OREGON EAR, NOSE AND THROAT, P.C.

☐ Joyce M. Brackebusch, M.D. ☐ Frank R. Buchanan, M.D. ☐ James J. Knackstedt, M.D.

Patient Information

Patient Name:_____ Social Security #:_____
Last First MI

Date of Birth:_____ Sex: M or F Marital Status: Single Married Other

Street Address:_____
Street City State Zip

Mailing Address:_____
Street City State Zip

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Employer / School:_____ Retired: Y or N

Primary Care Physician:_____ Who Referred the Patient?_____

Who can we contact in an emergency?_____/_____ Phone:_____
(Name / Relationship to Patient)

Responsible Party Information:

Responsible Party:_____ Date of Birth:_____ Social Security #:_____

Street Address:_____ Mailing:_____
Street City State Zip

Employer:_____ Phone:_____

Spouse:_____ Date of Birth:_____ Social Security #:_____

Employer:_____ Phone:_____

Billing Information

Is this visit because of an accident? Y or N If so, what type? Auto – Work – Other Date of Injury:_____

Primary Insurance:_____ Subscriber Name:_____ Date of Birth:_____
(Whose Policy is this?)

ID#:_____ Employer Name & Group #:_____

Ins. Address:_____ Phone:_____

Secondary Insurance:_____ Subscriber Name:_____ Date of Birth:_____
(Whose Policy is this?)

ID#:_____ Employer Name & Group #:_____

Ins. Address:_____ Phone:_____

Patient Responsibility and Consent:

I understand that it is my responsibility to notify this office of any change in my address or insurance. I assign the medical benefits paid by my insurance carrier(s) to Oregon Ear, Nose and Throat, P.C. I understand that I am financially responsible to Oregon Ear, Nose and Throat, P.C., for charges not covered by my insurance. I agree to pay all collection costs and reasonable attorney fees if I fail to promptly pay this account when due. I understand that a finance charge or late fee may be applied to my account, not to exceed what is allowed by law, if I fail to promptly pay this account when due. By signing this form, I am granting consent to request, use and disclose my protected health information including prescriptions for the purposes of continuity of medical care, payment of my bill, and health care operations.

_____
Patient and / or Responsible Party Signature Email Address Date

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IN ORDER TO COMPLY WITH THE NEW HEALTH CARE MANDATES

As an intended major step in enhancing the ability to monitor health care processes and outcomes for different population groups, target quality initiatives more efficiently and effectively and in order to comply with the new Health Care Mandates, Oregon Ear, Nose and Throat, P.C. is required to collect the following information:

PATIENT NAME (Please Print):_____DOB:_____

Race (Choose only one):

- American Indian or Alaska Native
- Asian
- Native Hawaiian
- Black or African American
- White
- Hispanic
- Pacific Islander
- Refused

PREFERRED LANGUAGE (Choose only one):

- English
- Indian (Includes Hindi & Tamil)
- Spanish
- Korean
- Other

ETHNICITY (Choose only one):

- Hispanic
- Non-Hispanic
- Refused

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Patient Name:_____ **Date**:_____

Occupation:_____ What pharmacy do you use?_____

What problems are you here for today? _____

Were you ever seen by another Ear, Nose and Throat specialist? Y or N / If so, was it within the last 3 years? Y or N

Major Illnesses: (circle)

Asthma Emphysema/COPD High Cholesterol Diabetes Thyroid Problems

AIDS/HIV Hepatitis A, B or C Heart Disease High Blood Pressure

Other:_____ Cancer: What type?_____

Current Medication and Dosages:

1.)_____ 4.)_____ 7.)_____

2.)_____ 5.)_____ 8.)_____

3.)_____ 6.)_____ 9.)_____

Do you currently take any medication containing Aspirin? Y or N
Name and Dosage:_____

Previous Surgical Procedures, dates and surgeon: (Procedures that were done under general anesthesia)

1.)_____ 5.)_____

2.)_____ 6.)_____

3.)_____ 7.)_____

4.)_____ 8.)_____

Do you need to take antibiotics before procedures or dental work? Y or N
Do you or any family members have a history of easy bruising or excessive bleeding? Y or N
If yes, please explain:_____

Drug Allergies:

1.)_____ 3.)_____ 5.)_____

2.)_____ 4.)_____ 6.)_____

Smoker? Y or N Packs/Day_____How many years?_____
If you have quit, how long ago? _____ Months _____Years _____

Chew Tobacco? Y or N How Many years?_____
If you have quit, how long ago? _____Months _____Years _____

