New Patient Registration

Patient Information

Patient Name

____

First MI Last

DOB ____/____/______ SS# ____________________

Marital Status_________ ◯ MALE ◯ FEMALE

Address ______________________________________

____

Home Phone _______________ Cell _______________

Work Phone _______________

Employer _____________________________________

Occupation ___________________________________

Name of Spouse _______________________________

Address: _____________________________________

____

◯ Check if same as patient's address

Race
◯ American Indian or Alaska Native ◯ Asian
◯ Native Hawaiian ◯ Black or African American ◯ White
◯ Other Pacific Islander ◯ Prefer not to answer

Ethnicity
◯ Hispanic/Latino ◯ Non-Hispanic/Latino
◯ Prefer not to answer

Preferred Language
◯ English ◯ Spanish ◯ French ◯ Indian (includes Hindu & Tamil) ◯ Other __________________

Preferred Pharmacy ___________________________

Location _____________________________________

Family Doctor ________________________________

Phone ____

Insurance Information

Primary Insurance Co ______________________________

Policy #: ________________________________

Policy holder information, if not same as patient:

Name ____

DOB ____/____/______ SS# ____________________

Secondary Insurance Co ____________________________

Policy #: ________________________________

Policy holder information, if not same as patient:

Name ____

DOB ____/____/______ SS# ____________________

Complete below if patient is a minor

Father's Name (or Guardian) ______________________

DOB ____/____/______ SS# ____________________

Home Phone _______________ Cell _______________

Work Phone _______________

Address: _____________________________________

____

◯ Check if same as patient's address

Employer _____________________________________

Mother's Name (or Guardian) _____________________

DOB ____/____/______ SS# ____________________

Home Phone _______________ Cell _______________

Work Phone _______________

Address: _____________________________________

____

◯ Check if same as patient's address

Employer _____________________________________

New Patient Registration

HIPAA Release

Patient Name

First MI Last

Do you have a Living Will? ◯ Yes ◯ No
Do you have an Advance Directive? ◯ Yes ◯ No

If you answered yes to either, please provide us a copy.

Emergency Contact:

Name Relationship

Phone #

I authorize Medical Associates of Brevard LLC to discuss my healthcare information with the below:

Name Relationship

Phone #

Name Relationship

Phone #

Preferred appointment reminder notification:
◯ Home Phone ◯ Cell ◯ Cell Text ◯ Work phone
◯ Mail ◯ E-Mail ◯ None
◯ With the person(s) authorized above

Preferred medical information notification:
I authorize Medical Associates of Brevard LLC to leave a detailed message which may contain personal health information via:
◯ Home Phone ◯ Cell ◯ Cell Text ◯ Work phone
◯ Mail ◯ E-Mail ◯ None
◯ With the person(s) authorized above

Note that authorization to contact via phone includes authorization for us to leave a message on your voicemail or answering machine.

Your HIPAA contact information will be recorded as you have indicated here. You will be asked to electronically sign to confirm this information.

YOU MUST READ BELOW FOR IMPORTANT INFORMATION AND NOTICES

Financial Policy

I understand that I am financially responsible for all charges for services to me, including co-payments, co-insurance, out-of-pocket, deductibles and noncovered services.
I authorize the payments from my insurance company(s) according to my medical benefits be made payable to ***Medical Associates of Brevard LLC*** for professional services rendered. I understand that I will receive statements, reflecting my account balance and that the FINAL PAYMENT of this account is my responsibility. Furthermore, should I default on payment for services rendered I agree to pay all collection costs including reasonable attorney's fee. I authorize the disclosure of my medical information to all of Medical Associates of Brevard as well as to my insurance company(s).

LIFETIME SIGNATURE AUTHORIZATION: This signature and assignment is to be a continuing one, remaining in effect until revoked in writing by the undersigned. It signifies that all information given is current.

NOTE: You will electronically sign for this Financial Policy agreement on the signature pad in your doctors' office to be stored in your electronic medical chart.

Notice of Privacy Practices

I acknowledge that I have received a copy of the **Provider Notice of Privacy Practices** for Medical Associates of Brevard LLC. The Provider Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Provider Notice of Privacy Practices also describes my right and the responsibilities of duties of Medical Associates of Brevard with respect to my protected health information.

NOTE: You will electronically sign for this Notice of Privacy Practices on the signature pad in your doctors' office to be stored in your electronic medical chart.

