Cape Fear Otolaryngology
Ear, nose, throat and allergy
2053 Valleygate Drive, Suite 101
Fayetteville, NC 28304
910-323-9222
FAX 910-223-9783
www.capefearoto.com

Medical History Questionnaire

Patient Name_____ Date of Birth _____

Patient's Pharmacy Name _____ Location _____

Medical Health History: Please check the box if you have any of the conditions listed below:

Illnesses:

❑ Asthma ❑ Anemia ❑ Diabetes ❑ High Blood Pressure ❑ Cancer

❑ Epilepsy ❑ Heart Problems ❑ Thyroid Problems ❑ Stroke

❑ Other _____

Previous Surgical Procedures:

❑ Ear Tubes ❑ Tonsillectomy ❑ Nose or Sinus Surgery ❑ Gallbladder

❑ Appendectomy ❑ Hysterectomy ❑ Heart or Bypass Surgery ❑ Cancer Surgery

❑ Other Surgeries _____

Family History: Please list significant medical problems for immediate family.

_____

Medications: Please list all medications you are taking.

_____ _____ _____

_____ _____ _____

Are you allergic to medication(s)? _____Yes _____ No If yes, list the medications you are allergic to:

_____ _____ _____

_____ _____ _____

Do you Smoke and/or Vapor? _____Yes _____ No If yes, how long and how much?_____

Do you Drink Alcohol? _____Yes _____ No If yes, how long and how much? _____

Do you use Recreational Drugs? _____Yes _____ No If yes, what type, how often, and how much?

_____

PATIENT NAME	RACE	MARITAL STATUS S M W DIV SEP	DATE OF BIRTH	SSN
STREET ADDRESS				PRIMARY PHONE NUMBER
PO BOX	CITY		STATE	ZIP CODE
EMAIL				
SPOUSE'S NAME			SPOUSE DOB	SPOUSE SSN (TRICARE ONLY)
EMERGENCY CONTACT	NUMBER		RELATIONSHIP	

BELOW PLEASE LIST THE FAMILY MEMBERS OR OTHER PERSONS, IF ANY, WHOM WE MAY INFORM/RELEASE GENERAL MEDICAL INFORMATION TO:

NAME (OPTION 1)	RELATIONSHIP	NAME (OPTION 2)	RELATIONSHIP

IF THE PATIENT IS A MINOR (PLEASE COMPLETE BELOW)

MOTHER'S NAME	STREET ADDRESS, CITY, STATE & ZIP CODE	DOB	PHONE NUMBER
FATHER'S NAME	STREET ADDRESS, CITY, STATE & ZIP CODE	DOB	PHONE NUMBER

I hereby give my consent for the following individuals to bring my child to: **CAPE FEAR OTOLARYNGOLOGY** For treatment of illnesses, injuries, or allergies. This agreement will remain in effect until I authorize cancellation by having this consent form removed from or updated in the chart.

Below are the names and relationships, whom may accompany my child:

Person(s) Authorized **Relationship**

_____

_____

_____

Patient/Guardian _____ **Signature:** _____ **Date:** _____
(Print)

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Financial Policy

We at Cape Fear Otolaryngology are committed to providing you the best possible care. Our staff works as a team to provide medical expertise as well as old-fashioned courtesy and compassion. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for services are due at the time services are rendered. We accept Cash, Check, MasterCard, Visa and Care Credit. If you are interested in applying for a Care Credit account, you can apply online at www.carecredit.com, speak with one of our staff, or visit our website at www.capefearoto.com.

Payment plans are only offered on certain costly services and must be approved by your physician prior to services being rendered. The minimum payment amount on a budget account will be $50.00 monthly.

As a courtesy to our patients, we will file and accept payment directly from your insurance company. Since most insurance companies do not pay 100%, you are responsible for your portion at the time of service. **Our office will estimate your financial responsibility but please keep in mind that this is only an estimate based on information provided by your insurance company.**

Returned checks (return check fee of $35.00 will be assessed), and balances older than 90 days will be subject to additional collections fees and charges. Charges may also be accrued for recurring cancellations and untimely cancellations of appointments without proper 48 hours of notice. Three missed appointments without the proper notification will result in dismissal from our practice.

