Mississippi Ear, Nose & Throat SURGICAL ASSOCIATES

PATIENT REGISTRATION FORM

Date: _____

Patient name: _____
Last Middle

Date of Birth: _____ **Age**: _____ **Sex:** Male **Marital Status**: Single

Address:_____
Street City State Zip

Employer_____ **SSN#:** _____

Work Phone _____ **Home phone** _____ **Cell Phone** _____

Email Address _____

Emergency Contact: _____ **Phone**: _____
Someone NOT living with you

If married:

Spouse's name: _____ **DOB:** _____**SSN#** _____

Spouse's Employer_____ **Work Phone** _____

If under 18:

Mother's name: _____**DOB**: _____**SSN#** _____

Mother's Employer_____ **Work Phone** _____

Father's name: _____**DOB**: _____**SSN#** _____

Father's Employer_____ **Work Phone** _____

PRIMARY INSURANCE: _____ **POLICY/ID#:** _____ **GROUP#:** _____

Subscriber's name: _____ **DOB:** _____**SSN#** _____

SECONDARY INSURANCE: _____ **POLICY/ID#:** _____ **GROUP#:** _____

Subscriber's name: _____ **DOB:** _____**SSN#** _____

***DOCTOR WHO REFERRED YOU TO OUR CLINIC:** _____

PRIMARY CARE DOCTOR: _____

PHARMACY:_____

PROCEDURE CONSENT

Payment/ Insurance Authorization

By signing below:

I hereby authorize Mississippi Ear, Nose and Throat Surgical Associates, P.C. to file my insurance claim for the services received in the office and any physician in this group (which includes Stephen F. Lee M.D., Benjamin T. Jeffcoat M.D., Beverly C. Fulcher, M.D. and/or J. Peyton Hines M.D.).

I hereby authorize Mississippi Ear, Nose and Throat Surgical Associates, P.C. to receive payment directly for my insurance benefits, including major medical, payable under the terms of your insurance contract.

I hereby authorize Mississippi Ear, Nose and Throat Surgical Associates, P.C. to release/send any medical information acquired in the course of treatment to my insurance company listed above that is needed for inquiries or to process your claim.

I hereby authorize photocopies of this form to be valid as the original.
I hereby agree to be responsible for the payment of this account, including co-pays, deductibles, co-insurance, return check fees and non-covered amounts. Payment is due at the time of service.

If l am under 18, then the parent/guardian requesting treatment assumes responsibility.

"I agree to pay up to 33 % of the unpaid balance for collection fees, or alternatively the maximum lawful fee, at such time my account is placed with a collection agency. I further understand that I am responsible for reasonable collection costs and in the event the account is referred to an attorney for collection, I agree to be liable for such additional reasonable court costs and attorney's fees as may be determined by a court."

Signature _____ **Date** _____

(If patient is a minor) Patient's Name: _____

Mississippi Ear, Nose & Throat SURGICAL ASSOCIATES

Consent to Treat

*** I _____ do give the listed physicians:**
(Name of Patient)

Stephen F. Lee, M.D., Benjamin T. Jeffcoat, M.D., Beverly C. Fulcher, M.D., J. Peyton Hines, M.D. and their clinical staff, permission to administer medical treatment to myself or my child
_____.
(Name of Patient)

*I authorize them to use their medical judgement in the treatment of the (above mentioned patient) so long as myself / he/ or she is under their care.

_____	_____	_____
Patient or Guardian's Signature	**Relationship to Patient**	**Today's Date**

_____	_____
Clinic Staff Witness	**Today's Date**

Mississippi Ear, Nose & Throat SURGICAL ASSOCIATES

PROCEDURE CONSENT

Welcome to MISSISSIPPI EAR, NOSE AND THROAT SURGICAL ASSOCIATES, P.C. We are happy you have entrusted us with your care. As you know, we are a specialty clinic dealing with diseases of the ears, nose and throat area.

