FARRAGUT
ENT & ALLERGY

Facial Plastic and Reconstructive
Sinus and Allergy
Voice Disorders
Pediatric
Hearing

Farragut *Dowell Springs* *Sweetwater* *Newport* *Sevierville* *Tennova South* *Athens*

PATIENT INFORMATION

Name: _____ SSN: _____ Sex (Circle): M F

Date of Birth: _____ Age: ____ Marital Status: ____ Married ____ Single____ Divorced ____ Widowed

Race: _____ Ethnicity: ____ Hispanic or Latino ____ Not Hispanic or Latino

Preferred Language: _____

Street Address: _____ Apt # _____

City: _____ State: _____ Zip: _____

Phone #: _____ Cell #: _____ Work #: _____

E-mail address: _____

Employer: _____ Occupation: _____

Employer's Address & City: _____

Spouse/Parent: _____ Phone #: _____

Emergency Contact: _____ Phone #: _____

Referring Doctor: _____ Primary Doctor: _____

Insured/Guarantor Name: _____ Insured DOB: _____

Person Responsible for Bill: _____ Insured SSN: _____

The information provided within this form is true and accurate to the best of my knowledge.

_____ _____
Patient Signature (Parent's if Minor) Date

_____ _____
Patient Name (Printed) Chart Number

How did you hear about us? □ TV □ Radio □ Billboard □ Newspaper □ Internet □ Health Fair □ Insurance
□ Doctor's Referral from Dr. _____ □ Other: _____

APPOINTMENT REMINDER AUTHORIZATION

Patient Name: _____

Please check the box next to your preferred contact method:

- ☐ Home Phone: _____
- ☐ Cell Phone: _____
- ☐ Work Phone: _____
- ☐ E-mail Address: _____

I authorize Otolaryngology Head & Neck Surgery Associates to send appointment reminders and additional practice information using the contact information that I have provided above. I understand this service is offered free of charge, however mobile carrier rates may apply.

_____ _____

Patient Signature (Parent's if Minor) Date

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PRACTICE POLICIES

FINANCIAL POLICY
IT IS THE POLICY OF THIS OFFICE THAT ALL PAYMENTS BE MADE EACH VISIT AND I AM RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED REGARDLESS OF INSURANCE COVERAGE. I request that payment of authorized insurance benefits be made to me on my behalf to Otolaryngology Head and Neck Surgery Associates/ Farragut ENT Allergy for services furnished me. I authorize any holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services. I will notify the office of any changes in the above information.

LIMITATION OF LIABILITY
In no event shall Otolaryngology Head & Neck Surgery Associates or any other party involved in the creation, production, or delivery of the MicroMD Electronic Health Record system, or any software application associated with the Electronic Health Record be liable for any direct, indirect, special, incidental, consequential, or punitive damages of any kind, or any damages whatsoever resulting from computer virus or system failure, or loss of data, or electronic record errors either by the software producer or the medical provider arising out of or in connection with the use or performance of the Electronic Health Record, or users' inability to use the content contained within the Electronic Health Record on any theory of liability. Otolaryngology Head & Neck Surgery Associates assumes no liability or responsibility for any loss or damage incurred caused by or arising from your reliance on the content of the Electronic Health Record.

FRAGRANCE POLICY
All office locations within the Otolaryngology Head & Neck Surgery Associates network are fragrance free facilities. Colognes, perfumes, body mists, and other strongly scented products should not be worn within any office location.

I, THE UNDERSIGNED PARTY, AGREE AND WILL ADHERE TO THE STATEMENTS ABOVE.

