Thank you for choosing Suncoast ENT Surgical Specialists, A Division of Select Physicians Alliance, PL offices of Drs. Dolgin, Donnelly, Davis and Anderson for your health care needs. Please complete this patient information packet prior to your arrival.

- ✓ Plan to arrive 20 minutes prior to your appointment time to finalize paperwork and the registration process
- ✓ Bring Healthcare Insurance ID Cards and a picture ID
- ✓ Complete and sign **all** documents, failure to do so will delay your appointment or may need to reschedule.
- ✓ Have your referring physician's office fax pertinent medical records, CT/MRI scan reports and lab testing at least 2 days in advance or bring them with you at time of visit. Bring any CD or Films of your most recent MRI and/or CT scan (if applicable)
- ✓ Your insurance policy may require an authorization and/or referral in order to see us. Make sure your Primary Care Physician faxed the authorization and/or referral information to our office **PRIOR to your appointment date**. Not doing so will require rescheduling your appointment.

While it is our desire to provide you with the best care possible, there are some limitations and restrictions that your managed care or insurance plan may impose which we cannot control. Because of this, there are certain policies and guidelines that we want you to be aware of and agree when dealing with our office as outlined below:

1. Payment is due at time of service: You are responsible for any co-pay, deductible, as well as any unpaid balance on your account prior to receiving medical services. This is part of the contract we (and you) have with your health insurance carrier. If you are not prepared to prepay for co-pays, deductibles, co-insurance, etc., we may ask you to reschedule your appointment. Any balance on your account should be paid within 30 days of receiving treatment.
2. Cancellation policy: We require that you give our office at least 24-hour notice if you need to cancel or reschedule an appointment. For office visits you will be subject to a $35.00 charge, and for all in office procedures, such as Office Surgeries, ENG, Hearing tests and Allergy testing you will be subject to a $50.00 charge. All surgery cancellations also require at least 72-hour notice or you will be subject to a $100.00 charge.
3. We expect that any lab test, x-rays, surgery or other diagnostic exams that we order will be done within 7-10 days. We are not party to or agree with your insurer or managed care plan if they deny authorization or coverage. If your plan denies authorization for our recommendations we ask that you initiate an appeal with them immediately and notify us in writing. If they require a letter from us, we will provide it.
4. Make a follow-up appointment within one week (or next available) after you have done any testing to discuss the results and recommendations. Do not wait for us to call you.
5. Self-pay patients: all services must be paid at time of service.
6. There will be a charge for any and all medical forms (FMLA, Disability) filled out by this office. As a courtesy, a one-page progress report will be furnished upon request.
7. "Abuse Free Zone" – At Suncoast ENT we appreciate and respect our staff. It is our belief that our staff should have a work environment free from verbal and physical abuse. We expect each one of you to treat each one of our staff members as you would like to be treated. Outbursts against our staff will not be tolerated and may result in discharge from the practice.

❖ Signature of Patient, Parent or guarantor:_____

Excellence in Specialty Care for the Head and Neck ~ A Division of Select Physicians Alliance, PL

PATIENT INFORMATION Date _____

Last Name _____ First _____ M _____ DOB ____/____/____

REASON FOR APPOINTMENT: _____

Email _____ SSN _____-_____-_____ Gender: Male / Female

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work #_____ Mobile #_____

Marital Status _____ Language(s) Spoken _____ Race _____

PREFERRED METHOD OF CONTACT (please circle) Home Work Mobile

Employer(s) Name _____ Phone _____ Occupation _____

Guardian Information (If Patient is a minor / Responsible Party):

Last Name _____ First _____ M _____ DOB ____/____/____

Relationship to patient_____

Emergency Contact Name _____ Relationship_____ Phone_____

How did you hear about us (please circle)? Google – Yahoo – Internet - Yellow Pages – Family/Friend
A Physician _____ Other: _____

REFERRING PHYSICIAN: Name _____City _____ State _____
Phone _____ Fax _____

PCP/PRIMARY CARE PHYSICIAN: Name _____City _____ State _____
Phone _____ Fax _____

PHARMACY Name _____ Phone _____ Fax _____
Address _____ City _____ State _____ Zip _____

