You are scheduled to see Dr. Joseph Russell at _____ on _____

Location:	North Area	East Cooper
	7555Northside Dr.	900 Bowman Rd. Ste. 201
	N. Charleston, SC 29420	Mt. Pleasant, SC 29464

(First)	(Middle Initial)	(Last)
Date of Birth:	Age:	S e x:
Address:	City:	State: Zip:
Home Phone #:	Work Phone #:	Cell #:
S.S.#:	Driver's License #:	Marital Status:
Race:	Ethnicity:	Language:
Email Address :		
Employed By :		
Address :		
Spouse/Parent:	Driver's License #:	
D.O.B.:	S.S. #:	
Employed by:	Work Phone:	
Primary Care Physician:	Phone:	
Referring Doctor:	Phone:	
Pharmacy Name, Address and Telephone Number:		

PRIMARY INSURANCE INFORMATION	
Ins. Company Name:	Effective Date:
Insured:	Insured's SS #:
Insured Address:	
Insured Phone #:	Insured D. O. B.:
Policy No:	Group No:
SECONDARY INSURANCE INFORMATION	
Ins. Company Name:	Effective Date:
Insured:	Insured's SS#:
Insured Address:	
Insured Phone #:	Insured D. O. B.:
Policy No:	Group No:

I authorize the release of any medical information necessary to process any insurance claims and access to Pharmacy records. I also authorize payments of medical benefits NATIONAL ALLERGY & ENT. I understand that I am financially responsible for all charges not covered by my insurance, irrespective of the amount of insurance coverage. I understand that my insurance coverage may not cover all of my medical charges, and that I am responsible for any and all billing and/or collection fees.

_____ _____

Signature of Patient or Responsible Party (if a minor) Date

_____ _____

Signature of Witness Date

Patient Name: _____ DOB:_____ Date:_____

What is the reason you are here today? _____

How would you prefer the doctor to address you? Mr. Ms. Mrs. Dr. First Name Nickname: _____

ALLERGIES? ☐ **No Allergies**

Allergies to Medications	Type of Reaction		Allergies to Medications	Type of Reaction

Have you ever had an allergy test? ☐ Yes ☐ No

Have you ever taken allergy shots? ☐ Yes ☐ No

If yes, are you still taking them? ☐ Yes ☐ No How much relief from shots? ☐ minimal ☐ partial ☐ significant

LIST ALL MEDICATIONS YOU ARE TAKING (Prescription, over-the-counter or herbal) or

Allow ENT & Allergy Assoc to obtain medication history via electronic means directly from insurer/pharmacy _____initial here

☐ **No Current Medications**

Medication	Dosage	How often taken		Medication	Dosage	How often taken

Pharmacy Name (Include Address &/or Phone)_____

Preferred Lab: (circle one or indicate 'other') Quest Labcorp Other_____

***MEDICAL / SURGICAL HISTORY*: HAVE YOU EVER BEEN *DIAGNOSED* WITH ANY OF THE FOLLOWING?**

☐ **No Medical / Surgical History**

Cardiovascular:	**Yes**	**Surgery/Management**
Coronary Artery Disease	☐	_____
Elevated Cholesterol (hyperlipidemia)	☐	_____
High Blood Pressure (hypertension)	☐	_____
Gastrointestinal:		
Hepatitis	☐	_____
Hernia	☐	_____
Gastroesophageal Reflux	☐	_____
Genitourinary:		
Prostate enlargement (Benign Prostate Hyperplasia)	☐	_____
Kidney Stones (Nephrolithiasis)	☐	_____
Renal Failure (Acute)	☐	_____
Ear / Nose / Throat: (HEENT)		
Cataracts	☐	_____
Glaucoma	☐	_____
Chronic Ear Infections (Otitis Media)	☐	_____
Hearing Loss	☐	_____
Sinus Problems (chronic sinusitis)	☐	_____
Nasal Polyps	☐	_____
Nasal Allergies	☐	_____
Recurrent Tonsillitis	☐	_____
Tinnitus	☐	_____
Vertigo	☐	_____
Hematologic :		
Anemia	☐	_____
Immunologic:	Yes	**Surgery/Management**
Allergies Type: _____	☐	_____
Food Allergies Type: _____	☐	_____
Infectious Disease:		
Mononucleosis	☐	_____
STD Type: _____	☐	_____
Metabolic/endocrine:		
Diabetes Type: _____	☐	_____
Thyroid deficiency (hypothyroidism)	☐	_____
Thyroid excess (hyperthyroidism)	☐	_____
Neoplastic:		
Cancer Type: _____	☐	_____
Neurologic:		
Migraine	☐	_____
Obstetric:		
Pregnancy Date(s): _____	☐	_____