Consent to Obtain External Prescription History

I authorize Medical Associates of Brevard LLC and its physicians and staff to view my external prescription history via the electronic medical records system Medent, and the Surescripts service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.
MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

NOTE: You will electronically sign for this Consent to Obtain External Prescription History on the signature pad in your doctors' office to be stored in your electronic medical chart. **You will have the option to give consent or deny this access upon electronically signing.**

Community Chart Consent

I give consent to Medical Associates of Brevard LLC to access the Community Chart in order to access and share my medical records if available through other entities operating under the Carequality Interoperability Framework, including Surescripts. This includes demographic information as well as other relevant clinical documentation.

NOTE: You will electronically sign for this Community Chart Consent on the signature pad in your doctors' office to be stored in your electronic medical chart. **You will have the option to give consent or deny this access upon electronically signing.**

PATIENT'S NAME:____ **DATE:**__________

REASON FOR TODAY'S VISIT:

____

____

____

____

____

WHEN DID THE SYMPTOMS START?______________________________________

THE SYMPTOM INTENSITY IS: **Mild** **Moderate** **Severe**

THE SYMPTOMS ARE: **Intermittent** **Constant**

WHAT MAKES THE SYMPTOMS WORSE?______________________________________

WHAT MAKES THE SYMPTOMS BETTER?______________________________________

CURRENT MEDICATIONS AND DOSAGES. PLEASE INCLUDE SUPPLEMENTS AND NASAL SPRAYS.

____

____

____

____

HAVE YOU HAD ANY REACTIONS TO MEDICATIONS: Yes No

PLEASE TELL US THE MEDICATION AND WHAT REACTION YOU HAD (RASH, SWOLLEN TONGUE, STOPPED BREATHING, VOMITING, ABDOMINAL PAIN, DIARRHEA)

____

____

____

____

PLEASE LIST ALL PREVIOUS MEDICAL CONDITONS, PREVIOUS SURGERIES AND DATES, AND HOSPITALIZATIONS AND DATES

____

____

____

____

____

____

FAMILY MEDICAL HISTORY

THYROID PROBLEMS **No Father Mother Brother Sister**

HEARING LOSS **No Father Mother Brother Sister**

HEART DISEASE **No Father Mother Brother Sister**

SOCIAL HISTORY

DO YOU DRINK ALCOHOL? Yes Never Quit (year quit ____________)

WHAT ALCOHOL CONTAINING BEVERAGE DO YOU DRINK? BEER WINE
OTHER________________

HOW OFTEN DO YOU DRINK ALCOHOL? OCCASIONALLY WEEKENDS DAILY

DO YOU SMOKE? Yes Never Quit (year quit ____________)

CIGARETTES CIGARS MARIJUANA CHEWING TOBACCO SNUFF PAN
OTHER___________________

HOW MUCH DO YOU SMOKE? ______ PACK(S) PER DAY,

HOW MANY YEARS DID YOU SMOKE OR HAVE BEEN SMOKING?_________Years

DO YOU USE ANY RECREATIONAL DRUGS? Yes Never Quit (year quit ____________)

If Yes or Quit, please list drugs used:____

OCCUPATION:____

If retired, what was the last thing you did before you retired?________________________

MARITAL STATUS: SINGLE MARRIED DIVORCED SEPARATED ENGAGED

ARE YOU (THE PATIENT) EXPOSED TO SECOND HAND SMOKE? Yes No

DO YOU CURRENTLY HAVE ANY OF THESE SYMPTOMS?

CONSTITUTIONAL SYMPTOMS

Fevers	Yes	No
Night Sweats	Yes	No
Weight loss	Yes	No

EYES

Pain	Yes	No
Blurred vision	Yes	No
Double vision	Yes	No
Loss of Vision	Yes	No

CARDIOVASCULAR

Chest pain	Yes	No
Heart failure	Yes	No

RESPIRATORY

Difficulty breathing	Yes	No
COPD/emphysema	Yes	No
Asthma	Yes	No

GASTROINTESTINAL

Heartburn	Yes	No
Difficulty swallowing	Yes	No

INTEGUMENTARY

Rash	Yes	No

PSYCHIATRIC

Depression	Yes	No
Impaired memory	Yes	No

EAR NOSE THROAT MOUTH

Hearing loss	Yes	No
Ringing in ears	Yes	No
Ear pain	Yes	No
Ear discharge	Yes	No
Dizziness	Yes	No
Ear infections	Yes	No
Surgery in the ears	Yes	No
Sore throat	Yes	No
Had tonsils out	Yes	No
Hoarseness	Yes	No
Mouth lesions	Yes	No
Snoring	Yes	No
Stop breathing at night	Y	N
Tired during day	Yes	No

