ADVANCED
OTOLARYNGOLOGY & AUDIOLOGY

Mark C. Loury, MD, F.A.C.S. • Brooke Weinstein, PA-C • Stephanie McCormick, NP-C • Natalie Phillips, Au.D., FAAA

PATIENT NAME: _____

PERSONAL PHYSICIAN: _____ REFERRED BY: _____

PHARMACY: _____ LABORATORY: _____

Please complete the following questions

What medical problems may we help you with today? _____

_____

Medicine allergies (please include reaction): _____

_____

What medicines are you taking (include prescription and over-the-counter drugs)? _____

_____

What medical problems do you regularly see your doctor for (such as high blood pressure, heart disease, etc) _____

_____

What surgeries have you had? _____

_____

Please list non-surgical hospitalizations _____

_____

Please list diseases that run in the family (such as heart disease, cancer, allergies, etc.) _____

_____

Current occupation: _____

Hobbies/Interests do you have? _____

Ethnicity: _____ Religion: _____ Primary Language: _____

Do you use tobacco products? YES / NO If yes, form, how many years, and how much per day?

_____

Do you drink alcohol? YES / NO If YES, how many drinks per week? _____

2001 South Shields Street • Building E, Suite 101 • Fort Collins, Colorado 80526
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Dear patient,

Your health status is important to us. Please circle any of the following signs or symptoms you may have.

GENERAL - fevers, chills, sweats, weight loss, weight gain

SKIN - itching, bruising, bleeding, non-healing sores, pigmentation change

MUSCULOSKELETAL - arthritis, muscle inflammation, joint swelling, joint stiffness, muscle weakness

ENDOCRINE SYSTEM - weakness, goiter, skin or hair dryness, heat or cold intolerance, excessive appetite / drinking / urination

ALLERGY / IMMUNOLOGY- dermatitis, hives, eczema, asthma, hay fever

HEAD / NECK - headache, migraine, seizures, fainting, visual loss, double vision, deafness, vertigo, ear drainage, ear pain, nasal drainage, nasal blockage, hoarseness, neck stiffness / pain

RESPIRATORY SYSTEM - painful breathing, shortness of breath, wheezing, awakening short of breath, cough, sputum or blood with coughing

CARDIOVASCULAR SYSTEM - palpitations, fast heart rate, irregular heart rate, chest pain, leg swelling, leg pain with exercise / sleeping

GASTROINTESTINAL SYSTEM - swallowing problems, nausea, vomiting, abdominal pain, jaundice, rectal bleeding, black or bloody stools

GENITOURINARY SYSTEM – change in urine color, painful urination, bloody urine, frequent urination, incontinence, stones

NERVOUS SYSTEM – paralysis, in coordination, difficulty speaking, numbness, tingling, staggering, vision changes

Date of completion:_____

Signature of Patient: _____

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PATIENT INFORMATION: **DATE:** _____

_____ _____ _____
Last Name First Name Middle Initial

_____ _____ _____ ____M/F____
Soc. Sec. # Date of Birth Age Sex

_____ _____ _____ _____
Street Address Apt. # City State Zip

(_____)_____ _____ _____ _____
Preferred Phone Contact Number Marital Status E-mail Address (required by CMS)

_____ _____ (_____)_____
Employer Employer's Address Business Phone

IF PATIENT IS A CHILD PLEASE GIVE PARENT'S / GUARDIAN'S NAME:

_____ _____ _____
Mother Father Guardian

EMERGENCY NOTIFICATION – IN CASE OF EMERGENCY PLEASE NOTIFY:

_____ _____ (_____)_____
Guardian, Relative or Friend Relationship Phone

_____ _____ _____ _____
Address City State Zip

INSURANCE INFORMATION:

Name of Insurance: _____

Name of Policy Holder: _____

Address of Policy Holder: _____

Employer of Policy Holder: _____

Relationship to Patient: _____

Date of Birth for Policy Holder: _____ / _____ / _____

Please note if the billing statements need to go to a different address please let the front office know

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Private Insurance Company:

_____ I hereby instruct the insurance company listed above to pay benefits directly to ADVANCED OTOLARYNGOLOGY, P.C. and/or Mark C. Loury, MD, 2001 S. Shields St. Suite E-101, Fort Collins, CO, 80526-1827

HMO and Group Insurance:

_____ Should there be a referral required through an HMO or Group Insurance plan that has not been obtained, I agree to pay in full any charges incurred.