Psychiatric:

Adjustment Disorder - Anxiety ☐ _____

Major Depression ☐ _____

Pulmonary:

Asthma ☐ _____

COPD ☐ _____

Emphysema ☐ _____

Sleep Apnea ☐ _____

Tuberculosis ☐ _____

If YES to any of the above Diagnosis was surgery performed?

What_____ **Where/When**_____ **By Who**_____

FAMILY HISTORY of:	**Who**		**Who**		**Who**
ADD/ADHD	☐	CVA (Stroke)	☐	Learning disability	☐
Alcoholism	☐	Depression	☐	Mental illness	☐
Allergies	☐	Developmental delay	☐	Migraines	☐
Alzheimer's Disease	☐	Diabetes	☐	Obesity	☐
Asthma	☐	Eczema	☐	Osteoarthritis	☐
Blood disease	☐	Hearing deficiency	☐	Osteoporosis	☐
CAD (Coronary Artery Disease)	☐	Hyperlipidemia	☐	PVD	☐
CAD-Premature	☐	Hypertension	☐	Renal disease	☐
Cancer Type: _____	☐	Irritable Bowel Syndrome	☐	Seizure disorder	☐

Other Family History: _____

Tobacco Use? ☐ **Yes** ☐ **No** ☐ **Former**

Type of Tobacco	**Packs/ Day**	**For ? Years**	**Yr. Quit?**
Cigarettes			
Other: (list type)			

Do you consume alcohol? ☐ **Yes** ☐ **No** ☐ **Former**

Type of Alcohol	**Frequency?**	**Amt?**	**Last Drink?**

Exposed to second hand smoke? ☐ **Yes** ☐ **No**

Caffeine Consumption? ☐ **Yes** ☐ **No** **Type:** _____ **Amount per day?** _____

REVIEW OF SYSTEMS: Please mark where applicable:

General health problems

No Yes

☐ ☐ Fatigue
☐ ☐ Fever
☐ ☐ Night sweats
☐ ☐ Weight loss
☐ ☐ Weight gain

Eye problems

No Yes

☐ ☐ Double vision
☐ ☐ Itchy eyes
☐ ☐ Redness

Ear problems

No Yes

☐ ☐ Drainage
☐ ☐ Hearing loss
☐ ☐ Infections
☐ ☐ Dizziness
☐ ☐ Itchiness
☐ ☐ Exposure to Excessive Noise
☐ ☐ Ear pain
☐ ☐ Ringing /noise in ears

Nose & Sinus problems

No Yes

☐ ☐ Congestion
☐ ☐ Facial Pain
☐ ☐ Mouth Breathing
☐ ☐ Nose Bleeds
☐ ☐ Sneezing
☐ ☐ Runny Nose
☐ ☐ Post Nasal Drainage

Prefe

Mouth & Throat problems

No Yes

☐ ☐ Difficulty Swallowing
☐ ☐ Sleep Apnea
☐ ☐ Snoring
☐ ☐ Sore Throat
☐ ☐ Hoarseness
☐ ☐ Sores/Ulcers in Mouth

Heart or circulation problems

No Yes

☐ ☐ Heart Murmur
☐ ☐ Chest pain
☐ ☐ Swelling of Ankles/Edema
☐ ☐ Blacking Out
☐ ☐ Irregular Heartbeat/Palpitations