In order for our doctors to perform a thorough ENT exam, they may perform an Audiogram (hearing test), Tympanogram (to check fluid in the ears), or a Nasal Endoscopy (a procedure where an instrument referred to as a scope is used to allow them to visualize your sinus cavities or throat), depending on your symptoms or complaint.

Each individual doctor will decide based on your symptoms if the use of the scope is necessary. This procedure is not very time consuming because out doctors are trained to look for any abnormalities in the nose and throat area, so you may not realize the significance of performing these procedures.

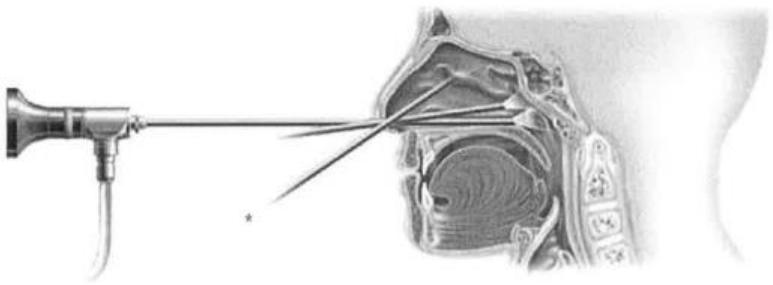
These same instruments are used in surgery and require the skills that our doctors possess. By using these scopes in their exams, our doctors have been able to diagnose diseases in their early stages.

By reading and signing this form, you are giving permission for our doctors to perform the diagnostic procedures necessary to treat your condition appropriately.

Patient/Guardian signature: _____ Date:_____

Clinical/Staff witness: _____

Patient Account number: _____



Courtesy of P. Delaere, Leuven

Mississippi Ear, Nose & Throat SURGICAL ASSOCIATES

HIPAA PRIVACY NOTICE

YOU HAVE THE FOLLOWING RIGHTS REGARDING YOUR MEDICAL INFORMATION

- The right to requests restrictions on certain uses and disclosures of your Protected Health Information (PHI). We are not required to agree to your requested restriction, but if we do, we will honor it.
- The right to receive communications from us in a confidential manner.
- The right to inspect and copy your medical information. This right is subject to certain specific exceptions and you may be charged a reasonable fee for any copies of your records.
- The right to request an amendment of your medical information. We may deny your request for certain specific reasons, and, if denied, we will provide you with written explanation for the denial and information regarding further rights you would have at that point.
- Th right to receive an accounting of the disclosures of your medical information in the six years prior to your request (following April 14, 2003), except for disclosures for treatment, payment, or practice operational purposes, disclosure pursuant to an authorization and certain other specific disclosure types.
- The right to request a paper copy of this Notice of Privacy Practices or Protected Health Information.
- The right to complain to the Practice and/or to the U/S/ Department of Health and human Services, if you believe that the Practice has violated your privacy rights. To complain to the Practice, please call:

Melissa Smith, Compliance Officer at (601)709-7700

If you choose to file a complaint, you will not be retaliated against in any way.

THIS NOTICE IS EFFECTIVE AS OF OCTOBER 1, 2012

I acknowledge that I have received and had an opportunity to ask questions concerning the Practice's Notice of Privacy Practices for Protected Health Information.

Further, by signing below I provide my permission for this facility to use and disclose my medical information for the permitted purposes of treatment, payment and healthcare options as discussed in the Notice of Privacy Practice.

_____ _____

Patient Signature Date

AUTHORIZATION TO RELEASE INFORMATION

Please list name(s) of the Personal Representative(s) of the patient below. List anyone you wish to have access to any of your personal health information, billing information or any aspects of your medical care. If a person(s) name is not listed below, we will not be able to discuss and/or release any of your information with them.