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Spring Hill: 4655 Keysville Ave · Spring Hill Florida 34608 · P: 352.688.0800 · F: 352.688.0468

MEDICATION LIST ☐ SEE ATTACHED LIST

Please list ALL medications (include over the counter drugs) you are taking now, include dosage & frequency

Medication	Dosage	Frequency	Medication	Dosage	Frequency

MEDICAL HISTORY: Please indicate if you have/had a history of the following ☐ SEE ATTACHED LIST

_____Arthritis
_____Asthma
_____Anxiety
_____COPD
_____Diabetes
_____Emphysema
_____Hepatitis
_____Heart Disease
_____Heart Stents
_____High Blood
_____High Cholesterol
_____HIV
_____Stroke
_____Thyroid Disease
_____TIA
_____Reflux (GERD)
_____Treatment for Alcoholism
_____Treatment for Substance Abuse
_____**Cancer:**_____

SURGICAL / HOSPITALIZATION HISTORY: ☐ SEE ATTACHED LIST

OPERATION (S)	YEAR	HOSPITALIZATION (S)	YEAR

FAMILY HISTORY

Family Members:	Father	Mother	Siblings	Children
	Alive: ❑Yes ❑ No	Alive: ❑Yes ❑ No		
Cancer				
Diabetes				
Heart Disease				
High Blood Pressure				
Mental Illness				
Migraine				
Stroke				
Thyroid				

PATIENT NAME: _____ **HEIGHT:** _____ **WEIGHT:** _____

DRUG ALLERGIES: _____ **OTHER ALLERGIES:** _____

SOCIAL HISTORY

What is your occupation?
Are you retired? Yes / No What was your occupation?
Do you drink caffeine or use caffeine stimulants? Yes / No How many servings per day?
Do you smoke? Yes/No If yes, how much per day?
Did you ever smoke? Yes/No If yes, how long and when did you quit?
Do you drink alcohol? Yes / No How much?
Do you use recreational drugs? Yes / No
How much water do you drink?

REVIEW OF SYSTEMS: Please indicate if you are currently having problems with any of the following:

CONSTITUTIONAL	EYES	CARDIOLOGY	GASTROENTEROLOGY	RESPIRATORY
❑ Fever	❑ Glaucoma	❑ Chest Pain	❑Loss of Appetite	❑Asthma
❑ Recent weight gain	❑ Visual Disturbance	❑ Irregular Heart	❑Nausea	❑Cough
❑ Recent weight loss	❑ Dry eyes	❑ Murmur	❑Heartburn	❑Spitting blood
❑ Night Sweats	❑ Double vision		❑Difficulty swallowing	
❑ Fatigue		ENDOCRINOLOGY	❑	NEUROLOGY
	ENT	❑ Leg Swelling		❑Headaches
SKIN	❑ Nosebleeds	❑ Sleep problems	HEMATOLOGY	❑Stroke
❑ Skin Cancer	❑ Hoarseness	❑ Temperature	❑Easy bruising	❑Paralysis
❑ Healing problems	❑ Ringing in the ears	❑ Excessive Thirst	❑Bleeding disorder	❑Tingling
❑ Rash	❑ Allergies		❑Anemia	❑Seizures
❑ Discoloration	❑ Snoring		❑Blood clots in legs	❑Dizziness
	❑ Ear pain			❑Memory loss
	❑ Ear drainage			
	❑ Throat pain			
	❑ Sinus			
	❑ Hearing loss			

I certify that I have disclosed all of my medical history known to me. I acknowledge that I am responsible to make your office aware of any changes to my medical health.

Signature:_____ Date:_____

Permission for Treatment

I, the undersigned, hereby voluntarily consent to medical care/diagnostic treatment and/or surgical treatment by Suncoast ENT Surgical Specialists deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office. I authorize the release of any of my past/current medical records that are needed for my treatment from any prior healthcare providers.

Signature _____ Date _____

Authorization and Assignment

I hereby authorize Suncoast ENT Surgical Specialists to furnish information to my insurance carriers or CMS concerning my medical condition, illness and treatment to determine the benefits for related services. I hereby authorize (assign) my insurance carrier(s) or CMS to make payment directly to Suncoast ENT Surgical Specialists for medical/diagnostic/surgical benefits payable for the services rendered. I understand that any unpaid balance not covered by this policy will be payable by me.

