

Welcome to Bartram Park Family ENT & Audiology

Thank you for completing these forms

Today's Date: _____

PATIENT INFORMATION

Name _____ Soc Sec. # _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Other Phone _____

Email: _____ Race: _____ Preferred Language: _____

Marital Status: married single widowed Sex: M F Age _____ Birthdate _____

Patient Employed by _____ Occupation _____

In Case of emergency who should be notified _____

Name/relation to patient

phone

INSURANCE INFORMATION (if different from above)

Policyholder Name: _____

Last Name

First Name

M. Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (If different from above) _____

City _____ State _____ Zip _____

Person responsible employed by _____ Occupation _____

Insurance Company _____

ADDITIONAL INFORMATION

Preferred Pharmacy Name: _____ Pharmacy location: _____

By whom were you referred? _____

If not referred by your physician, how did you hear about this office? _____

Who is your primary care physician? _____

Circle either yes or no for the following questions:

May we leave messages on your answering machine? YES NO May we call you at work? YES NO

ASSIGNMENT OF BENEFITS

I hereby authorize Bartram Park Family ENT to bill my insurance company directly for medical services rendered. I authorize and assign my insurance benefits to be paid directly to Bartram Park Family ENT. I permit a copy of this authorization to be used in place of the original. I understand I am financially responsible for charges not covered or paid by my insurance company and I agree to pay the cost of collection by an outside agency, including a reasonable attorney's fee, if payments are not made. I authorize the release of pertinent medical information to insurance carriers for claims review or processing. If a referral or authorization is required by my insurance company prior to being seen, I understand it is my responsibility to obtain it from my primary care physician, or pay for the visit in full at the time the services are rendered. I acknowledge that I have carefully read, understand and agree to the above terms.

Signature of Patient, Legal Guardian, or Responsible Party

Date

BARTRAM PARK FAMILY ENT & AUDIOLOGY

MEDICAL INFORMATION

Please circle the appropriate answers. Please complete this form as accurately as possible. Established patients are requested to provide updated information with each visit.

PATIENT NAME: _____ **DATE:** _____

DOB: _____

CHIEF COMPLAINT: (What brings you to the office today?)

CURRENT MEDICATIONS: (Please list name and dosage. Use back of page if necessary)

Not currently on any medications

Drug name	Mg	Drug name	Mg

MEDICAL HISTORY (Please circle all that apply to patient and provide an explanation in the space below)

Diabetes Heart Disease Stroke Kidney Failure Prostate disease
Asthma Glaucoma COPD Liver Disease Sleep Apnea/CPAP
Seizures Nose Bleeds Arthritis Thyroid Disease High Blood Pressure
Reflux Sinusitis Chest Pain Chronic Cough Emphysema
Vertigo Hoarseness Headaches Chronic Bronchitis Cancer_____

Other/Describe_____

DRUG ALLERGIES: Please list any allergies to medications and the type of reaction:

No known drug allergies

Drug Name	Reaction

Are you allergic to latex? Yes No

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SURGICAL HISTORY:

Date (mo/year)	Surgery	Date (mo/year)	Surgery

HOSPITALIZATIONS such as ER VISITS:

(ex: chest pain, vertigo attack, trouble breathing)

Date (mo/year)	Reason	Date (mo/year)	Reason

FALLS:

Have you fallen in the past year? yes No

If yes, did you sustain injury from fall? yes No

Have you had 2 or more falls in the past year? yes No

FAMILY HISTORY: Have any of your immediate relatives (Mother, father, sisters and brothers) had any of the following diseases? Please circle and explain in the space below.

Father: Living/Deceased Bleeding disorders Hearing loss Cancer Diabetes

Mother: Living/Deceased Bleeding disorders Hearing loss Cancer Diabetes

Siblings: Bleeding disorders Hearing loss Cancer Diabetes

SOCIAL HISTORY:

Tobacco Products? No () Yes () How much?: _____ Quit () When? _____

Recreational Drug Use? No () Yes () Please Describe: _____

Caffeine Use? No () Yes () How many cups a day? _____

Alcohol Use? No () Yes () How many drinks per week? _____

Please use this space to explain anything else that you wish the physician to know about your care:

I attest that the above information is correct and true to the best of my knowledge. I agree to inform this office of any changes in my medicine or medical status.

Patient Signature: _____ Date: _____

BARTRAM PARK FAMILY ENT & AUDIOLOGY

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JaxFamilyENT.com

E-PRESCRIBING CONSENT FORM

E-Prescribing is defined as a physician’s ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an E-Prescribe program. These include:

- **Formulary and benefit transactions** – Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** – Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification** – Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient’s prescription has been picked up, not picked up or partially filled.

