SCOTCH INSTITUTE
ENT | Hearing | Allergy | Sleep
A Division of ENT and Allergy Associates of Florida

PATIENT REGISTRATION

Date: _____

Please present insurance card & photo ID

Patient Information

Patient Last Name: _____ First Name: _____ MI: _____

First Name Used (Nickname): _____ Marital Status: □ Married □ Single □ Divorce □ Widow

Social Security #: _____ Date of Birth: _____/_____/_____ Gender: □ male □ female

Preferred Language: English / Other: _____ Race: _____ Ethnicity: Not-Hispanic / Hispanic

Phones: Home (_____) _____ Work (_____) _____ Cell (_____) _____

Contact Preference (circle one): Home / Work / Cell **Email:** _____

(If Patient under 18) Mother's Name: _____ Father's Name: _____or Guardian: _____

Emergency Contact Name: _____ Relation to patient: _____

Emergency Contact Home Phone: (_____) _____ Emergency Contact Cell: (_____) _____

Local Address: _____ City: _____ State: _____ Zip:_____

Permanent Address: _____ City: _____ State: _____ Zip: _____

Employer Name: _____ Occupation: _____

Who referred you to our practice?

Doctor (name) _____

Insurance Plan _____ ZocDoc _____

Friend/Family (name) _____ Advertisement (paper) _____

Internet (website name) _____ Other (please specify) _____

Responsible Party Information (if same as patient, write SELF, otherwise enter parent or spouse's information)

Patient's relationship to the Guarantor/Responsible Party: _____

Guarantor Last Name: _____ First Name: _____ MI: _____

Guarantor Date of Birth: _____/_____/_____ Is guarantor's address the same at the patient? Yes / No

Guarantor Address: _____ City: _____ State: _____ Zip: _____

Guarantor Social Security #: _____-_____-_____ Guarantor Phone: (_____) _____

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PATIENT REGISTRATION

Name: _____

Please list other **family member names** (and note relationships) that are existing patients:

_____

_____

Primary Care Physician: _____

Referring Physician: _____

Primary Insurance: _____ HRA Plan?_____

ID #_____ Group #_____ Phone #: _____

Policy Holder Last Name: _____ First Name: _____ MI: _____

Social Security #: _____-_____-_____ Date of Birth: ____ /____ /_____ Gender: □ male □ female

Secondary Insurance: _____

ID #_____ Group #_____ Phone #: _____

Policy Holder Last Name: _____ First Name: _____ MI: _____

Preferred Pharmacy: _____ Pharmacy Location: _____

Pharmacy Phone # if known: _____ (shopping plaza or cross streets if address not known)

Which ENT office location do you prefer to be seen at?

□ Wesley Chapel □ Trinity □ Telemedicine/Virtual

May we send you an occasional newsletter/email? □ Yes □ No

(You always have the option to Opt-Out at any time)

SCOTCH INSTITUTE
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PATIENT REGISTRATION

Name: _____

Financial Consent

I hereby authorize said assignee to release all information necessary to secure payment. I certify that the information given by me for payment by my insurance plan(s) is correct. I authorize any holder of medical or other information about me to release to the above plan or its intermediaries or carriers any information needed for this or any related insurance claim. I request that the payments of authorized benefits be made to ENT and Allergy Associates of Florida, P.A. on my behalf. I assign the benefits payable for medical services to the physician or organization furnishing the services and authorize such physician/organization to submit a claim to the above insurance on my behalf.

I understand that I am financially responsible for all charges whether or not paid by my insurance, including any deductibles, co-pays, and co-insurance, and that payments are due at the time services rendered.

I understand and agree that if I fail to make payment for services rendered to me, my name and account may be turned over to an attorney and/or a 3rd party collection agency and I agree to pay the additional collection fee of 30% of the outstanding amount owed, including any court cost, and/or reasonable attorney fees that may be incurred in the collection of any outstanding balance.

