

# ALLERGY, EAR, NOSE & THROAT CLINIC OF NE TEXAS

Specialists in Otolaryngology/Head & Neck Surgery

Thomas V. Ripp, M.D. Camille A. Graham, M.D. Neil M. Vora, M.D. Wha-Joon Lee, M.D.

## Patient Information

Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ (Age) \_\_\_\_  
Social Security # \_\_\_\_\_ TDL# \_\_\_\_\_  
Marital Status: S M D W Sex: M F  
Address(Street) \_\_\_\_\_ (City) \_\_\_\_\_ (St) \_\_\_\_\_ (Zip) \_\_\_\_\_  
Phone(Home) \_\_\_\_\_ (Cell) \_\_\_\_\_  
Employer: \_\_\_\_\_ Wk Phone: \_\_\_\_\_

## Parent/Guardian Information (if patient is under 21)

Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
Social Security # \_\_\_\_\_ TDL# \_\_\_\_\_  
Marital Status: S M D W Sex: M F  
Address(Street) \_\_\_\_\_ (City) \_\_\_\_\_ (St) \_\_\_\_\_ (Zip) \_\_\_\_\_  
Phone(Home) \_\_\_\_\_ (Cell) \_\_\_\_\_  
Employer: \_\_\_\_\_ Wk Phone: \_\_\_\_\_

## Spouse Information

Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_  
Social Security # \_\_\_\_\_ TDL# \_\_\_\_\_  
Marital Status: S M D W Sex: M F  
Address(Street) \_\_\_\_\_ (City) \_\_\_\_\_ (St) \_\_\_\_\_ (Zip) \_\_\_\_\_  
Phone(Home) \_\_\_\_\_ (Cell) \_\_\_\_\_  
Employer: \_\_\_\_\_ Wk Phone: \_\_\_\_\_

## Insurance Information

Primary Insurance: \_\_\_\_\_ Insurance Phone# \_\_\_\_\_  
Insured Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Insured ID# \_\_\_\_\_ Group# \_\_\_\_\_ Employer \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Insurance Phone# \_\_\_\_\_  
Insured Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Insured ID# \_\_\_\_\_ Group# \_\_\_\_\_ Employer \_\_\_\_\_

## Emergency Contact (NOT LIVING WITH YOU)

Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ Relation to Patient \_\_\_\_\_  
Phone(Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

How did you hear about our practice? Doctor Referral (name) \_\_\_\_\_  
Friend (name) \_\_\_\_\_  
Advertisement \_\_\_\_\_

## **Authorization to Treat, Authorization to Release Information & Assignment of Benefits:**

I authorize the physician(s) of Allergy ENT to treat me. I authorize any physician/agent of Allergy ENT to release my medical records or medical information to any physician, hospital or other medical provider or supplier who may participate in my medical care. I authorize any physician, hospital, or other supplier to release my medical records and information to the physician(s) of Allergy ENT. I authorize any physician/agent of Allergy ENT to release my medical records and/or information to my insurance carrier to determine my benefits. I authorize my insurance carrier(s) to pay my medical benefits directly to the physician(s) of Allergy ENT. I understand that I am financially responsible for all charges not paid by the insurance carrier(s). I agree that a photocopy of this agreement will be considered the same as the original.

Date: \_\_\_\_\_

\_\_\_\_\_  
Patient Signature (Parent or Guardian, if patient is a minor)

