ENT specialists, p.c.

Patient's Name: _____

Social Security: _____

Family Physician/Pediatrician: _____

Office Location (City Only): _____

Pharmacy(with location): _____

Subscriber's Employer: _____

Please Tell Us How You Found Our Practice

Check (√) those that apply:

- ☐ Physician Referral (who?):
- ☐ Family Member or Friend
- ☐ Advertisement
  - ☐ Newspaper
  - ☐ Marketeer
  - ☐ Yellowpages
- ☐ Hearing Aid Dealer
- ☐ Other (Please Explain):
- ☐ Internet
  - ☐ Google Search
  - ☐ Yahoo Search
  - ☐ Microsoft / Bing
  - ☐ Insurance Web Site
  - ☐ Yellowpages.com

COMMUNICATIONS REQUEST

We would like to request your points of contact. This information will be used *only* for future communications directly from ENT Specialists, such as appointment reminders. Your information will be kept strictly confidential and will not be given to any third party. Please fill in all applicable fields.

Cell/Primary Phone: _____ Home/Secondary Phone: _____

Email (portal access): _____ Consent to text (circle one): Yes / No

CONSENT TO TREAT

I give permission for ENT Specialists to provide medical treatment. **Initials** _____

I understand, I have the right to refuse any procedure or treatment. **Initials** _____

I have the right to discuss all medical treatments with my clinician. **Initials** _____

I understand that the practice of medicine does not provide uniform results and acknowledge that no guarantees have been made to me. **Initials** _____

PAYMENT AND CANCELLATION POLICY

We would like to remind you that payment for services received is due upon the day of service. We appreciate your cooperation when collecting insurance co-payments or deductibles *prior* to your visit with the physician. If you are unable to make payment on the day of service, we would like to inform you that it is our policy to add a $10 surcharge for any billing statements sent to collect on co-payments. This is to recuperate costs associated with processing, sending, and filing these statements. If you are unable to keep an appointment, please call the office and give proper notification that you will be unable to do so. If you are unable to keep your appointment, please call the office within 24 hours to cancel. If you do not give us appropriate notification you will be charged a $25 no-show fee, this fee will be increased to $50 if you do not show up for a scheduled office surgery. This must be paid in full before your next visit. This is in an effort to allow other patients the opportunity to schedule an office visit with our physicians. We understand urgent situations may arise preventing you from keeping your appointment, we only ask for the courtesy of a phone call as soon as possible.

Patient/Responsible Party Signature: _____ Date: _____

28080 Grand River
Suite 208
Farmington Hills, MI 48336
(248) 477-7020
Fax (248) 477-2440

25500 Meadowbrook Rd
Suite 220
Novi, MI 48375
(248) 477-7020
Fax (248) 477-2440

6249 Grand River
Brighton, MI 48114
(810) 844-1900
Fax (810) 844-1981

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REVIEW OF GENERAL MEDICAL SYSTEMS

Check (√) either YES or NO for each Item

Patient's Name:_____

	YES	NO
GENERAL		
Fever	☐	☐
Chills	☐	☐
Night Sweats	☐	☐
Weight Loss	☐	☐
General Weakness	☐	☐
Bruise Easily	☐	☐
Memory Loss	☐	☐
Swollen Glands	☐	☐
EYES		
Blurry Vision	☐	☐
Double Vision	☐	☐
Halos	☐	☐
Light Flashes	☐	☐
EARS		
Hearing Loss	☐	☐
Ear Pain	☐	☐
Ear Drainage	☐	☐
Buzzing / Ringing	☐	☐
NOSE & THROAT		
Sinus Problems	☐	☐
Nosebleeds	☐	☐
Swallowing Problems	☐	☐
Persistent Hoarseness	☐	☐
Cough	☐	☐
Dental Pain	☐	☐
Mouth Sores	☐	☐
Loss of Taste / Smell	☐	☐
KIDNEY		
Blood in Urine	☐	☐
Pain while Urinating	☐	☐
Difficulty Urinating	☐	☐
Frequent Urination	☐	☐
NEUROMUSCULAR		
Leg or Arm Weakness	☐	☐
Dizziness	☐	☐
Balance Problems	☐	☐
Fainting Spells	☐	☐
Headaches	☐	☐
Speech Problems	☐	☐