While filing of insurance claims is a courtesy that we extend to our patients, please be aware:

_____ Initial Your insurance is a contract between you, your employer and your insurance company.

_____ Initial Insurance may pay all, some or none of your bill; however, your portion will be due prior to service. If insurance has not paid a claim within 30 days you will be billed for unpaid balances.

_____ Initial Not all services are a covered benefit. Some companies arbitrarily select certain services that they will not cover. Please familiarize yourself with your insurance plan and coverage, benefits vary.

As your health care provider we must emphasize, our relationship is with you, not your insurance company. We realize that financial problems may arise and affect timely payment of your account. If this should occur, please do not hesitate to contact our insurance and billing staff so that they may assist you in managing your account.

If you have any questions regarding our financial policy, or if you are uncertain of your insurance coverage, please contact our staff. We are here to help you!

_____ Initial I hereby authorize payment of my medical benefits to Cape Fear Otolaryngology for services rendered, as well as my authority to submit claims, accept assignment of benefits, and authorize release of information related to my claims.

_____ Initial I consent that Cape Fear Otolaryngology staff may leave personal messages regarding my account on voicemail as well as answering machine.

I understand this financial policy and agree to all provisions stated above:

Patient / Guarantor Signature _____ Date _____

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Notice of Privacy Practices (1)

As permitted by federal regulations, we require that requests to inspect a copy of your protected health information be submitted in writing. To get copies of your records or to request that they be sent to another party, you may obtain a records release form from our staff at the front desk. Once this signed authorization has been received, we reserve the right to allow our office personnel to copy your records and send them to the requesting party within 7 business days.

Contacts for More Information and/or Complaints:
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to the contact listed below:

Cape Fear Otolaryngology, PA
2053 Valleygate Drive, Suite 101
Fayetteville, NC 28304
Attn: Practice Administrator

If you believe your privacy rights have been violated, you should call attention to the matter by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Please read both pages of this form then return the signed form to our front desk staff.

This notice is effective on and after January 1, 2003.

Consent to Disclosure of Protected Health Information

Notice of Privacy Practices:
You should review the Notice of Privacy Practices above for a complete description of how your protected health information may be used or disclosed. Please review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information:
You may request a restriction on the use or disclose of your protected health information.

Cape Fear Otolaryngology may or may not agree to restrict the use of disclosure of your protected health

If Cape Fear Otolaryngology agrees to your request, the restriction will be binding on the practice. Use of disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent:
You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Rights to Change Privacy Practices:
Cape Fear Otolaryngology reserves the right to modify the privacy practices outlined in this notice.

Signature:
I have reviewed this consent form and give my permission to Cape Fear Otolaryngology , PA to use and disclose my health information in accordance.

Patient's Printed Name _____ Patient Signature_____

CFO Witness _____ Date_____

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Notice of Privacy Practices (2)

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

Uses and Disclosures:
Treatment - Your health information may be used by staff members or disclosed to other health professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical records to all health professionals who may provide treatments or who may be consulted by staff members.

Payment - Your health information may be used to seek payment from your health plan, from other sources of coverage such as automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of services, the services provided, and the medical condition being treated.

Health Care Operations - Your health information may be used as necessary to support the day-to-day activities and management of Cape Fear Otolaryngology, PA. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement - Your health information may be disclosed to public health agencies, without permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting - Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other Uses and Disclosures (Require Your Authorization):
Disclosure of your health information or its use of any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use of disclosure or information that occurred before you notified us of your decision.

Additional Use of Information (Require Your Authorization):
Appointment Reminders - Your health information will be used by our staff to send you appointment reminders. We will also contact you by phone to remind you of your upcoming appointment. Our policy regarding a reminder call that is answered by voicemail or machine, we will leave a message stating the name of our office, our telephone number and the date and time of the upcoming appointment.

Information About Treatments - Your health information may be used to send you information on the treatment and management of your medical condition that you may find out of interest. We may also send you information describing other health-related goods and services that we may believe may interest you.

Individual Rights:
You have certain rights under federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communication concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

Cape Fear Otolaryngology, PA Duties:
We are required to abide by privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices:
As permitted by law we reserve the right to amend or modify our privacy practices or policies. These changes in our policies and practices may be required by changes in federal and state law/regulations. Whatever the reason for these revisions, we will provide you with a revised policy upon your next office visit. The revised practices and policies will be applied to all protected health information.