Name :_____ Relationship:_____Date:_____

Name :_____ Relationship:_____Date:_____

Mississippi Ear, Nose & Throat SURGICAL ASSOCIATES

HISTORY

Name: _____ Age: _____ DOB: _____ Sex: _____

Preferred Pharmacy: _____ City: _____

How did you hear about us? _____

Do you know anyone else who comes here? If so, whom? _____

Are you or could you be pregnant? _____

PAST MEDICAL HISTORY - Check All That Apply

☐ Abnormal Heart Beat	☐ Diabetes Type II	☐ Hiatal Hernia	☐ Pneumonia
☐ Anxiety	☐ Emphysema	☐ High Blood Pressure	☐ Prostate Enlargement
☐ Arthritis	☐ Gastric Reflux	☐ High Thyroid	☐ Rheumatoid Arthritis
☐ Asthma	☐ Glaucoma	☐ Low Thyroid	☐ Seizures
☐ Back Pain	☐ Goiter	☐ Immune Deficiencies	☐ Stroke
☐ Bronchitis	☐ Gout	☐ Kidney Stones	☐ Ulcers
☐ Depression	☐ Heart Attack	☐ Lupus	
☐ Diabetes Type I	☐ Heart Failure	☐ Neck Pain	

☐ Cancer List Type: _____

Other: _____

PAST SURGICAL HISTORY

☐ Adenoidectomy	☐ Neck Surgery	☐ PE Tubes	☐ Tonsillectomy
☐ Ear Surgery	☐ Nose Surgery	☐ Sinus Surgery	

Other: _____

MEDICINES - List drugs you are taking on a regular basis including OTCs

Drug	Dosage

ALLERGIES

List all drugs, food, insects, etc. you are allergic to.

_____ _____ _____

_____ _____ _____

Previous Allergy Evaluation: ☐ No ☐ Yes If yes, Doctors name: _____

Previous Allergy Test Results: _____

FAMILY HISTORY - Check only if mother, father, siblings or children have condition

- ☐ Allergies
- ☐ Anesthesia Problems
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Chronic Ear Disease
- ☐ Diabetes
- ☐ Early Hearing Loss
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Cancer What Type: _____
- Other: _____

SOCIAL HISTORY

Smoking Status: ☐ Never ☐ Former ☐ Current

Alcohol Status: ☐ Never ☐ Former ☐ Occasionally ☐ Daily

REVIEW OF SYSTEMS - Check All That Apply

Constitutional	☐ Body Aches ☐ Chills ☐ Fever
Eyes	☐ Discharge From Eye ☐ Impaired Vision
Cardiovascular	☐ Chest Pain
Respiratory	☐ Cough ☐ Shortness of Breath ☐ Wheezing
Gastrointestinal	☐ Nausea ☐ Vomiting
Skin	☐ New Skin Lesions ☐ Rash
Neurologic	☐ Incoordination ☐ Tingling and Numbness
Endocrine	☐ Excessive Thirst ☐ Excessive Urination
Heme-Lymph	☐ Lymph Node Enlargement or Tenderness
Immunology	☐ Frequent Illness

Patient Signature:

Please sign and date this form to verify all of the above information is correct: _____

DAMAGE OF EQUIPMENT AGREEMENT

I, _____, understand that the exams rooms at MISSISSIPPI EAR, NOSE AND THROAT SURGICAL ASSOCIATES, P.C are stocked with surgical grade equipment. Equipment includes but is not limited to exam chairs, carts, scopes and microscopes.

I understand that neither I nor my child(ren) should touch or manipulate any equipment located in the exam rooms. I understand that by doing so, I am at risk of causing damage to aforementioned equipment.

I also understand that by damaging equipment owned by MISSISSIPPI EAR, NOSE AND THROAT SURGICAL ASSOCIATES, P.C., I could be held liable for repair or replacement costs.

