or foods? YES / NO Latex allergy? YES/ NO

If YES, Medication AND reaction: \_\_\_\_\_

**SURGERIES / HOSITALIZATION:**

Please list any surgeries you have had, and the approximate year done:

\_\_\_\_\_

Have you been recently admitted into the hospital for an illness or injury? Yes / No

If yes, please indicate condition and approximate year: \_\_\_\_\_

Currently receiving any type of medical therapy in home or outpatient? If yes what kind? Physical / Speech / Occupational/ Swallowing/ Respiratory

With what agency? \_\_\_\_\_

### FAMILY HISTORY

How many: Brothers \_\_\_\_\_ Sisters \_\_\_\_\_ How many: Sons \_\_\_\_\_ Daughters \_\_\_\_\_

**Any family members diagnosed with the following? Please indicate all that apply with M- mother, F- father, S- siblings, C-children, GP-grandparent**

Asthma \_\_\_\_\_ High cholesterol \_\_\_\_\_ Diabetes \_\_\_\_\_

High BP \_\_\_\_\_ Mental Illness \_\_\_\_\_ Bleeding disorder \_\_\_\_\_

Allergies \_\_\_\_\_ Thyroid disorder \_\_\_\_\_ Hearing loss \_\_\_\_\_

Headaches \_\_\_\_\_ Heart disease \_\_\_\_\_ Cancer, type: \_\_\_\_\_

### SOCIAL HISTORY

**Do you currently live: (please circle)**

Alone Spouse/Family Assisted Living Long term Care Rehabilitation Group Home Transient

**MARITAL STATUS:** SINGLE MARRIED WIDOW(ER) OTHER: \_\_\_\_\_

**Employment:** FULLTIME RETIRED DISABLED UNEMPLOYED STUDENT

**Do you drink Caffeine?** YES / NO **If yes, what kind?** Coffee, Tea, Soda, Energy drinks **How many a day** \_\_\_\_\_

**Do you currently smoke?** YES / NO **Use chewing tobacco?** YES / NO

**What do you smoke?** Cigarettes \_\_\_\_\_ E-cigarettes \_\_\_\_\_ Pipe \_\_\_\_\_ Cigars \_\_\_\_\_ Hookah \_\_\_\_\_

**How long have you smoked?** \_\_\_\_\_ **How many packs a day?** \_\_\_\_\_

**Are you interested in quitting?** YES / NO

**Did you smoke in the past?** YES / NO **If YES:** \_\_\_\_\_ Packs/day for \_\_\_\_\_ years. **QUIT:** \_\_\_\_\_

**Are you frequently exposed to second hand smoke?** YES / NO

**Do you drink Alcohol?** YES / NO **If yes, how many drinks a day/week?** \_\_\_\_\_

**Do you engage in recreational drug use?** YES / NO **If yes, what kind?** \_\_\_\_\_ **For how long?** \_\_\_\_\_

*For patients being seen for snoring or sleep apnea related issues:*

**0= No change of dozing      1= slight chance of dozing      2= Moderate chance      3= High chance of dozing**

\_\_\_\_ Sitting and reading      \_\_\_\_\_ Lying down to rest in the afternoon      \_\_\_\_\_ In a stopped car in traffic

\_\_\_\_ As a passenger in car more than 1 hour w/o break      \_\_\_\_\_ Sitting quietly after lunch w/o alcohol

\_\_\_\_ Sitting & talking with someone      \_\_\_\_\_ Watching TV      \_\_\_\_\_ Sitting inactive in a public space

**EPWORTH SLEEPINESS SCALE:** \_\_\_\_\_ / 24