EAR
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THROAT
ENT and Allergy Center

NOTICE OF PRIVACY POLICY

ENT & Allergy Center
Effective 1/1/2015

We intend to abide by the Final Omnibus Rule of the HIPAA regulations regarding your **protected health information,** hereafter abbreviated as **PHI.** The term PHI refers to your medical, billing and payment records; your name, address, date of birth, social security number and payment history; the name of your health plan and account number; and other data that identifies you.

We are permitted by law to disclose PHI to you and anyone who needs it to carry out treatment, payment or health care operations. We will be required to obtain your signature for authorization to release PHI for most uses unrelated to treatment, payment and health care operations. We will retain your authorization and provide you with a copy if you wish to have it. PHI will be provided within 30 days of the written request in hard copy form. Information may be available for transfer onto USB media if the patient provides the media. You may revoke your authorization in writing at any time.

We may disclose PHI as required by law to entities, including but not limited to the following:

- Public health activities
- Victim of abuse, neglect or domestic violence
- Reportable diseases
- Adverse events to medicines
- Work-related injuries may be reported to OSHA or your employer
- Criminal investigations
- Orders by the court or law
- Organ donation data
- Coroners, medical examiners and funeral directors' requests
- Certain military or veterans' activities
- Schools (childhood immunizations only)
- Family of the deceased, according to previously signed authorizations

We may use your PHI to contact you for appointment reminders or health information we believe will be of interest to you.

We **DO NOT** sell or disclose PHI for the purpose of marketing or fundraising.

We may transmit PHI via email to you if requested. However, this will only be done after discussing the risk to you and only after a signed consent is received.

You have the right to:

- Request restrictions on uses and disclosures to your health care plan for those services paid out of your pocket.
- Request restrictions on uses and disclosures. Other than the above, we are not required to agree with the restrictions.
- Receive confidential communications of PHI.
- Inspect and copy PHI.
- Request amendments to PHI by submitting the desired changes in writing.
- Receive an accounting of disclosures of PHI.
- Receive a copy of our Notice of Privacy Policy.

You may complain if you believe your privacy rights have been violated. You may call (479) 521-3363 and ask to speak to the privacy compliance officer. We will not retaliate against you for filing a complaint. You may complain directly to the secretary of Health and Human Services.

We have a legal obligation to maintain the privacy of your PHI and abide by the terms of the notice currently in effect.

We have a legal obligation to notify you in the event of a breach of PHI unless, after completing a risk analysis as outlined by the Omnibus Rule, it is determined that there is a low probability of PHI compromise. We have the right to change the terms of this notice. The revised notice will be posted in our lobby and on our website. You may also request a hard copy.

Details of the HIPAA Privacy and Omnibus Rules are available in the Federal Register at your public library.

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AUTHORIZATION AND ASSIGNMENT

ENT & Allergy Center
Effective 1/1/2015

Initial each of the following.

_____ I have received a copy of the ENT and Allergy Center Compliance Final Patient Privacy Rule Part 164 HIPPA.

_____ I understand that it is my responsibility to notify the ENT and Allergy Center in writing of any changes to the above permissions.

_____ I hereby authorize the ENT & Allergy Center to furnish information to Medicare and other insurance carriers concerning my illness and treatments, and I hereby assign to the physician(s) all payments for medical services rendered to myself and my dependents. I understand that I am responsible for any amount not covered by insurance.

_____ I consent to the email delivery of all information, including but not limited to protected health information under HIPAA.

Email _____

_____ I consent to notifications via text message from the ENT and Allergy Center, including protected health information under HIPAA.

Cell Phone Number _____

_____ I consent and allow the ENT and Allergy Center to contact my pharmacy to obtain my medication history.

Pharmacy Name _____

Pharmacy Location _____

_____ I authorize and consent to my blood being tested for communicable diseases if any person is exposed to my blood or other bodily fluids at the ENT and Allergy Center.

Signature _____ Date _____

Signature of Parent or Legal Guardian (if applicable) _____ Date _____

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PATIENT INTAKE

Patient Name _____

Preferred Name _____

Mailing Address _____

City _____ State _____ Zip _____

Daytime Phone Number _____ ☐ Home ☐ Work ☐ Cell Okay to Text? ☐ Yes ☐ No

Age _____ Sex: ☐ M ☐ F Marital Status: ☐ S ☐ M ☐ W ☐ D ☐ Sep SSN _____

Email _____ Date of Birth _____

Employer _____ Phone _____

GUARDIAN OR SPOUSE INFORMATION

Name _____ Date of Birth _____

Mailing Address _____

City _____ State _____ Zip _____ SSN _____

Employer _____ Phone _____

EMERGENCY CONTACT (OUTSIDE OF HOUSEHOLD)

Name _____ Home Phone _____

Relationship _____ Other Phone _____

HOW DID YOU HEAR ABOUT US?

☐ Patient ☐ Primary Care Physician

Name of Referring Provider _____

RELEASE OF INFORMATION

The ENT and Allergy Center has my permission to release medical and billing information to the following family member or friend:

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

INSURANCE INFORMATION

Insurance Company _____ ID# _____ ☐ Group ☐ Self-Funded

Policyholder Name _____ DOB _____ SSN _____

PAYMENT POLICY

You are required to pay for the portion of services that the insurance company deems as your responsibility. This includes the deductible, co-pay, co-insurance and any non-covered services. However, you are required to sign that your insurance benefits be sent directly to our office. If, for some reason, your insurance does not pay as expected, you will be responsible for the balance. All surgical procedures require payment to be made in advance of the date of surgery.

Any other arrangements must be made in advance with the accounts manager. I understand and agree with the above policy.

Signature _____ Date _____

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MEDICAL HISTORY FORM

Name _____ Date _____

Preferred Name _____ Date of Birth _____

List your allergies to medicines:

☐ No Drug Allergies ☐ Penicillin ☐ Sulfa ☐ Codeine

☐ Other _____

Race/Ethnicity

☐ White ☐ African/American ☐ Hispanic ☐American Indian ☐European ☐ Asian

☐ Other _____

Preferred Language ☐ English ☐ Spanish ☐ Other

Do you take any medications?

☐ Yes ☐ No If yes, please list name of medication, and reason or condition for taking. _____

_____

Do you have the following?

☐ Diabetes ☐ Hypertension ☐ Heart Disease

List any other medical conditions _____

Alcohol/Tobacco Use:

Alcohol ☐ Daily ☐ Weekly ☐ Monthly ☐ Never

☐ Smoking ☐ Nicotine ☐ Other

☐ Vape ☐ Nicotine ☐ Other

Do you have secondhand smoke exposure? ☐ Yes ☐ No

Have you ever had a surgery?

☐ Yes ☐ No

If yes, please list _____

_____

_____

_____

Preferred Pharmacy _____

_____ I authorize the ENT and Allergy Center to contact my preferred pharmacy as needed for care and treatment.