	YES	NO
SKIN		
Rash	☐	☐
Changing Moles	☐	☐
Pigmentation	☐	☐
HEART & LUNGS		
Irregular Heartbeat	☐	☐
Shortness of Breath	☐	☐
Wheezing	☐	☐
Frequent Cough	☐	☐
Coughing Blood	☐	☐
Chest Pains	☐	☐
Swollen Ankles	☐	☐
BONES		
Joint Pain	☐	☐
Joint Swelling	☐	☐
NECK		
Stiffness	☐	☐
Swelling	☐	☐
Lumps / Bumps	☐	☐
GASTROINTESTINAL		
Poor Appetite	☐	☐
Indigestion / Heartburn	☐	☐
Nausea / Vomiting	☐	☐
Vomiting Blood	☐	☐
Abdominal Pain or Cramps	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
Blood in Stool	☐	☐
ENDOCRINE		
Constant Thirst	☐	☐
Always Feel Warm	☐	☐
Always Feel Cold	☐	☐
Often Feel Depressed	☐	☐
SLEEP		
Fall Asleep Easily	☐	☐
Awaken Easily	☐	☐
Snoring	☐	☐
Stop Breathing at Night	☐	☐
Feel Sleepy throughout the Day	☐	☐
Fall Asleep at Work	☐	☐

I have reviewed the above Review of Systems. Physician's Signature:

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed and/or received a copy of the Notice of Privacy Practices. This notice describes the use and disclosure of my protected health information and rights I have regarding my protected health information. Additional copies are available at the front desk, on our website at www.entspecialistspc.com, or upon further request by mail.

Print Name	**Signature**	Date
Relationship if Patient is Under Age 18		

According to the Notice of Privacy Practices, we may not disclose your protected health information to family members or friends who may be involved with your treatment or care without your written permission. Please note the name and relationship to the patient of those you give us permission to disclose medical information:

Legal Last Name	First Name	Relationship to Patient
Legal Last Name	First Name	Relationship to Patient
Legal Last Name	First Name	Relationship to Patient

INSURANCE AUTHORIZATION

Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible. **It is your responsibility to know your individual coverage.** Failing to comply with this suggestion could result in you, the patient, being responsible for all costs incurred. Please remember your insurance policy is between you and your company and not with the insurance company and your doctor.

ENT Specialists PC is hereby authorized to give my insurance company or its representative, any and all information they may have regarding my or my dependent's condition when under observation or treatment by them, including history obtained, diagnosis and treatment. A photocopy of my signature may be used. I hereby assign the benefits payable under my insurance to ENT Specialists PC for any services provided. I authorize all medical information about me to be released to the Health Care Financing Administration and its agents to determine these benefits or the benefits payable for related services.

I herby authorize release of any information necessary to file a claim with my insurance company and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO THE DOCTOR OR GROUP INDICATED ON THE CLAIM.

I understand I am financially responsible for any balance not covered by my insurance carrier.

A copy of this signature is as valid as the original.

Print Name	**Signature**	Date

28080 Grand River
Suite 208
Farmington Hills, MI 48336
(248) 477-7020
Fax (248) 477-2440

25500 Meadowbrook Rd
Suite 220
Novi, MI 48375
(248) 477-7020
Fax (248) 477-2440

7575 Grand River
Suite 110
Brighton, MI 48114
(810) 844-7680
Fax (810) 844-7684

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Ear, Nose, Throat • Head and Neck Surgery • Otology
Allergy • Hearing Aids • Facial Plastics • Audiology

Patient-Provider Partnership Agreement

Thank you for choosing to partner with our medical practice for patient-centered care. We appreciate the trust and confidence you have placed in us for your care.

Patient Responsibilities

Communicate openly

Participate with your health care team in the development of treatment plans to improve your health.

Provide Health Care Team with **feedback** regarding Action and treatment plans.

Respect the time of others by being on time for appointments and procedures.

Schedule and attend appointments at intervals suggested by Health Care Team.

Involve yourself in Physician's and other health care professionals' recommendations with respect to maintenance or improvement of your health and wellness.

Participate in **action planning** and goal setting with respect to maintenance or improvement of your health and wellness.

Participate in developing and maintaining a **comprehensive health record** by authorizing delivery and circulation of clinical information to and from clinicians and health care institutions.

Specialist Responsibilities

Communicate with your Primary Care Provider about treatment plans, medications, test orders and test results.

Support the treatment plans and health goals set by your Primary Care Provider.

Have an agreement with your Primary Care Provider regarding who will have the lead responsibility for your care if a chronic disease exists.

Have same day appointments available for urgent problems and appointments within 1-3 weeks available depending on your medical needs.

Work with your Primary Care Provider to coordinate all aspects of your care including need for community resource.

Provide telephone **availability** to reach a Provider for communication for after-hour calls.

Patient/Guardian Signature:_____

Date:_____

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Suite 220
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