By signing this consent form, you are agreeing that Bartram Park ENT can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Bartram Park ENT to enroll me in the E-Prescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Print Patient Name

Date

Signature of Patient or Guardian

Relationship to Patient

PRIVACY NOTICE ACKNOWLEDGEMENT

I acknowledge that I have had the opportunity to review a copy of Bartram Park Family ENT’s Privacy Notice. I understand that it is my responsibility to read this Notice and notify Bartram Park Family ENT, in writing, of any request for restrictions in the use or disclosure of my individually identifiable health information. I understand the notice included electronic access to my medication history. Bartram Park Family ENT has the right to revise this Notice at anytime and will post a copy of the current Notice in the office in a visible location at all times and on their website at www.JaxFamilyENT.com. Bartram Park Family ENT will provide me with a copy of most recent Notice upon request.



Signature of Patient or Legal Representative

Date

EXCEPTION FOR DISCLOSURE: I authorize the following people to be involved in my care. This consent for disclosure includes both health and financial information as it relates to my care. **Please list the names of any family, friends or physicians that you would like to have access to your health and financial information.**

FINANCIAL RESPONSIBILITY

I understand that in consideration of the services provided to the patient, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered by Bartram Park Family ENT. I am responsible for any applicable deductible, co-insurance or co-payments. **I understand that all payments are due at the time services are rendered unless prior arrangements have been made with our billing department.** For surgery, Bartram Park Family ENT will provide me with an estimate of my total financial responsibility upon request and the date by which this amount must be paid in full. I understand that this fee is only an estimate. In the event my care exceeds the amount of the estimate, I will be financially responsible for the balance. Any patient credits will be applied to my other outstanding patient balances prior to any refund issued. I further understand that such payment is not contingent on any insurance, settlement or judgment payment.

Bartram Park Family ENT may file a claim for payment with my insurance company as required by contractual agreement. If the insurance company fails to pay Bartram Park Family ENT in a timely manner for any reason, then I understand that I will be responsible for prompt payment of all amounts owed to Bartram Park Family ENT. All outstanding balances older than 90 days will be subject to review and forwarded to our collection department where an additional collection fee will be added to the account balance and forwarded to the Credit Bureau. Should the account be referred to a collection agency or attorney for collection, the undersigned shall pay all costs of collection, including a reasonable attorney’s fee.

SIGNATURE

By signing this agreement, I acknowledge that I have carefully read, understand and agree to the above terms and conditions.



Signature of Patient or Legal Representative

Date

CONSENT TO TREAT

I hereby consent and authorize the performance of all appropriate procedures and treatment, the administration of all topical anesthetics, and any and all medications which in the judgment of my provider may be considered necessary or advisable for my diagnosis and/or treatment. **I understand that if any additional procedures are performed, such as nasal endoscopy or laryngoscopy, there may be additional charges that I will be responsible for.**

PROOF OF INSURANCE AND REFERRALS

I understand that it is my responsibility to provide Bartram Park Family ENT with a copy of my current insurance card and picture ID. I understand that if it is required by my insurance company, **it is my responsibility to obtain a referral** from my Primary Care Physician. Bartram Park Family ENT is not obligated to see patients without a valid referral. I will notify Bartram Park Family ENT immediately upon any change to my insurance.

INSURANCE WAIVER AND NON-COVERED SERVICES WAIVER

If I do not have insurance or a valid referral, I will be considered a Private Pay patient and will be financially responsible for the total amount of the services rendered. In addition, there may be a service I desire, that is suggested or provided to me that is not covered under my insurance plan, called "Non-Covered Services". **I understand that I will be financially responsible for these Non-Covered Services** and if feasible, a waiver will be completed for each Non-Covered Service.

ADDITIONAL INFORMATION

Bartram Park Family ENT currently accepts assignment with Medicare and participates with most managed care plans. If we do not participate with your insurance plan you may have to pay a higher out-of-pocket expense for utilizing a non-participating provider. Additionally, we file secondary insurance as a courtesy. If your secondary insurance fails to remit payment within 60 days, we require you pay the remaining balance. **Bartram Park Family ENT does not file 3rd party liability claims such as auto accident claims or workman's compensation.**

AUTHORIZATION TO RELEASE OR RECEIVE MEDICAL INFORMATION

I hereby authorize Bartram Park Family ENT to release to insurance carriers, federal or state agencies, employers or their fiscal intermediaries such medical information as may be required or requested for the processing of claims for insurance, social security, or workman's compensation in connection with the medical care of the patient. This information may include, but is not limited to, information related to psychiatric evaluation and treatment, sickle cell anemia, alcohol and drug abuse evaluation and treatment, HIV status, AIDS or AIDS related diagnoses, if any such information exists.



Signature of Patient or Legal Representative

Date

SIGNATURE

By signing this agreement, I acknowledge that I have carefully read, understand and agree to the above terms and conditions.



Signature of Patient or Legal Representative

Date

Please print patient name

Patient Date of birth