SPACE COAST ENT & AUDIOLOGY

1344 SOUTH APOLLO BLVD, SUITE 301

MELBOURNE, FLORIDA 32901

PHONE: 321-309-2806 **FAX: 321-308-4020**

PATIENT INFORMATION

Last Name: _____ **First Name:** _____ **MI:** _____ **Date of Birth:** _____ **Social Security # :** _____	**SEX:** ☐ MALE ☐ FEMALE **ETHNICITY:** ☐ HISPANIC ☐ NON - HISPANIC	**MARITAL STATUS:** ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPERATED ☐ WIDOWED
Is this your legal name? YES / NO If No, what is your legal name?_____	**PRIMARY CARE DOCTOR:** _____	

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

Street Address: _____ _____ **City:** _____ **State:** _____ **Zip Code**:_____	**Phone:** _____ CELL / HOME **Alternate phone?** _____
Pharmacy Information NAME: _____ Address: _____ Phone: _____	**EMAIL:** _____ Web enable for Patient Portal? 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: _____ *(insurance requirement)* Address (if different): _____ _____ 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 ASSCOCIATES / 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 of 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.

_____ _____

PATIENT OR GUARDIAN SIGNATURE ***DATE***

SPACE COAST ENT & AUDIOLOGY

STEVEN HO, MD ***MEGAN FULLEN, PA-C***

MAIJA SWEENEY, Au.D. **LINNETTE LUNA, Au.D.**

1344 S. Apollo Blvd. Suite 301 Melbourne, FL 32901 Ph: 321-309-2806 Fax: 321-308-4020

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