## ALLERGY, EAR, NOSE & THROAT CLINIC OF NE TEXAS - FINANCIAL POLICY

- 1) **You are responsible for full payment of all fees incurred at Allergy, Ear, Nose & Throat.** While we file your insurance as a courtesy; you have the final responsibility for payment in full. Payment of deductibles and co-insurance is due at the time of service.
- 2) In the event there becomes an unexpected balance on your account, Allergy, Ear, Nose & Throat will bill you one time free of charge. Each statement thereafter will have a **\$5.00 fee added**. If your account remains unpaid and it becomes necessary to turn the account over to the collection agency there will be a **40% fee added to your balance**.
- 3) You are responsible for full payment of all fees incurred by any child that you bring into the office for treatment. **WE DO NOT BILL THE OTHER PARENT.**
- 4) **Regarding Medicare:**
  - You are expected to pay your annual Medicare deductible and the 20% co-insurance that Medicare does not pay.
  - Our office will make one attempt at filing your supplemental insurance and will reimburse you after they make payment. Our refunds are done on or about the 15<sup>th</sup> of each month.
- 5) **Regarding Medicaid:**
  - Current Medicaid card is required at each visit.
  - Referral from Primary Care Physician (PCP) if required.
- 6) **Regarding Multiple Insurance Policies:**
  - We will file two separate insurance policies for you as a courtesy. You will be responsible for any additional policies that need to be filed.
- 7) **Regarding Referrals:**
  - You are responsible for obtaining any required referral from your primary care physician (PCP) to our office.
  - If we do not have a valid referral, you may do one of the following:
    - 1) Wait to see if a referral can be obtained from the referring physician.
    - 2) Reschedule to another day.
    - 3) Elect to stay and be seen without a referral.
  - If we do not have a valid referral, you will be expected to pay in full at the time that service is rendered. We cannot file a claim to your insurance if we do not have a referral.
- 8) **Regarding Your Insurance Policy:**
  - Your co-payment to see an ENT physician may be different from the co-payment at your PCP's office.
  - Your co-payment may cover the office visit only. Various procedures such as the use of flexible or rigid scopes may require you to meet separate "surgical" deductibles. Allergy tests, allergy injections, CT scans, hearing test and hearing aids may be subject to deductibles and/or co-insurance. Again, payment of deductibles and co-insurance is due at time of service.
- 9) **Regarding Fees from Labs, Radiology Facilities, Hospitals and Anesthesiologist:**
  - Our fees are for our services only.
  - Labs, radiology and pathology facilities, anesthesiologists and hospitals will bill you separately for utilizing any of their respective services. You should speak directly to their office with any questions that you may have regarding their fees and/or policies.

I have read, understand and agree to the Financial Policy of Allergy, Ear, Nose & Throat Clinic.

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Signature of Patient or Legal Guardian

Relationship to Patient

Date

**ALLERGY, EAR, NOSE & THROAT CLINIC OF NE TEXAS**

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**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

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I acknowledge that I have received a copy of this office’s Notice of Privacy Practices.

\_\_\_\_\_  
Please print your name here

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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**FOR OFFICE USE ONLY**

We have made every effort to obtain a written acknowledgement of receipt of our Notice of Privacy Practices from this patient, but it could not be obtained because:

\_\_\_\_\_ The patient refused to sign.

\_\_\_\_\_ Due to an emergency situation it was not possible to obtain an acknowledgement.

\_\_\_\_\_ We weren’t able to communicate with the patient.

\_\_\_\_\_ Other (*Please provide specific details*)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

**HIPAA Consent for Use/Disclosure of Health Information**  
This form does not constitute legal advice and covers only federal, not state laws.



# ALLERGY, EAR, NOSE & THROAT CLINIC OF NE TEXAS

## NOTICE OF PRIVACY PRACTICES

### THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws requires us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this notice. We must follow the privacy practices as described below. This Notice will take effect on \_\_\_\_\_ and will remain in effect until it is amended or replaced by us.

It is our 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, Teresa Daws. Information on contacting us can be found at the end of this Notice.

#### TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

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

**Treatment:** We may use your health information to provide you with our professional services. 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.

**Disclosure:** We may disclose and/or share your health care information 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.

**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 or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

**Emergencies:** We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays, or other similar forms of health information and/or supplies unless you have advised us otherwise.

**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, outside health or management reviewers and individuals performing similar duties.

**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.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a 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.

**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.

**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.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders, including but not limited to, voicemail messages, postcard, or letters.

#### **HIPAA Authorization for Release of Information**

This form does not constitute legal advice and covers only federal, not state, laws.

NOTICE OF PRIVACY PRACTICES - CONTINUED

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**YOUR PRIVACY RIGHTS AS OUR PATIENT**

**Access:** 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). 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. Copies, if requested will be \$25.00 for the first 10 pages and \$0.25 for each additional page. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or an explanation of our fee structure.

**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.

**Non-routine Disclosures:** You have the right to receive a list of non-routine disclosures we have made of your health care information (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures; therefore these are not available). You have the right to a list of instances in which we, or our business associates, disclosed information for reasons *other than* treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. (Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available).

**Restrictions:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement (Except in emergencies). Please contact our Privacy Officer if you want to further restrict access to your health care information. This request may be submitted in writing.

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**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.

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**HOW TO CONTACT US**

Practice Name: Allergy, Ear, Nose & Throat of NE Texas  
Name of Privacy Officer: Teresa Daws  
Practice Address: 3000 Horizon Rd.  
Rockwall, TX 75087  
Phone: (972)772-4200 Fax: (972)772-4202 Email: None

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**PATIENT CONFIDENTIAL COMMUNICATIONS**

Patient's Name: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_

The Health Insurance Portability and Accountability Act (HIPAA) gives you the right to request that we communicate financial and/or medical information to you in confidence by a particular method. In order to protect the privacy and confidentiality of your information; please complete the following, which tells us how you wish to be contacted and who we may discuss your healthcare with.