No Show Fees:
We require that you give our office **at least 24 business hours notice** if you need to cancel or reschedule an office or diagnostic testing appointment. We require at least **7 days notice** to cancel a scheduled surgery. Business hours are Monday through Friday from 8:30 AM to 5:00 PM.
The following no show/cancellation fees will apply:

- No show / late cancellation appointment with Physician, Nurse, or Audiologist: **$35**
- No show / late cancellation appointment for Allergy Testing with physician follow up: **$100**
- No show/ cancellation of surgery less than 7 days prior: **$75**

Privacy Consent
I have been provided a copy or access to a copy of the Practice's Notice of Privacy Practices.

Consent for Treatment
I hereby voluntarily consent to outpatient care at ENT and Allergy Associates of Florida, P.A., encompassing routine diagnostic procedures, examination, and medical treatment including, but not limited to, routine laboratory work (such as blood, urine and other studies), endoscopes, CT's, audiology testing, allergy testing and treatment, and administration of medications prescribed by the physician. I understand that the above diagnostic procedures and testing are separate from my office visit and may be subject to deductible and co-insurance.

I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the physicians and their mid-level providers, including audiologist, medical assistants, or their designees as is necessary in the physician' judgment.

Message Consent

SCOTCH INSTITUTE
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PATIENT REGISTRATION

Name: _____

It is our policy to verbally notify you, the patient, of all test results ordered by your care provider and to confirm scheduled appointments. By indicating a response below, you are authorizing our staff to leave a detailed message on your voicemail and/or answering machine. **Please check response: □ Yes □ No**

SCOTCH INSTITUTE
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PATIENT REGISTRATION

Name: _____

Authorization for the Use or Diclosure of Health Information for Treatment or Payments

As part of your healthcare, this practice originates and maintains paper and/or electronic records describing your health history, symptoms, examinations, test results, diagnoses, treatment, any plans for future care or treatment and payment for the services or treatment we provided. We use this information to:

- Plan your care and treatment
- Communicate with other health professionals or entities who contribute to your healthcare • Submit your diagnosis and treatment information for payment for the services or treatment provided to you

"ONLY AS PERMITTED OR REQUIRED BY FEDERAL OR STATE LAW", WE MAY USE YOUR PROTECTED HEALTHCARE INFORMATION TO DO THE FOLLOWING:

- To disclose, as may be necessary, your health information (including HIV+/AIDS status, drug/alcohol abuse notes and qualified mental health notes) to other healthcare providers and healthcare entities (such as: referrals to or consultation with, other healthcare professionals, laboratories, hospitals, etc.) or to others as may be required by law or court order concerning your treatment, payment and/or healthcare.
- To request from other healthcare entities and/or healthcare providers (i.e. doctors, dentists, hospitals, labs, imaging centers, etc.) specific healthcare information we may need for planning your care and treatment.
- To submit the necessary information to your insurance company(s) for coverage verification as well as the diagnosis and treatment information to your insurance company(s), other agencies and/or individual(s) for payment of our services or treatment we provided to you.
- To leave appointment reminders or other minimum necessary information related to your healthcare or healthcare payments on your answering machine, your mobile voice mail or with a household family member.

[ ] **Please check here if you do not want us to leave messages on your answering machine or with a household family member.**

[ ] **Please check here if you do not want us to leave a message on your mobile voice mail.**

To discuss your health or payment information (only the minimum necessary in our judgment) with family members or other persons who are or may be involved with your healthcare treatment or payments.

If you choose, please list by name and relationship the persons with whom we may share your healthcare or payment information

_____

_____

You have read or have had the right to read the "*Notice of Patient Privacy Practices"* prior to signing this authorization.

Patient/ Guardian Signature:_____ **Date:**_____

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PATIENT REGISTRATION

Name: _____

PBM Consent

By signing this consent form I am authorizing ENT and Allergy Associates of Florida, P.A. to request and use my prescription medication history from other healthcare providers and/or third-party pharmacy payors for treatment purposes.

Pharmacy Benefits Managers (PBM) are third party administrators, prescriptions programs, whose primary responsibility is processing and paying prescription drug claims. They also develop and maintain formularies which are lists of dispensable drugs covered by a particular benefit plan.

Appointment Reminders

ENT and Allergy Associates of Florida, P.A. uses a third-party appointment reminder system, to notify patients of their upcoming appointment via email, text message and phone.