PATIENT NAME: _____

PARENT or GUARDIAN: _____

SIGNATURE: _____ DATE: _____

CLINICAL STAFF WITNESS: _____ DATE: _____

MEDICAL RECORDS REQUEST

REQUEST FROM:

Physician Name: _____

Address: _____

City/State: _____

TO BE RELEASED TO:

Physician Name: _____

Name: _____

Address: _____

City/State: _____

Patient Name: _____

Date of Birth: _____

Address: _____

City/State: _____

_____ _____

Patient Signature Date

_____ _____ _____

Patient Representative Relation to patient Date

I understand that this authorization authorizes the release of all medical records, to be faxed or mailed including Psychiatric, Alcohol, Drug Abuse and HIV/AIDS records. The use of this information may be protected by Public Law 93-255, Section 408; Public Law 93-282, Section 333; or Federal Regulation 42 CFR, Part 2. The information provided is confidential and any redisclosure by the recipient is prohibited.

**********all medical records will be released unless specific dates are requested**********

Employee Initials: _____

COMMUNICATION CONSENT

I,_____, understand that it is important for MENTSA or an Authorized Entity to be able to communicate with me and have current information about me, my address, my phone numbers and any other information about me that may assist MENTSA or an Authorized Entity in locating me or communicating with me. In consideration on MENTSA or Authorized Entity providing me services and other good and valuable consideration the receipt and sufficiency of which is hereby acknowledged, consumer expressly consents and agrees to the terms and conditions in the Communication Consent. Authorized Entities: The term "Authorized Entities" shall mean MENTSA and any related or affiliated health care provider, physician, service provider, independent contractor(including but not limited to billing services) and each of their respective successors, assigns, agents, attorneys, insures, representatives, employees, officers, shareholders, partners, parents, subsidiaries, affiliated entities and all agents and representatives of the previously listed persons/entities and all corporations, persons or entities in privity with of the previously listed persons/entities and all corporations, persons or entities in privity with any of them.

Communication Consent: I understand that the purpose of this agreement is to authorize the delivery of calls to me including but not limited to, using an automatic telephone dialing system or an artificial or prerecorded voice or calls to a telephone number assigned to a paging service, cellular telephone service, specialized mobile radio service or other radio common carrier service or any service for which I am charge for the call.

I also understand that my agreement to the terms of this Communication Consent is not conditioned of any Authorized Entity's willingness to provide services to me. To the extent permitted by applicable law and without limiting any other rights the Authorized Entities may have, I expressly consent and authorize the Authorized Entities to communicate with me for any reason, including reasons related to the services provided by Authorized Entities or services to be provided in the future by the Authorized Entities including collection of amounts owed for said services, via Authorized Communications at the telephone numbers I provide below or that is provided on my behalf. In addition, I further express consent and authorize the Authorized Entities to communicate with me via SMS text messages, other forms of electronic messages, electronic mail or other electronic communication sent or directed to me through any medium, no matter how the Authorized Entity obtain such contact information.

Any Authorized Entity may communicate with me using any current or future means of communication methods described in this paragraph even if I will incur a fee or a cost to receive such communications. I further promise to immediately notify if any telephone number, email address or other unique electronic identifier or mode of communication that I provide to any Authorized Entity changes or is no longer used by me. I hereby consent and authorize that a photocopy of this authorization may be considered as valid as the original. This consent shall insure to the benefit of and be binding upon heirs, agents, spouses, executors, administrators, successors and assigns. I intend for all Authorized Entities to be third party beneficiaries of the consent I have provided herein.

MEDICARE AUTHORIZATION and ASSIGNMENT

PATIENT NAME: _____MEDICARE ID: _____

SIGNATURE: _____

CLINICAL STAFF WITNESS: _____

DATE: _____

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct.

I authorize any holder of Medical or other information about me to release to the SSA or its intermediaries or carriers any information needed for this or a related Medicare Claim.

I request that payment or authorized benefits be made either to me or on my behalf.

MISSISSIPPI EAR, NOSE AND THROAT SURGICAL ASSOCIATES, P.C.