I understand and agree (regardless of my insurance status), that I am ultimately responsible for the balance of any professional services rendered. I understand that I am responsible for any charges incurred if my account is sent to a collection agency and for any returned checks. I understand that my insurance carriers or CMS do not cover all office services/procedures. I agree to take full responsibility for the patient's account in accordance with the regular rates and terms of the facility. Should the account be referred for collection procedures, the undersigned shall pay responsible attorney's fees and collection expenses. At present, that fee is a minimum of 30% of charges collected and is payable before the patient is seen in the offices of Suncoast ENT Surgical Specialist. I certify that the information I have given here is true and correct to the best of my knowledge. I will also notify you of any changes in my status or changes in the above information.

Signature _____ Date _____

Designated Relative

I authorize discussion and release of my general medical condition and diagnosis (including treatment, payment and health care operations), and/or in case of emergency contact:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Release of Confidential Information

I, _____ Date of birth _____

(Please print your name)

Authorize Suncoast ENT Surgical Specialists to release any and all medical information to physicians or medical facilities regarding my care. The information to be released may include office notes, laboratory tests, radiology studies and other testing and information. I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health care provider; the released information may no longer be protected by federal privacy regulations. I understand that this consent shall be valid for a period of 1 year from the date of authorization and may be revoked at any time upon written notice, except to the extent that the information had already been released in reliance upon this authorization. I further understand that the confidentiality of this information may be protected by Federal Regulations (42CFR, Part II) prohibiting any further disclosure of this information without specific written authorization of the undersigned, or as otherwise regulated.

_____	_____	_____
Printed name of patient	Signature of patient	Date
_____	_____	_____
Parent or guardian (print)	Signature of parent/guardian	Date

E-PRESCRIBING/MEDICATION HISTORY CONSENT FORM

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an e-Prescribe program.

I hereby authorize all pharmacies and insurers that may have access to my medical history for the past two years that may exist in a privacy respecting database to release information to Suncoast ENT Surgical Specialist. Optimizing our ability to care for you and lowering your risk of adverse reactions to medications and other treatment is the goal of obtaining your medication information. This consent grants permission to health care providers, pharmacists, and the active staff of the above named prescription data management services to release a list of all medications for which these entities have medication records which may be of a personal and private nature. Note that these databases may be incomplete if your pharmacy does not participate in database sharing. Neither will this list include over-the-counter medications and supplements/vitamins which you use. This list will not contain information on how well you utilize the prescriptions or why you may have stopped the prescription. To the degree you have supplied allergy information, this database should provide an allergy list but if you have developed an allergy which you have not told a participating pharmacy service about, it will not be listed. Thus, we still need you to bring us a list of all medications and supplements which you use and complete list of your allergies, including the type of allergic reaction you experience to the degree that you can give that information to us.

By signing this consent form you are agreeing that Suncoast ENT Surgical Specialists, PA (A Division of Select Physicians Alliance, PL) can request and use your prescription medication history from other healthcare providers, your pharmacy and/or insurers for treatment purposes. Understanding all of the above, I hereby provide informed consent to Suncoast ENT Surgical Specialists, PA (A Division of Select Physicians Alliance, PL) to enroll me in the Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____ _____

Print Patient Name or Guardian | Date of Birth

_____ _____

Signature of Patient or Guardian | Relationship to Patient

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Revised as of July 31, 2013

By law, we are required to make available to you a copy of our Notice of Privacy Practices ("Notice"). By signing below you acknowledge that you received, or been offered and declined, a copy the Notice. A current copy of the Notice is also posted in the office, or is available to you upon request. If the Notice is revised, you may review and obtain the new version at any time. You may decline to sign this acknowledgement.

I have received, or declined, a copy of the Notice of Privacy Practices.

Patient Name (Print):_____ Date of Birth:_____

Signature of Patient or Legal Representative:_____

If Legal Representative, list Relationship to Patient:_____

Date:_____

***** For Office Use Only: We were unable to obtain this written acknowledgement because: *****

_____

Initials: _____ Date: _____