Consent Forms Acknowledgement

I, the patient, hereby have read and understand the following:

- Financial Consent
- Privacy Consent
- Consent for Treatment
- PBM Consent
- Message Consent

Furthermore, I acknowledge I have been given the opportunity to ask questions regarding these Consents.

Patient/ Guardian Signature:_____ **Date:**_____

Medicare Consent (applies to Medicare beneficiaries ONLY)

I certify that the information given by me in applying for payment under Title XVIII and/or Title XIX, of the Social Security Act, is correct. I authorize any holder of medical or other information about me to release to the social Security Administration or its intermediary carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician/audiology services. I understand that I am responsible for my health insurance deductibles and co-insurance.

Patient/ Guardian Signature:_____ **Date:**_____

SCOTCH INSTITUTE
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PATIENT REGISTRATION

Name: _____

ALLERGY & MEDICATION LIST
ALLERGIES:

Allergy	Reaction

☐ **No Known Drug Allergies**

MEDICATIONS: Date: _____ Reconciled by:_____

Medication Name	Rx = Prescription OTC = Over the Counter, Vitamin/Mineral, Herb Dietary Supplement	Dose	Frequency	Route: Oral, topical, Injection, Inhalation

Message Consent

It is our policy to verbally notify you, the patient, of all test results ordered by your care provider and to confirm scheduled appointments. By indicating a response below, you are authorizing our staff to leave a detailed message on your voicemail and/or answering machine. **Please check response: □ Yes □ No**

Patient/Guardian Signature: _____

Print Patient Name: _____ D.O.B:_____

SCOTCH INSTITUTE
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PATIENT REGISTRATION

Name: _____

MEDICAL HISTORY FORM

Patient Name:_____ Date of Birth:_____ M or F

Referring Physician: _____ *Pharmacy Name _____

*Pharmacy Cross Street_____

*Pharmacy Phone Number_____

Primary Care Physician:_____ **Weight:**_____ **Height**: _____

Briefly, why are you seeing our physician today? _____

1. **Patient History -** Please check your response

	Yes	No		Yes	No
Cancer (enter details below)	( )	( )	Nasal: Allergies	( )	( )
Heart (enter details below)	( )	( )	Nasal: Nasal Trauma	( )	( )
Cardio: Hypertension	( )	( )	Nasal: Nose Bleeds	( )	( )
Ear: Dizziness	( )	( )	Nasal: Sinusitis	( )	( )
Ear: Hearing Loss	( )	( )	Neuro: Headaches/Migraines	( )	( )
Ear: Tinnitus/Ringing in Ear	( )	( )	Neuro: Nervous System	( )	( )
Endocrine: Diabetes	( )	( )	Neuro: Seizure Disorder	( )	( )
Endocrine: Thyroid Disorders	( )	( )	Ophth: Eyes/Glaucoma	( )	( )
G.I.: Bowel Disorders	( )	( )	Oral: Sleep Apnea	( )	( )
G.I.: Liver Disorders	( )	( )	Pysch:PsychiatricDisorders	( )	( )
G.I.: Stomach Disorders/Ulcers	( )	( )	Pulm: Lungs	( )	( )
G.I.: Reflux/GERD/Heartburn	( )	( )	Pulm: Tuberculosis	( )	( )
Immuno: HIV	( )	( )	Uro:Bladder Disorders	( )	( )
Immuno: Immune Dieases	( )	( )	Uro: Kidney	( )	( )
Lymph: Anemia	( )	( )			
Lymph: Bleeding Disorders	( )	( )	Other: _____		

Details of Yes answers:_____

_____

2. **Surgeries -** Please list any surgeries/hospitalizations: _____

3. **Social History -** Are you a current smoker? (Y or N) You now smoke_____packs of cigarettes aday.

You smoked_____packs per day and quit_____years ago.

You consume_____alcoholic beverages per day / week / month (circle).