I wish to be contacted in the following manner (Check all that apply)

- You may contact me at home.
- You may contact me at work.
- You may contact me by cell phone.
- You may leave a message with office/contact name only and call back number on voice mail/answering machine.
- You may leave a message on voicemail/answering machine leaving detailed medical information and contact name/number.
- You may give information to the following family member(s).

	(Name)	
(Relationship)		

	(Name)	
(Relationship)		

	(Name)	
(Relationship)		

Our office will continue to communicate with you according to your above response(s) until you change your preferences. You may do so by completing a new form.

By signing below, you agree to be contacted in the above manner.

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Signature of Patient/Legal Guardian of Minor Patient	Date
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**MEDICAL HISTORY QUESTIONNAIRE: PLEASE ANSWER ALL QUESTIONS & PRINT LEGIBLY**

NAME \_\_\_\_\_ DOB: \_\_\_\_\_ AGE \_\_\_\_\_ DATE \_\_\_\_\_

WHY ARE YOU SEEING THE DOCTOR TODAY? \_\_\_\_\_

WHEN DID SYMPTOMS START? \_\_\_\_\_

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDING OVER THE COUNTER OR HERBAL):

ARE YOU ALLERGIC TO ANY MEDICATIONS? NO \_\_\_\_\_ YES \_\_\_\_\_ LIST \_\_\_\_\_

CIRCLE IF YOU TAKE: ASPIRIN/BLOOD THINNER NASAL SPRAY INHALER FOR LUNGS BIRTH CONTROL PILLS

HAVE YOU EVER HAD SURGERY? NO \_\_\_\_\_ YES \_\_\_\_\_ LIST \_\_\_\_\_

ANY PROBLEMS WITH ANESTHESIA? NO \_\_\_\_\_ YES \_\_\_\_\_ LIST \_\_\_\_\_

ANY HOSPITALIZATIONS? NO \_\_\_\_\_ YES \_\_\_\_\_ LIST \_\_\_\_\_

DO YOU SMOKE OR USE CHEWING TOBACCO (CIRCLE WHICH)? NO \_\_\_\_\_ OR QUIT \_\_\_\_\_ (FILL) YEAR AGO  
YES \_\_\_\_\_ LIST PACKS \_\_\_\_\_ PER DAY; FOR \_\_\_\_\_ YEARS

DO YOU DRINK ALCOHOL? NO \_\_\_\_\_ YES \_\_\_\_\_ LIST NUMBER OF DRINKS \_\_\_\_\_ PER DAY

OCCUPATION: \_\_\_\_\_ ANY PETS INDOORS? NO \_\_\_\_\_ YES \_\_\_\_\_ LIST \_\_\_\_\_

**FAMILY HISTORY: CIRCLE IF YOUR FAMILY HAS HAD ANY OF THE FOLLOWING ILLNESSES:**

ALLERGY ASTHMA HEARING LOSS EAR TUBES HEAD/NECK CANCER THYROID PROBLEMS

DIABETES PROBLEMS WITH ANESTHESIA HIGH BLOOD PRESSURE HEART DISEASE FREE BLEEDING

**PERSONAL HISTORY: CIRCLE IF YOU HAD OR CURRENTLY HAVE ANY OF THE FOLLOWING PROBLEMS:**

1) GENERAL: WEIGHT LOSS APPETITE LOSS SNORING SLEEP APNEA

2) CVS: HEART ATTACK HEART MURMUR HIGH BLOOD PRESSURE HIGH CHOLESTEROL CHEST PAIN

3) PULMONARY: ASTHMA COPD SHORTNESS OF BREATH COUGH

4) GI: DIFFICULTY SWALLOWING INDIGESTION REFLUX/HEARTBURN STOMACH ULCER

5) CNS: STROKE DEVELOPMENTAL DELAY VERTIGO

6) ENDOCRINE: DIABETES THYROID PROBLEMS

7) HEMATOLOGY: BLOOD TRANSFUSIONS FREE BLEEDING IN SELF

8) SKIN: RASH ECZEMA FOOD ALLERGIES

9) INFECTIOUS: HEPATITIS HIV AIDS

10) EYES: ITCHY WATERY DRY VISION PROBLEMS

11) DENTAL: RECENT DENTAL WORK

PLEASE USE EXTRA SPACE TO EXPLAIN/ELABORATE MEDICAL HISTORY: \_\_\_\_\_

REFERRING OR FAMILY PHYSICIANS NAME: \_\_\_\_\_  
\*\*\*\*\*

PHYSICIAN USE ONLY: I CERTIFY THAT I HAVE REVIEWED THIS INFORMATION WITH THE PATIENT

\_\_\_\_\_  
SIGNED

\_\_\_\_\_  
DATE