Alcohol? Y or N oz/day_____How many years?_____
If you have quit, how long ago? _____ Months _____Years _____

Street Drugs? Y or N If yes, what types? _____
If you have quit, how long ago? _____ Months _____Years _____

FAMILY INFORMATION EXCHANGE/RELEASE OF INFORMATION, VERBAL OR WRITTEN

(To be signed by patient, parent, guardian, or Power of Attorney)

I,_____, hereby authorize Oregon Ear, Nose and Throat, P.C. to inform and/or
Patient Name-please print
involve the following family members and friends in my care planning. I understand that their participation will include giving information to the staff of Oregon Ear, Nose and Throat, P.C. regarding my condition. I also understand that the staff of Oregon Ear, Nose and Throat, P.C. may share information with the family and/or friends listed below about my care planning.

Spouse or primary significant other:

Name	Relationship	Address/Street	Phone/Home
		City/State/Zip	Phone/Work

Other family and friends:

Name	Relationship	Address/Street	Phone/Home
		City/State/Zip	Phone/Work
Name	Relationship	Address/Street	Phone/Home
		City/State/Zip	Phone/Work
Name	Relationship	Address/Street	Phone/Home
		City/State/Zip	Phone/Work

I understand that information specific to drug and alcohol treatment, psychiatric treatment, and AIDS/HIV testing may be released with this consent. I can cancel this at any time, but I understand that the cancellation will not affect any information that was released prior to the cancellation. I understand what this agreement means and I am satisfied with any explanations I may have requested and received.

Patient Signature		Date
Authorized Signature	Relationship	Date

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Notice of Privacy Practices

To our patients. This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information.

Use and Disclosure of Your Health Information in Certain Special Circumstances

The following circumstances may require us to use or disclose your health information:

1. Use or disclosure of your health information for treatment, payment, or health care operations.
2. To public health authorities and health oversight agencies that are authorized by law to collect information.
3. Lawsuits and similar proceedings in response to a court or administrative order.
4. If required to do so by a law enforcement official.
5. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
6. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
7. To federal officials for intelligence and national security activities authorized by law.
8. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
9. For Workers Compensation and similar programs.

Your rights regarding your health information:

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Oregon Ear, Nose and Throat, P.C.

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, you must submit your request in writing to Oregon Ear, Nose and Throat, P.C. You must also provide us with the reason that supports your request for amendment.

5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, contact Oregon Ear, Nose and Throat, P.C.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Oregon Ear, Nose and Throat, P.C. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact your physician with Oregon Ear, Nose and Throat, P.C. By signing this form, you are acknowledging that you have been presented with a copy of the Oregon Ear, Nose and Throat, P.C. "Notice of Privacy Practices".

_____

Patient and / or Responsible Party Signature Date

Oregon Ear, Nose and Throat, P.C.

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Financial and Office Policies

Please arrive 10 minutes prior to your appointment time to update any paperwork. Please give us your most current insurance card and a photo ID for us to copy for your file.

Copayments are due when services are rendered. We accept checks and cash. We are not set up for any type of card transaction. Any office procedures, diagnostic hearing tests or endoscopies are billed separately from your office visit. Some insurances require a separate copay or apply deductible for these services. If you are scheduled for surgery, we bill for the surgeon component of the service only. Any facility, anesthesia or pathology charges are billed separately by them. You will be responsible for any copays, deductible or co-insurance and any non-covered charges.

Our office will file claims with your insurance as a courtesy. For insurance plans with whom we participate, we will automatically file the claim. If you do not have health insurance, please remember that all professional services rendered will be charged to you. Please be advised that even if you do have insurance, some services may be considered non-covered or not medically necessary under Medicare and/or other medical insurance programs, and those charges will be your personal responsibility.

Missed Appointments
If you miss three or more consecutive appointments without at least a 24 hour prior notification we may not schedule you for future appointments.

Minors
The adult parent or guardian accompanying the minor is responsible for payment of the minor's account regardless of the identity of the minor's policy holder. For unaccompanied minors, non-emergency treatment may be denied until a parent/guardian is present or we have written permission for treatment. If anyone other than the parent/guardian accompanies the minor to the office, the parent/guardian must fill out a consent to treat form prior to evaluation and treatment.

No Insurance / Self Pay Accounts and / or Application for Financial Discount
If you have no insurance, we do require a down payment of $100 by either check or cash at the first appointment. For any follow up appointments, payment would be due in full at the time of service unless prior arrangements have been made. If you will need to make payment arrangements due to financial hardship, please request an application for a discount or contact us for options.

Thank you for reading our financial policies. For any questions, please call the office at 541-349-9333.