How many caffeinated beverages do you drink per day? _____

4. **Family History -** Please check your response

	Yes	No		Yes	No
Allergies	( )	( )	Premature Hearing Loss	( )	( )
Cancer	( )	( )	Sinusitis	( )	( )
Diabetes	( )	( )	Sleep Apnea	( )	( )
Headaches/Migraine	( )	( )	Thyroid Disorders	( )	( )
Immune Disease	( )	( )			

Details of Yes answers:_____

Patient Signature:_____ Date: _____

SCOTCH INSTITUTE
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PATIENT REGISTRATION

Name: _____

Sleep Questionnaire

Patient Name: _____ Date: _____

Use the following scale to choose the most appropriate number for each situation:

0 = would never doze or sleep

1 = slight chance of dozing or sleeping

2 = moderate chance of dozing or sleeping

3 = high chance of dozing or sleeping

Situation	**Chance of Dozing or Sleeping**
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place	_____
Being a passenger in a motor vehicle for an hour or more	_____
Lying down in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after lunch (no alcohol)	_____
Stopped for a few minutes in traffic while driving	_____
Total score (add the scores up)	_____

SCOTCH INSTITUTE
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PATIENT REGISTRATION

Name: _____

Scope Procedure

Please be aware that depending on the nature of your specific medical condition and treatment, your physician may perform certain in-office procedures (e.g. nasal endoscopy, laryngoscopy) that are not included in the standard office visit.

This is because, as a highly trained specialist, your physician wants to ensure that all appropriate steps are taken to provide you with the absolute best medical care possible.

These procedures will be billed separately from your visit charges. Depending on your individual insurance policy and carrier, these procedures may be classified as "surgery" and applied to an in-network deductible. In those cases, the amount allowed for the procedure by your insurer will be due from you.

Please be assured that the physicians of Scotch Institute of Ear Nose & Throat always follow strict billing and coding guidelines, and that all procedures are performed in the best interest of you, our valued patient.

By signing below, you acknowledge that you have read the above and agree and understand.

Date: _____

Patient Name Printed: _____

Patient Signature: _____

SCOTCH INSTITUTE
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A Division of ENT and Allergy Associates of Florida

PATIENT REGISTRATION

Name: _____

ENT AND ALLERGY ASSOCIATES OF FLORIDA, P.A.'s 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.

I. Our Duty to Safeguard Your Protected Health Information.

We understand that medical information about you is personal and confidential. Be assured that we are committed to protecting that information. We are required by law to maintain the privacy of protected health information and to provide you with this Notice of our legal duties and privacy practices with respect to protected health information. We are required by law to abide by the terms of this Notice, and we reserve the right to change the terms of this Notice, making any revision applicable to all the protected health information we maintain. If we revise the terms of this Notice, we will post a revised notice and make paper and electronic copies of this Notice of Privacy Practices for Protected Health Information available upon request. We are required by law to notify you in the event of a breach of your protected health information.

In general, when we release your personal information, we must release only the information needed to achieve the purpose of the use or disclosure. However, all of your personal health information that you designate will be available for release if you sign an authorization form, if you request the information for yourself, to a provider regarding your treatment, or due to a legal requirement. We will not use or sell any of your personal information for marketing purposes without your written authorization.

II. How We May Use and Disclose Your Protected Health Information.

For uses and disclosures relating to treatment, payment, or health care operations, we do not need an authorization to use and disclose your medical information:

For treatment: We may disclose your medical information to doctors, nurses, and other health care personnel who are involved in providing your health care. We may use your medical information to provide you with medical treatment or services. For example, your doctor may be providing treatment for a heart problem and need to make sure that you don't have any other health problems that could interfere. The doctor might use your medical history to determine what method of treatment (such as a drug or surgery) is best for you. Your medical information might also be shared among members of your treatment team, or with your pharmacist(s).

To obtain payment: We may use and/or disclose your medical information in order to bill and collect payment for your health care services or to obtain permission for an anticipated plan of treatment. For example, in order for Medicare or an insurance company to pay for your treatment, we must submit a bill that identifies you, your diagnosis, and the services provided to you. As a result, we will pass this type of health information on to an insurer to help receive payment for your medical bills.