ENDOCRINE

Thyroid disease	Yes	No
Diabetes	Yes	No

ALLERGIC/IMMUNOLOGIC

Sneezing	Yes	No
Runny nose	Yes	No
Nasal congestion	Yes	No
Facial pain	Yes	No
Nosebleed	Yes	No
Lost sense of smell	Yes	No

GENITOURINARY

Frequent urination	Yes	No
Stones	Yes	No

MUSCULOSKELETAL

Joint pain	Yes	No
Back pain	Yes	No

HEMATOLOGIC/LYMPHATIC

Bleed easily	Yes	No
Enlarged glands	Yes	No

NEUROLOGIC

Headaches	Yes	No

MOUTH

Dentures	Yes	No

*If you wear dentures please be prepared to remove them for exam.

Request Amendment. You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Right to Request Restriction of PHI: If you pay in full out of pocket for your treatment, you can instruct us not to share information about your treatment with your health plan; if the request is not required by law. Effective March 26, 2013, The Omnibus Rule restricts provider's refusal of an individual's request not to disclose PHI.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so. Effective March 26, 2013, we are required to obtain an authorization for marketing purposes if communication about a product or service is provided and we receive financial remuneration (getting paid in exchange for making the communication). No authorization is required if communication is made face-to-face or for promotional gifts.

Fundraising: We may use certain information (name, address, telephone number or e-mail information, age, date of birth, gender, health insurance status, dates of service, department of service information, treating physician information or outcome information) to contact you for the purpose of raising money and you will have the right to opt out of receiving such communications with each solicitation. Effective March 26, 2013, PHI that requires a written patient authorization prior to fundraising communication include: diagnosis, nature of services and treatment. If you have elected to opt out we are prohibited from making fundraising communication under the HIPAA Privacy Rule.

Sale of PHI: We are prohibited to disclose PHI without an authorization if it constitutes remuneration (getting paid in exchange for the PHI). "Sale of PHI" does not include disclosures for public health, certain research purposes, treatment and payment, and for any other purpose permitted by the Privacy Rule, where the only remuneration received is "a reasonable cost-based fee" to cover the cost to prepare and transmit the PHI for such purpose or a fee otherwise expressly permitted by law. Corporate transactions (i.e., sale, transfer, merger, consolidation) are also excluded from the definition of "sale."

Breach Notification Requirements: It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services. **HOW TO CONTACT US:**

James T Go, MD, FACS
ENT
Office Contact: Carolyn Herrnkind
2290 West Eau Gallie Blvd, Ste 110
Melbourne, FL 32935
Tel: (321) 421-7555 Fax: (321) 421-7554

MAB Privacy Officer: Alison Alvarez
Tel: (321) 253-2900 Fax: (321) 435-0100

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. HOW YOU CAN GET ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITIES TO PROTECT YOUR HEALTH INFORMATION.

PLEASE REVIEW IT CAREFULLY

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We are required to abide by the terms of this Notice of Privacy Practices. This Notice will take effect on September 1, 2013 and will remain in effect until it is amended or replaced by us.

We reserve the right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer. Information on contacting us can be found at the end of this Notice.

We will keep your health information confidential, using it only for the following purposes:

Treatment: While we are providing you with health care services, we may share your protected health information (PHI) including electronic protected

health information (ePHI) with other health care providers, business associates and their subcontractors or individuals who are involved in your treatment, billing, administrative support or data analysis. These business associates and subcontractors through signed contracts are required by Federal law to protect your health information. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

***Payment*:** We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations, collections or other third parties that may be responsible for such costs, such as family members.

***Healthcare Operations*:** We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, insurance operations, health care clearinghouses and individuals performing similar activities.

***Disclosure*:** We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so. As of March 26, 2013 immunization records for students may be released without an authorization (as long as the PHI disclosed is limited to proof of immunization). If an individual is deceased we may disclose PHI to a family member or individual involved in care or payment prior to death. Psychotherapy notes will not be used or disclosed without your written authorization.The Genetic Information Nondiscrimination Act (GINA) prohibits health plans from using or disclosing genetic information for underwriting purposes. Uses and disclosures not described in this notice will be made only with your signed authorization.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. A fee will be charged to cover coping costs and the staff time required to locate and copy your health information. Please contact our Privacy Officer for an explanation of our fee structure.