Lung or respiratory problems

No Yes

☐ ☐ Cough
☐ ☐ Shortness of Breath
☐ ☐ Wheezing

Musculoskeletal:

No Yes

☐ ☐ Leg pain

Stomach problems

No Yes

☐ ☐ Abdominal Pain
☐ ☐ Constipation
☐ ☐ Diarrhea
☐ ☐ Heartburn
☐ ☐ Nausea
☐ ☐ Vomiting

Brain or Nervous system problems

No	Yes	
☐	☐	Headache
☐	☐	Seizures
☐	☐	Focal Weakness
☐	☐	Numbness

Glands & Hormone problems

No	Yes	
☐	☐	Heat Intolerance
☐	☐	Cold Intolerance
☐	☐	Neck Enlargement/Goiter

Blood or Lymph nodes problems

No	Yes	
☐	☐	Easy Bleeding
☐	☐	Easy Bruising

Allergy problems

No	Yes	
☐	☐	Food Allergies
☐	☐	Bee Sting Allergies
☐	☐	Environmental Allergies
☐	☐	Urticaria / Hives

Skin

No	Yes	
☐	☐	Itchy Skin/ Pruritis
☐	☐	Rash
☐	☐	Contact Allergy

Patient Name: _____ **DOB:** _____

Responsible Party Signature: _____ **Date:** _____

NATIONAL ALLERGY & ENT
National Experts, World-Class Care

Please be aware that, in order to determine the correct diagnosis so that the most appropriate treatment can be recommended for your medical condition, your physician may need to perform certain in-office procedures which enable that diagnosis to be made.

If performed, these diagnostic procedures are billed as an additional item charge on your office visit statement. Although these procedures are purely diagnostic in nature, your particular insurance carrier may classify them as "surgical procedures." If so, the charge may be subject to the surgical deductible of your particular insurance plan. As per the rules of your insurance carrier, you will be responsible for covering any deductible payment.

The physicians of National Allergy & ENT follow strict federal and state billing and coding guidelines. The most common diagnostic procedures which may fall under your surgical deductible are Nasal Endoscopy, Nasopharyngoscopy, Flexible Laryngoscopy, and Videostroboscopy.

☐ By checking this box, you are acknowledging that you have read the above

_____ _____

Signature Date

PATIENT FINANCIAL POLICY

We are dedicated to providing the best possible care and service to you. We want to work with you to manage the financial responsibilities you incur as our patient. The following information explains our financial policy:

- Unless other arrangements have been made in advance by either you or your health coverage carrier, **full payment is due at the time of service.** For your convenience, we will accept VISA, Mastercard, American Express, Discover or debit card.
- Your insurance policy is a contract between you and your insurance company; the doctor is not involved. Failure to supply our office with current insurance cards and personal information may result in you being responsible for the visit and/or fees **We cannot waive any co-pay, co-insurance or deductible due to healthcare fraud laws.**
- As a courtesy, we will file your insurance claim for you if you assign the benefits to the physician. In other words, you agree to have your insurance company pay the physician directly. If your insurance company does not pay the practice within a reasonable length of time, we will have to look to you for payment.
- We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We can bill those plans with whom we have an agreement and can only require you to pay the authorized co-payment at the time of service.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, our charges for your care and treatment are due at the time of service.
- By signing this agreement, you understand the amount of coverage provided by your insurance for these services and agree to cover the remaining balance.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be ***"not covered"***, you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- For all services provided in the hospital, we will bill your health plan. Any balance due is your responsibility and is due upon receipt of a statement from our office.
- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.
- In order to provide the best possible service and availability to all our patients, please call at least 24 hours prior to your appointment if you know you will need to reschedule your appointment. There will be a $50 charge if the appointment is not cancelled in the appropriate amount of time or if the patient is a "no show".
- We charge $35.00 for checks returned for insufficient funds.
- If your plan requires a referral from your primary care physician it is YOUR responsibility to obtain it prior to your appointment to ensure we have received the referral. It is also your responsibility to keep track of your authorization and make sure you have one each time you see the doctor to receive allergy injections. If the referral is not in hand at the time of service the appointment must be rescheduled.
- We require a physician visit to complete any forms for school, work, etc.
- Your physician may require an office visit in order to process a prior authorization for medication.
- At the physician's discretion, a physician may bill for a "physician to patient" phone call.
- If **full** payment is not made at the time of service you will be referred to an outside collection agency. You will be responsible for all reasonable collection fees.
- You agree, in order for us to service your account or to collect any amounts you may owe, we as well as our third party debt collector may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We as well as our third party debt collector may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.
- I agree that I will be responsible for all attorney costs and court fees required to settle my account. This agreement is governed by the laws of the SC.
- ***I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to-time by the practice. If you have any questions about the policy, please discuss them with our Administrator.***