For health care operations: We may use and/or disclose your medical information in the course of operating our practice. For example, we may use your medical information in evaluating the quality of services provided, or disclose your medical information to our accountant or other professional for audit purposes.

In addition, unless you object, we may use your health information to send you appointment reminders or information about treatment alternatives or other health-related benefits that may be of interest to you. For example, we may look at your medical record to determine the date and time of your next appointment with us, and then send you a reminder or call to help you remember the appointment. Or, we may look at your medical information and decide that another treatment or a new service we offer may interest you.

We may also use and/or disclose your medical information in accordance with federal and state laws for the following purposes:

- We may disclose your medical information to law enforcement or other specialized government functions in response to a court order, subpoena, warrant, summons, or similar process.
- We may disclose medical information when a law requires that we report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity, or in response to a court order. We must also disclose medical information to authorities who monitor compliance with these privacy requirements.
- We may disclose medical information when we are required to collect information about disease or injury, or to report vital statistics to the public health authority. We may also disclose medical information to the protection and advocacy agency, or another agency responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents
- We may disclose medical information relating to an individual's death to coroners, medical examiners or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.
- In certain circumstances, we may disclose medical information to assist medical research.
- In order to avoid a serious threat to health or safety, we may disclose medical information to law enforcement or other persons who can reasonably prevent or lessen the threat of harm, or to help with the coordination of disaster relief efforts.
- If people such as family members, relatives, or close personal friends are involved in your care or helping you pay your medical bills, we may release important health information about you to those people We may also share medical information with these people to notify them about your location, general condition, or death.
- We may disclose your medical information as authorized by law relating to worker's compensation or similar programs.
- We may disclose your medical information in the course of certain judicial or administrative proceedings.

Other uses and disclosures of your medical information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you provide permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided you.

III. Your Rights Regarding Your Medical Information.

You have several rights with regard to your health information. If you wish to exercise any of these rights, please contact our Privacy Officer at 561-939-0177. Specifically, you have the following rights:

- You have the right to ask that we limit how we use or disclose your medical information. You have the right to ask that we send you information at an alternative address or by an alternative means. We will consider your request, but are not legally bound to agree to the restriction. We will agree to your request as long as it is reasonably easy for us to do so. To request confidential communications, you must make your request in writing to our medical records department. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted.
- You have the right to restrict disclosure of medical information to a health plan in the event that you have paid out of pocket in full for such service or healthcare item.
- With a few exceptions (such as psychotherapy notes or information gathered for judicial proceedings), you have a right to inspect and copy your protected health information if you

put your request in writing. If we deny your access, we will give you written reasons for the denial and explain any right to have the denial reviewed. We may charge you a reasonable fee if you want a copy of your health information. You have a right to choose what portions of your information you want copied and to have prior information on the cost of copying.

- If you believe that there is a mistake or missing information in our record of your medical information you may request that we correct or add to the record. Your request must be in writing and give a reason as to why your health information should be changed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your medical information. If we approve the request for amendment, we will amend the medical information and so inform you.
- In some limited circumstances, you have the right to ask for a list of the disclosures of your health information we have made during the previous six years. The list will not include disclosures made to you; for purposes of treatment, payment or healthcare operations, for which you signed an authorization or for other reasons for which we are not required to keep a record of disclosures. There will be no charge for one such list in each 12-month period. There may be a charge for more frequent requests.
- You have a right to receive a paper copy of this Notice and/or an electronic copy from our Web site. If you have received an electronic copy, we will provide you with a paper copy of the Notice upon request.

IV. How to Complain about our Privacy Practices:

If you want more information about our privacy practices or have questions or concerns, we encourage you to contact us.

If you think we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, we encourage you to speak or write to our Privacy Officer. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services at the Office for Civil Rights' Region IV office. We will provide the mailing address at your request.

We support your right to the privacy of your health information.

If you have questions about this Notice or any complaints about our privacy practices, please contact our Privacy Officer, either by phone or in writing at:

Dawn Villacci, Privacy Officer
1601 Clint Moore Road, Suite 212
Boca Raton, FL 33487
561.939.0175

V. Effective Date: This Notice was effective on **April 14, 2003, updated June 19, 2017.**