Please date and Sign:

_____ _____
Patient Signature (Parent's if Minor) Date

_____ _____
Patient Name (Printed) Chart Number

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PATIENT MEDICAL INFORMATION

Name: _____ Chart #: _____ Date: _____

What are you seeing the Doctor for? _____
Severity of problem on scale of 1-10 (with 10 being worst): _____
How long has this bothered you? _____ When did it start? _____
What makes it better? _____ Is it related to any other problem? _____
Have you been treated for this before? _____ If so, by whom? _____

Check all that apply:

GEN
___ Fever
___ Wt. Loss
___ Fatigue

HEENT
___ Blurred Vision
___ Eye Pain
___ Itchy Eyes
___ Hearing Loss
___ Dizziness
___ Ear Noise
___ Ear Pain
___ Stuffy Nose
___ Runny Nose
___ Sneezing
___ Snoring
___ Mouth Sores
___ Mouth Bleeding
___ Sore Tongue
___ Can't Swallow
___ Lump in Throat
___ Hoarse
___ Allergies

CARDIO
___ Chest Pain
___ Palpitations

PULMONARY
___ Short of Breath
___ Cough
___ Wheezing

GI
___ Abdominal Pain
___ Diarrhea
___ Constipation
___ Heart burn
___ Bloody/Dark Stools

MUSC/SKEL
___ Rash
___ Jaw Pain
___ Joint Swelling/Pain
___ Back Trouble
___ Edema

ENDO
___ Hot/Cold Intolerance
___ Thyroid Trouble/Goiter
___ Bleeding Tendencies

NEURO
___ Headaches
___ Head Trauma
___ Depression
___ Nervous Breakdown
___ Tremors
___ Flushing
___ Numbness

GU
___ Frequent Urination
___ Painful Urination
___ Pregnancy
___ Vaginal Bleeding

OTHER
___ Blood Transfusion
___ HIV

Please write which family members had the following (or leave blank if none):

Hypertension _____
Heart Disease _____
Diabetes _____
Arthritis _____
Cancer _____
Thyroid Disease _____
Hearing Problems _____
Hearing Aids _____
Bleeding Problems _____
Anesthesia Problems _____

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Smoking Status: ____ Every Day Smoker ____ Some Day Smoker ____ Former Smoker ____ Never Smoked

LIST ALL DRUG ALLERGIES: _____

Please list ALL long term medications (including drugstore):

Medication	Dose	Taken for?

Surgical History

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____

Medical History
Check all that apply:

___ High Cholesterol
___ Hypertension
___ Heart Attack
___ Coronary Artery Disease/Heart Attack
___ Arrhythmia
___ Chronic Obstructive Pulmonary Disease (COPD)
___ Asthma
___ Emphysema
___ Gastroesophageal Reflux Disorder (GERD)
___ Peptic Ulcers
___ Crohn's Disease
___ Ulcerative Colitis
___ Temporomandibular Joint Disorder (TMJ)
___ Hepatitis/Liver Disease
___ Rheumatoid Arthritis
___ Lupus
___ Fibromyalgia
___ Anxiety
___ Migraines
___ Stroke
___ Seizures
___ Hypothyroidism
___ Parathyroid Disease
___ Thyroid Disorder
___ Radiation Exposure
___ Deep Vein Thrombosis (DVT)
___ Bleeding Disorder (list type) _____
___ Cancer (list type) _____

Please list any other medical conditions: _____

Who would help take care of you if you had surgery? _____

Are your immunizations up to date? ____ Yes ____ No

PHARMACY

Preferred Pharmacy
Name: _____
Address: _____
_____
Phone: _____
Secondary Pharmacy
Name: _____
Address: _____
_____
Phone: _____

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PATIENT PAYMENT/ARBITRATION/CONDUCT POLICY

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care. If you need further information about any of these policies, please ask to speak with a Billing Specialist or the Practice Manager.

How May I Pay?
We accept payment by cash, check, VISA, Mastercard, American Express, and Discover

Do I Need A Referral?
If you have an HMO plan with which we are contracted, you need a referral authorization from your primary care physician. If we have not received and authorization prior to your arrival at the office, we have a telephone available for you to call your primary care physician to obtain it. If you are unable to obtain a referral at that time, you will be rescheduled.

Which Plans Do You Contract With?
Most major medical insurances accepted. We are required by law that you present a current insurance card and photo I.D. at the time of visit; it is your responsibility to inform us of any changes in your insurance coverage.

What Is My Financial Responsibility for Services?
Your financial responsibility depends on a variety of factors, explained below. As a courtesy, we will file insurance claims on your behalf, but ultimately you are responsible for any bill incurred. If the account becomes delinquent and collection or legal action becomes necessary, you will be assessed a 35% collection fee and/or many legal fees.