By signing, you understand you will be responsible for any remaining balance.

Signature of Patient or Responsible Party (if a minor): _____Date: _____

Signature of Co-Responsible Party: _____ Date: _____

Printed Name of Patient: _____

I voluntarily consent to medical treatment and diagnostic procedures provided by National Allergy & ENT and its associated physicians, clinicians and other personnel. I consent to the testing for infectious diseases. I am aware that the practice of medicine is

not an exact science and I acknowledge that no guarantees have been made as to the result of treatments or examinations. I have read or have had read to me this consent and understand and agree to its contents.

_____
Initials

Authorization for Release of Information and Assignment of Insurance Benefits:
My physician is authorized to release any medical information required in the processing of applications and submission of information for financial coverage. I also agree to the release of medical or other information about me to government regulatory agencies (federal or state) as required by law. For Medicare/Medicaid beneficiaries - I provided all necessary information for proper assignment of Medicare/Medicaid benefits.

_____
Initials

Agreement of Financial Responsibility:
I guarantee payment of all charges associated with services received from National Allery & ENT. I agree to assign any insurance benefits or other funding to National Allergy & ENT. I understand it is my responsibility to verify participation status of the physician with my health plan prior to the patient's visit and to obtain all authorization as required by my health plan prior to the patient's visit.

_____
Initials

H.I.P.A.A. (Health Insurance Portability and Accountability Act) Notification:
I acknowledge my receipt of a copy of the National Allergy & ENT's Notice of Privacy Practices.

I understand that the consent for medical treatment, authorization for release of information, assignment of insurance benefits, and agreement of financial responsibility can only be revoked upon written notice. By signing below, I acknowledge that this consent form has been read in full and explained as necessary.

I authorize National Allergy & ENT physician's and staff to contact me via mail, by phone, or cell phone. If I am unavailable, the physicians or staff may leave messages for me with person or machine at the phone number I have provided.

_____
Initials

_____ _____
Date and Time Signature of Patient (Parent or Legal Guardian)

_____ _____
Signature of Witness Signature of Guarantor (if different from the patient)

NOTICE OF PRIVACY

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 March 26, 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, Amber Murphy.
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.
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, 2003 immunization records for students may be released without an authorizations (as long as the PHI disclosed is limited to proof of immunizations). If an individual is deceased you may disclose PHI to a written authorization. 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. 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. 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. Lists, if requested, will be $0.65 for each page and the staff time charged will be $15. Please contact our Privacy Officer for an explanation of our fee structure.
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.
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.
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 an emergency involving your care, your location, your general condition or death. If at all possible we will provide you the opportunity to object to this use or disclosure. Under emergency conditions or 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, insurance operations, health care clearinghouses and individuals performing similar activities.

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.
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 safely 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. 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 or 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”.

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

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.) 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. Copies, if requested will be $0.65 for each page and the staff time charged will be $15. If you want the Copies mailed to you, postage will also be charged. Access to your health information in electronic form if (readily producible) may be obtained with your request. If for some reason we aren’t capable of an electronic format, a readable hardcopy will be provided. 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 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.

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 others 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.