



**AUTHORIZATION FOR TREATMENT, RELEASE OF MEDICAL INFORMATION, AND ASSIGNMENT OF BENEFITS**

- Our office is happy to file your insurance claims for you. Please provide your insurance card and photo ID. You are required to pay your copay today upon checking out.
- If you do not have your insurance card, you will be required to prepay \$200 and arrange payments for any remaining balance. Once you have supplied your insurance information, we will file your claim and refund you according to your benefits.
- If you do not have insurance coverage, you will be required to prepay \$200 and must be prepared to make arrangement for any remaining balance with a post-dated check or visa/master card number upon checking out.
- My signature below gives Ear Nose and Throat Consultants/FYZICAL, and all providers within, my consent for treatment by means providers consider necessary and proper treatment of the identified patient. This treatment may require diagnostic procedures, audiology testing, laboratory testing and x-rays.
- My signature below authorizes ENT Consultants/FYZICAL to release or disclose information to the insurance companies and/or outpatient programs from my medical record pertaining to my treatment as needed to process claims.
- My signature below acknowledges that I am aware and financially responsible to ENT Consultants/FYZICAL for any and all charges not covered by this assignment.

**Print Patient Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_/\_\_\_\_/\_\_\_\_

**X** \_\_\_\_\_ / \_\_\_\_/\_\_\_\_  
**Signature of patient / parent / or guardian** **Today's Date**

**HIPAA CONSENT FORM**

I authorize Ear Nose and Throat Consultants and Hearing Services, PLC to release information that does contain private health information including but not limited to the following services: exams, lab and test results, prescription, purchased products, scheduling of appointments and scheduling surgery. You must check mark anyone who you want to be able to obtain information about you and your health. If you have been referred here by another physician, exam results will be sent to them automatically. I acknowledge I have been offered a copy of the Privacy Statement and I have no further questions.

**Please circle:** None Parents / Step Foster parents Spouse Cellular Home answering machine  
 Significant other (name) \_\_\_\_\_ Caregiver (name) \_\_\_\_\_

Interpreter (name) \_\_\_\_\_ Telephone number \_\_\_\_\_

In the event of an **EMERGENCY**, or if we are unable to reach you, please list someone **outside of your household**  
 Name: \_\_\_\_\_ Telephone \_\_\_\_\_

By checking this box, I consent to have my FYZICAL medical records shared with my primary care provider.

**X** \_\_\_\_\_ / \_\_\_\_/\_\_\_\_  
**Signature of patient / parent/ or guardian** **Today's Date**



### Client Health Questionnaire

Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Please describe your current complaint or limitation: \_\_\_\_\_

Please describe *how* and *when* your problem began: \_\_\_\_\_

List tests or other interventions for this condition that you have had: \_\_\_\_\_

Have you had other physical therapy or speech therapy this year? NO YES - If yes, how many sessions? \_\_\_\_\_

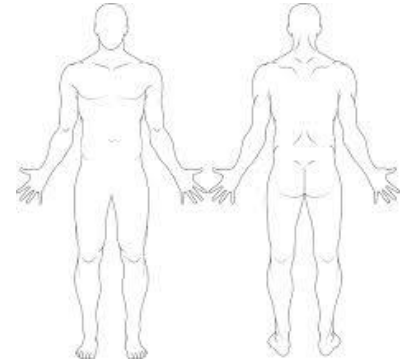
Please indicate the daily activities that you cannot perform: \_\_\_\_\_

Did you have surgery for this issue? No Yes Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Procedure: \_\_\_\_\_

Please describe the nature of your symptoms (check **all** that apply):

Please mark locations of pain on the picture

<p><b>Dizziness/Imbalance:</b></p> <input type="checkbox"/> Spinning/vertigo <input type="checkbox"/> Lightheadedness <input type="checkbox"/> Imbalance <input type="checkbox"/> Feeling "off" <input type="checkbox"/> Motion intolerant <input type="checkbox"/> Migraine/Headaches <input type="checkbox"/> Ear Pressure/Pain <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Changes in hearing <input type="checkbox"/> Head Injury/Concussion	<p><b>Pelvic Health:</b></p> <input type="checkbox"/> Leaking urine <input type="checkbox"/> Bladder urgency <input type="checkbox"/> Leaking bowel <input type="checkbox"/> Pain in pelvic region	<p><b>Pain Description:</b></p> <input type="checkbox"/> Sharp Pain <input type="checkbox"/> Dull (Pain) Ache <input type="checkbox"/> Throbbing <input type="checkbox"/> Numbness <input type="checkbox"/> Shooting <input type="checkbox"/> Tingling
<p><b>Symptom Frequency:</b></p> <input type="checkbox"/> Constant (76 – 100%) <input type="checkbox"/> Frequent (51 – 75%) <input type="checkbox"/> Occasional (26 – 50%) <input type="checkbox"/> Intermittent (25% - or less)		



Level of symptoms at **worst** from 0 (No symptoms) to 10 (Unbearable symptoms) \_\_\_\_\_

Level of symptoms at **best** from 0 (No symptoms) to 10 (Unbearable symptoms) \_\_\_\_\_