***Non-routine Disclosures*:** You have the right to receive a list of non-routine disclosures we have made of your health care information. You can request non-routine disclosures going back 6 years starting on April 14, 2003.

***Appointment Reminders*:** We may use your health records to remind you of recommended services, treatment or scheduled appointments.

***National Security*:** The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

***Abuse or Neglect*:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.)
We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Research: We will use and disclose your protected health information to researchers provided the research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Your Health Information Rights

Inspect and Copy. Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) We will provide access to health information in a form / format requested by you. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Coping fees as allowed by Florida Statues will apply. If you prefer a summary or an explanation of your health information, we will provide it for a fee. If you want the copies mailed to you, postage will also be charged. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act allows you the right to request a copy of your health information in electronic form if we store your information electronically. Access to your health information in electronic form, if readily producible, may be obtained with your request. A fee will be charged to cover the cost of staff to produce the electronic copy and the cost of the electronic media unto which the copy is saved. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. Please contact our Privacy Officer for an explanation of our fee structure.

Sino Nasal Diagnosis

Date: ______________
Patient name: ____ DOB: ___________________________________

Sometimes it can be difficult to determine if your sinus symptoms are the result of allergies and the common cold or if pressure, pain and dizziness are being caused by chronic sinusitis. To help you determine which sinus treatment is the right option for you, take a moment to complete this assessment.

No symptoms "0" Severe Symptoms "5"

1. Need to blow nose	0	1	2	3	4	5		o
2. Sneezing	0	1	2	3	4	5		o
3. Runny nose	0	1	2	3	4	5		o
4. Cough	0	1	2	3	4	5		o
5. Post-nasal discharge	0	1	2	3	4	5		o
6. Thick nasal discharge	0	1	2	3	4	5		o
7. Ear fullness	0	1	2	3	4	5		o
8. Dizziness	0	1	2	3	4	5		o
9. Ear pain	0	1	2	3	4	5		o
10. Facial pain/pressure	0	1	2	3	4	5		o
11. Difficulty falling asleep	0	1	2	3	4	5		o
12. Wake up at night	0	1	2	3	4	5		o
13. Lack of a good night's sleep	0	1	2	3	4	5		o
14. Wake up tired	0	1	2	3	4	5		o
15. Fatigue	0	1	2	3	4	5		o
16. Reduced productivity	0	1	2	3	4	5		o
17. Reduced concentration	0	1	2	3	4	5		o
18. Frustrated/restless/irritable	0	1	2	3	4	5		o
19. Sad	0	1	2	3	4	5		o
20. Embarrassed	0	1	2	3	4	5		o

Sinus Medication History:

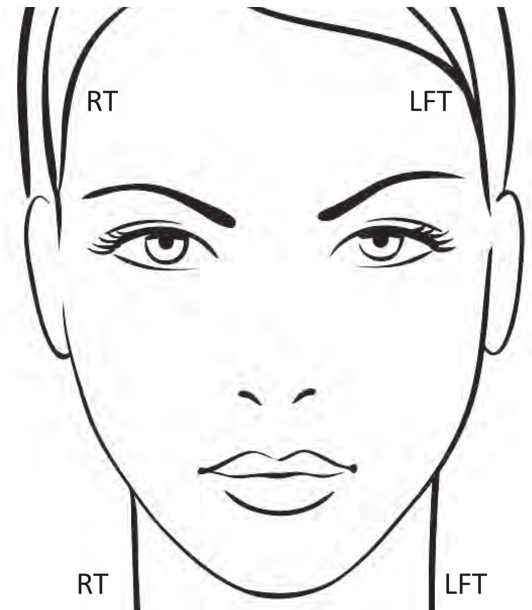
____
____
____
____

Doctors Notes:

____
____
____
____

Patient signature: ________________________________
Date: ______________________________

If you have facial pain or pressure, please place an "X" on the face below to show where you are feeling that pain or pressure:



Please rate your current facial pain/pressure on a scale of 1 to 5. 1 being no pain, and 5 being extremely painful.
1…………..2……………3………………4……………..5

Duration and Frequency
Have you experienced these symptoms for 12 or more consecutive weeks?...................YES NO

Have you experienced these symptoms for 10 or more days four or more times (with periods of no symptoms) in the last 12 months?..........................YES NO

On what date did you first start experiencing these symptoms?

____