OFFICE VISITS, OFFICE SERVICES, AND SURGERY

If You Have…	You Are Responsible For…	Our Staff Will…
Commercial Insurance Also known as indemnity, "regular" insurance, or "80/20" coverage.	Payment of the patient responsibility for all office visits, x-ray, injection, and other charges at the time of office visit.	File an insurance claim as a courtesy to you.
HMO & PPO plans with which we have a contract	If the services you receive are covered by the plan: All applicable copays and deductibles and requested at the time of the office visit. If the services you receive are not covered by the plan: Payment in full is requested at the time of the visit.	File and insurance claim on your behalf.

If You Have…	You Are Responsible For…	Our Staff Will…
Other Plans with which we are <u>not contracted.</u>	Payment in full for office visits, x-ray, injections, and other charges at the time of office visit.	Provide the necessary information for you to complete and file your claim directly with the insurance.
Point of Service Plan or Out of Network PPO	Payment of the patient responsibility – deductible, copay, non-covered services – at the time of the visit.	
Medicare	If you have Regular Medicare, and have not met your yearly deductible, we ask that it be paid and the time of service. Any services not covered by Medicare are requested aat the time of the visit. If you have Regular Medicare as primary, and also have secondary insurance or Medigap: No payment is necessary at the time of the visit. If you have Regular Medicare as primary, but no secondary insurance: Payment of your 20% copay is requested at the time of the visit	
Medicare HMO/Advantage Plan	All applicable copays and deductibles at the time of the office visit.	
Worker's Compensation	If we have verified the claim with your carrier: No payment is necessary at the time of the visit. If we are not able to verify your claim: Payment in full is requested at the time of the visit.	
Worker's Compensation (Out of State)	Payment in full is requested at the time of the visit.	
Occupational Injury	Payment in full is requested at the time of the visit.	
No Insurance	Payment in full at the time of the visit.	Work with you to settle your account. Please ask to speak with our staff if you need assistance.

SURGERY

If your physician recommends surgery, you will talk to his Surgery Coordinator. She will answer specific questions about the surgery scheduling process, discuss the paperwork and tests involved, and complete all pre-certification/authorization if your insurance company requires it. Please not while our staff will attempt to pre-certify/prior authorize or pre-determine and requirements of your insurance it may become necessary for you to handle this process if we are unsuccessful in our attempts. If authorization is obtained, please understand your insurance company still applies a disclaimer stating "authorization is not coverage of said procedure, coverage will be determined at the time the claim is received and is not a guarantee of payment". Pre-surgical deposits may be required dependent on your benefit levels, coverage, and deductible amount.

What if My Child Needs to See the Physician?

A parent or legal guardian must accompany patients who are minors. This accompanying adult is responsible for payment of the account, according to the policy outlined on the previous pages.

Non-Covered Services or Fees

- ♦$20 copying of medical records other than continuation of care
- ♦$25 completion of patient initiated medical forms
- ♦$50 returned check fee
- ♦$10 statement fee for failure to pay co-pay/balance at time of service
- ♦$10 statement fee for request to re-file appropriately filed claims after receipt of denial or failure to give correct insurance information
- ♦$25 failure to cancel office appointment without 24 hour notice
- ♦$100 failure to cancel ALLERGY testing appointment without 48 hour notice
- ♦$150 failure to cancel SURGERY scheduled without 48 hour notice

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles are my responsibility. I authorize my insurance benefits be paid directly to Farragut E.N.T. & Allergy. I authorize Farragut E.N.T. & Allergy to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim. In the event there is a question of standard of care in any procedure, diagnosis, or other service by Farragut E.N.T. & Allergy, or its employees, I agree to an arbitration process as the only recourse with expert witnesses certified or approved by the American Academy of Otolaryngology Head and Neck Association or those agreeable to Farragut E.N.T. & Allergy. The practice reserves the right to discontinue care/treatment to the patient if the patient or parent/guardian is non-compliant, inappropriate, or abusive with staff or is delinquent on their account.