Activities or positions that increase symptoms: \_\_\_\_\_

Activities or positions that decrease symptoms: \_\_\_\_\_

Occupation \_\_\_\_\_

**PAST PRESENT**

- High Blood Pressure
- Angina
- Heart Attack
- Stroke
- Asthma
- HIV/AIDS
- Cancer – Location: \_\_\_\_\_ Date: \_\_\_\_\_
- Tumor
- Systemic Lupus
- Hepatitis
- Epilepsy
- Diabetes
- Rheumatoid Arthritis
- Arthritis
- Pregnancy
- Incontinence
- Other \_\_\_\_\_
- Tobacco Use – packs/day: \_\_\_\_\_
- Drug or Alcohol Dependence

Present: Weight _____ Height _____ ft _____ in. Have you fallen in the last year? <input type="checkbox"/> NO <input type="checkbox"/> YES - If yes, how many? _____
Medication: (Name/Dosage/Frequency/Route Administered) _____ _____ _____ _____
<b>**If you need additional room for medications please bring a separate document on your next visit</b>
Hospitalization/Surgical Procedures (list if not described elsewhere): _____ _____ _____
Do you have a Pace Maker: <input type="checkbox"/> NO <input type="checkbox"/> YES

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At All	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3



Account # \_\_\_\_\_

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**PATIENT'S NAME:** \_\_\_\_\_  
(First) (M.I.) (Last)

**PATIENT'S DATE OF BIRTH:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **PATIENT'S SSN:** \_\_\_\_-\_\_\_\_-\_\_\_\_

**PATIENT'S ADDRESS:** \_\_\_\_\_  
(Street/PO Box) (City) (State) (ZIP)

**PATIENT'S HOME PHONE:** (\_\_\_\_) \_\_\_\_\_ **CELL PHONE:** (\_\_\_\_) \_\_\_\_\_

**EMAIL ADDRESS:** \_\_\_\_\_@\_\_\_\_\_

**PATIENT'S EMPLOYER:** \_\_\_\_\_ **PHONE:** (\_\_\_\_) \_\_\_\_\_

**Preferred Contact Method:** PHONE  EMAIL  TEXT

**Who is the insurance holder:** \_\_\_\_\_ Relation to patient \_\_\_\_\_

**Insured's:** DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_ Employer: \_\_\_\_\_

**Referring Physician:** \_\_\_\_\_ **Family Physician:** \_\_\_\_\_

**Have you had any physical, occupational, or speech therapy this year?** YES  NO

**Do you wish to receive FYZICAL updates via email?** YES  NO

**Please Circle:** Married Widowed Divorced Separated Single Common Law

**Please Circle:** Male Female

**Please Circle:** Black White Native American/Alaskan Native Hispanic/Latino Asian Other \_\_\_\_\_

**Language Spoken:** \_\_\_\_\_

**How did you hear about us?** Family Physician TV Website Billboard Social Media Internet Friend Other

**If you are married, please complete the following information:**

Spouse's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Cell phone: (\_\_\_\_) \_\_\_\_\_

**If patient is under 18, or under 26 on parent's insurance, complete the following information for BOTH parents:**

Father's Name: \_\_\_\_\_ Mother's Name: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

SSN: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_



## NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, initiate payment, or conduct health care operations for other purposes permitted or required by law. The medical practice reserves the right to make changes in the Notice of Privacy Practices. The Notice describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that related to your past, present or future physical or mental health condition and related health care services.

For a more complete and detailed version of this privacy practice notice, make your request known at the front desk.

We understand that medical information about you and your health is personal, and we are committed to protecting it. A record of the care and services you receive at this practice is created and maintained at this location.

We are required by law to:

- Make sure that medical information that identifies you is kept private
- Provide you this notice of our legal duties and privacy regarding your medical information
- Follow the term of the notice that is currently in effect

The following categories describe ways that we use and disclose medical information about you:

- Treatment
- Payment
- Healthcare operations
- Third party business associates such as billing or transportation

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternative or other health-related benefits and services that may be of interest to you. Your name and address may be used to send you a newsletter about our practice and the services we offer. You may contact our privacy officer to request that these materials not be sent to you.

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or physician's practice has taken action in reliance on the use or disclosure indicated in the authorization.

You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your healthcare will be disclosed.

Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly related to that person's involvement in your healthcare. We may use or disclose your protected health information in an emergency treatment situation.

We may use or disclose your protected health information in the following situations without your consent or authorization:

- Required by law
- Public health
- Communicable diseases
- Health oversight
- Abuse or neglect
- Food and Drug Administration
- Legal proceeding
- Law enforcement
- Coroners, funeral directors, and organ donation
- Worker's compensation
- Inmates
- Sale of closure of the practice

Your rights:

- Inspect and copy your protected health information
- Request a restriction of your protected health information
- Request to receive confidential communications from us by alternative means or location
- Have your physician amend your protected health information
- Receive an accounting of certain disclosures we have made, if any
- Receive a paper copy of this notice from us
- File a complaint

You may file a complaint to our office or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy officer of your complaint. You will not be penalized or retaliated against for filing a complaint.