Medicare:

_____ I request that payment of authorized Medicare benefits be made to Advanced Otolaryngology or me on my behalf for any services furnished by or in Advanced Otolaryngology, P.C., including physician services. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for related services.

A photocopy of this assignment shall be considered as effective and valid as the original.

I authorize the release of any information to any insurance company, adjuster, or attorney involved.

Financial:

I understand that payment for all services is my responsibility and agree to pay any balance over and above the insurance payment.

_____ Signature of Policy Holder

_____ Signature, if Patient is other than Policy Holder

_____ / _____ / _____
Date

WE MUST RECEIVE A COPY OF YOUR INSURANCE CARD WITHIN 24 HOURS OF TREATMENT OR YOU WILL BE HELD FINANCIALLY RESPONSIBLE FOR YOUR ACCOUNT!

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CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Use and Disclosure of Your Protected Health Information
Your protected health information will be used by **Advanced Otolaryngology** or disclosed to others for the purposed of treatment, obtaining payment or supporting the day to day health care operations of the practice.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent. By signing the bottom I acknowledge that I have received the Notice of Privacy Practices and have been given the opportunity to review it.

Requesting a Restriction on the Use or Disclosure of Your Information.
You may request a restriction on the use or disclosure of your protected health information.

Advanced Otolaryngology may or may not agree to restrict the use of disclosure of your protected health information.

If **Advanced Otolaryngology** agrees to your request, the restriction will be binding on the practice. Use of disclosure or protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices
Advanced Otolaryngology reserves the right to modify the privacy practices outlined in the notice.

****If I were unable in any situation to provide the necessary information, the following person/persons have my permission to speak on my behalf regarding scheduling appointments/procedures or billing****

1. _____ _____
   Name and phone number

2. _____ _____
   Name and phone number

SIGNATURE
I have reviewed this consent form and give my permission to Advanced Otolaryngol**ogy** to use and disclose my health information in accordance with it.

_____
Name of Patient (Print or Type)

_____ _____ / _____ / _____
Signature of Patient or Legal Guardian Date

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

USES AND DISCLOSURES

Treatment. Your health information may be used by staff members or disclosed to other health care professions for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health care information may be used as necessary to support the day to day activities and management of **Advanced Otolaryngology, P.C.** For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation the authorization. However, your decision to revoke the authorization will not affect or undo any use of disclosure of information that occurred before you notified us of your decision.

Additional Uses of Information.

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and service that we believe may interest you.

Fund raising. Unless you request us not to, we will use your name and address to support our fund raising efforts. If you do not want to participate in fund raising efforts, please check off the following box.

Please do not use my information for fund raising purposes.

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Individual Rights

You have certain rights under the federal privacy standards. These include:

- the right to request restrictions on the use and disclosure of your protected health information
- the right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and copy your protected health information
- the right to amend or submit corrections to your protected health information
- the right to receive an accounting of how and to whom your protected health information has been disclosed
- the right to receive a printed copy of this notice

Advanced Otolaryngology, P.C. Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our receptionist or privacy officer.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Privacy Officer
Advanced Otolaryngology, P.C.
2001 S. Shields, Bldg E-101
Fort Collins, Colorado 80526

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

This notice was updated 7/26/12

I understand that this information is necessary to provide me, my child/children or persons I am legally responsible for, with medical care in a safe and efficient manner. I have answered all the questions truthfully and to the best of my knowledge. I understand it is my responsibility to advise the office of any changes in the information contained on all forms.

_____ _____ / _____ / _____
Signature of Patient or Legal Guardian Date

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