_____	_____	_____
Printed Name	Signature	Date

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Information Authorization

Effective April 14, 2003, Federal Regulations required healthcare providers not to give any kind of information to any person other than you, the patient, without your prior permission. This includes not giving information to your spouse, parent, other household members, relatives, etc., even when they call or come in to Farragut E.N.T. & Allergy on your behalf or at your request, unless you have given us permission to talk to them.

Please tell us how we may contact you and whom we may disclose your health information.

Check all that apply:

□ Home Phone: (_____) _____ - _____
□ Cell Phone: (_____) _____ - _____
□ Work Phone: (_____) _____ - _____
□ Alternate Phone: (_____) _____ - _____
□ I do not want information released to anyone other than myself, including my spouse
□ No restrictions, speak with whomever necessary in my behalf
□ Leave message on home answering machine
□ You may speak with anyone who answers my home telephone number
□ I would like appointment reminder calls
□ I wish to receive information by mail regarding services offered by this office
You may speak with: □ my spouse □ my parent(s) □ person(s) I listed below
_____, about my medical condition(s) and treatment.
□ Obtain/release medical records from any participating healthcare facility/provider to help with continuing of my care via fax or postal mail.

♦ I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*. I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Privacy Officer.

♦ If I fail to specify an expiration date, this authorization will expire January 1st, in the next calendar year. I understand that authorizing the disclosure of this health information is voluntary. I need not sign this for in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 164.521. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Privacy Officer for Farragut E.N.T. & Allergy at (865) 777-1727.

_____ _____
Patient Signature Date Authorization Executed

_____ _____
Patient Name (printed) Date of Birth

Sino-Nasal Outcome Test (SNOT-22)

Date of completion:_____/_____/_____
M M D D Y Y Y Y

All questions must be complete.

Below you will find a list of symptoms and social/emotional consequences of your rhinosinusitis. We would like to know more about these problems and would appreciate you answering the following questions to the best of your ability. There are no right or wrong answers, and only you can provide us with this information. Please rate your problems as they have been over the past two weeks. Thank you for your participation. Do not hesitate to ask for assistance if necessary.

Considering how severe the problem is when you experience it and how frequently it happens, please rate each item below on how "bad" it is by *CIRCLING* the number that corresponds with how you feel using this scale:	**No problem**	**Very mild problem**	**Mild or slight problem**	**Moderate problem**	**Severe problem**	**Problem is as bad as it can be**
1. Need to blow nose	0	1	2	3	4	5
2. Nasal obstruction (blockage)	0	1	2	3	4	5
3. Sneezing	0	1	2	3	4	5
4. Runny nose	0	1	2	3	4	5
5. Cough	0	1	2	3	4	5
6. Post-nasal discharge	0	1	2	3	4	5
7. Thick nasal discharge	0	1	2	3	4	5
8. Ear fullness	0	1	2	3	4	5
9. Dizziness	0	1	2	3	4	5
10. Ear pain	0	1	2	3	4	5
11. Facial pain/pressure	0	1	2	3	4	5

Sino-Nasal Outcome Test (SNOT-22)

Considering how severe the problem is when you experience it and how frequently it happens, please rate each item below on how "bad" it is by *CIRCLING* the number that corresponds with how you feel using this scale:	**No problem**	**Very mild problem**	**Mild or slight problem**	**Moderate problem**	**Severe problem**	**Problem is as bad as it can be**
12. Decreased sense of smell or taste	0	1	2	3	4	5
13. Difficulty falling asleep	0	1	2	3	4	5
14. Wake up at night	0	1	2	3	4	5
15. Lack of a good night's sleep	0	1	2	3	4	5
16. Wake up tired	0	1	2	3	4	5
17. Fatigue	0	1	2	3	4	5
18. Reduced productivity	0	1	2	3	4	5
19. Reduced concentration	0	1	2	3	4	5
20. Frustrated/restless/irritable	0	1	2	3	4	5
21. Sad	0	1	2	3	4	5
22. Embarrassed	0	1	2	3	4	5

_____

Signature and Printed Name of Person Completing the Questionnaire