Advanced ENT
Physicians & Surgeons of CNY PC

PRINT FORM EMAIL FORM

Northeast Medical Center
4000 Medical Center Dr., #404
Fayetteville, New York 13066
Ph: (315) 671-8796 Fax: (315) 637-3694

Medical Center West
5700 West Genesee St., #229
Camillus, NY 13031
Ph: (315) 234-9861 Fax: (315) 234-9864

PATIENT INFORMATION SHEET

Date: _____ Patient Name: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Address: _____

City: _____ State_____ Zip _____

Sex: M F

Marital Status: Single Married Divorced Widowed Legally Separated

Email Address: _____

Patient's DOB: _____

Employer: _____ Occupation: _____ FT PT

Employer's Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Address: _____ Relationship: _____

If minor send bill to: Parent/Legal Guardian _____ DOB: _____

Relationship: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Referred By: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Primary Care Physician: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Insurance Information:
Please list the subscriber of the policy if other than the patient.
***If No Fault Insurance or Worker's Compensation, please complete the *** sections below.

Primary Insurance:_____ Policy#: _____

Address: _____ Group#: _____

Note: If the subscriber is the person other than the patient, please complete the following:

Subscriber: _____ Relationship: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Employer_____ Occupation: _____ ☐ FT ☐ PT

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

***Secondary Insurance: _____ Policy#: _____

Address: _____ Group#: _____

Note * If the subscriber is a person other than the patient, please complete the following:**

Subscriber: _____ Relationship: _____

DOB: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Employer: _____ Phone: _____

Address : _____

***No Fault Insurance Company/Worker's Compensation

Address: _____ Claim/Carrier/Case & WC# _____

Employer : _____ Date/Time of Accident: _____

Agent/Contact Name: _____

HIPAA Information:

1. I acknowledge that I have been given the opportunity to read and/or receive a copy of Advanced ENT Physicians & Surgeons of CNY Privacy Notice. ☐ Yes ☐ No

2 A&B Leaving messages:

2A. Leave **appointment messages** on:

Answering machine?	☐ Yes	☐ No
Office voice mail?	☐ Yes	☐ No
With person named below?	☐ Yes	☐ No
Mail?	☐ Yes	☐ No

Leave **other medical info** on:

Answering machine?	☐ Yes	☐ No
Office voice mail?	☐ Yes	☐ No
With person named below?	☐ Yes	☐ No
Mail?	☐ Yes	☐ No

3. Person(s) authorized to Discuss the Above & Relationship

_____ _____

_____ _____

Signature: _____ Date: _____

Statement to Authorize Payment of Insurance Benefits, Release of Information, and Billing Terms.

I certify that the infonnation given by me in applying for payment under my Insurance contract is correct. I authorize any holder of medical infonnation about me to release to my insurance carrier and or Advanced ENT Physicians & Surgeons of CNY, PC, any information required to process my insurance claims or complete my medical record. I request that payment under the medical insurance program be made either to myself or to Advanced ENT Physicians & Surgeons of CNY, PC for services provided to me for the duration of my medical treatment. If your account is not paid in full within the 90 day billing cycle, your account may be referred to our collection agency for further action.

As a courtesy, we will attempt to contact you by mail informing you of the status of your account. After your account is reported to our collection service, you may pay your bill directly to the collectors. Any cost for collection of the unpaid invoice including, but not limited to, collectors fees, legal fees and disbursements will be the obligation of the person named on the invoice or other responsible party.

Signature _____ Date: _____
(Must be at least 18 years of age to sign)

Statement to Authorize Payment of Medicare Benefit

I certify that the information given by me in applying for payment Under the Title XVIII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration, or its Carriers any information required to process any Medicare claims.

Signature _____ Date: _____

I request payment under the medical insurance program to be made either to myself or so Advanced ENT Physicians & Surgeons of CNY, PC for services provided to me for the duration of my medical treatment.

Signature _____ Date: _____

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Patient Clinical & Medical Information

Patient's Name: _____ DOB: _____

Vitals:

Height: _____ Weight: _____ Ethnicity: _____ Primary Language: _____ Race: _____

Primary Care Physician: _____

Pharmacy: _____ Address: _____

Reason for Appointment: _____

Please list medical conditions: _____

_____

_____

Please list any past surgeries: _____

_____

_____

Please list medications you are currently taking including dosage and frequency (include beta blockers):

_____

_____

_____

Please list medication allergies and type of reaction: _____

_____

Please list previous diagnostic tests, i.e., X-rays, CT Scans, etc: _____

_____

_____

Please list environmental or food allergies: _____

_____

Patient's Signature: _____ Date: _____

Constitutional: ☐ All Neg

Neg	Pos	
☐	☐	Chills
☐	☐	Fatigue
☐	☐	Fever
☐	☐	Weight Loss
☐	☐	Weight Gain
☐	☐	Night Sweats

Other Positives:

_____

Other Negatives:

_____

HEENT: ☐ All Neg

Neg	Pos	
☐	☐	Blurred vision
☐	☐	Choking on liquids
☐	☐	Choking on solids
☐	☐	Double vision
☐	☐	Dizziness
☐	☐	Drooling
☐	☐	Difficulty swallowing
☐	☐	Ear drainage
☐	☐	Hoarseness
☐	☐	Mouth ulcers
☐	☐	Ear aches
☐	☐	Sore throat
☐	☐	Ringing in ear
☐	☐	Vertigo
☐	☐	Visual changes
☐	☐	Hearing loss

Other Positives:

_____

Other Negatives:

_____

Respiratory: ☐ All Neg

Neg	Pos	
☐	☐	Apnea during sleep
☐	☐	Shortness of breath
☐	☐	Snoring
☐	☐	Wheezing

Other Positives:

_____

Other Negatives:

_____

Cardiovascular: ☐ All Neg

Neg	Pos	
☐	☐	Chest pain
☐	☐	Heart murmur
☐	☐	Palpitations

Other Positives:

_____

Other Negatives:

_____

Gastrointesinal: ☐ All Neg

Neg	Pos	
☐	☐	Abdominal pain
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Heartburn
☐	☐	Vomiting

Other Positives:

_____

Other Negatives:

_____

Genitourinary: ☐ All Neg

Neg	Pos	
☐	☐	Change in urine color
☐	☐	Dysuria
☐	☐	Urinary frequency

Other Positives:

_____

Other Negatives:

_____

Metabollic/Endocrine: ☐ All Neg

Neg	Pos	
☐	☐	Cold intolerance
☐	☐	Heat intolerance
☐	☐	Increased thirst

Other Positives:

_____

Other Negatives:

_____

Neurolgical: ☐ All Neg

Neg	Pos	
☐	☐	Difficulty falling asleep
☐	☐	Difficulty staying asleep
☐	☐	Excessive day sleepiness
☐	☐	Non-restorative sleep
☐	☐	Extremity numbness
☐	☐	Syncope
☐	☐	Tingling
☐	☐	Tremor
☐	☐	Weakness

Other Positives:

_____

Other Negatives:

_____

Psychiatric: ☐ All Neg

Neg	Pos	
☐	☐	Anxiety
☐	☐	Depression
☐	☐	Hallucinations

Other Positives: _____

Other Negatives:

_____

Complete Family History:

Are your parents alive?
Mother ☐ Yes ☐ No
Father ☐ Yes ☐ No
If no, what was the cause of death?

Mother_____
Father_____

How many brothers and sisters do you have?
Brothers_____ Sisters_____

Are they healthy? ☐ Yes ☐ No
If no, please explain: _____

_____

Does anyone in the family suffer from hearing loss? ☐ Yes ☐ No
If yes, please explain: _____

_____

Does anyone in the family have (if yes, please explain):

Diabetes ☐ Yes ☐ No

_____

_____

Heart disease ☐ Yes ☐ No

_____

_____

Lung disease ☐ Yes ☐ No

_____

_____

Fever with anesthesia ☐ Yes ☐ No

_____

_____

Bleeding disorders ☐ Yes ☐ No

_____

_____

Social History:

Do you smoke? ☐ Yes ☐ No
How much?_____
How long? _____
Have you ever smoked? _____
How much? _____
How long? _____

Drink alcohol? ☐ Yes ☐ No
How much? _____
How long? _____

Caffeine use? ☐ Yes ☐ No
Non-prescription drugs?

_____

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Notice of Privacy Practices

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

Advanced ENT Physicians & Surgeons of CNY is committed to maintaining the privacy of your health information. We are required by law to give you this Notice that describes our legal duties and privacy practices concerning your health information. If you have any questions about this Notice, please contact our Privacy Contact at the address or telephone number above.

Who will Follow this Notice

This Notice describes the health information privacy practices of Advanced ENT Physicians and Surgeons of CNY and its servicing physicians related to the medical and surgical services provided. The words "we" or "our" used in this Notice refer to the Practice and its employees and physicians providing services at the Practice.

Written Authorization: ***Unless you obiect in writing and there is not an emergency situation,*** we are permitted to release health information to people identified by you, such as family members, relatives, or close personal friends or others who are helping to care for you or helping you pay your medical bills. You may identify those individuals who you authorize to receive your health information or restrict these disclosures by informing the Privacy Contact or the registration staff when you are registering at the Practice. You may' also request the restriction in writing addressed to the Privacy Contact at the address at the top of this Notice.

NOTE: Except for the situations described in this notice, we must obtain your specific written authorization for any other release of your health information. If you sign an authorization form, you may withdraw that authorization at any time, as long as your withdrawal is in writing. If you wish to withdraw an authorization signed by you, please contact the Practice directly.

Uses and Disclosures: In general, when we release your health information, we must release only the information needed to achieve the purpose of the use or disclosure. Howev.er, all of your health information will be available for release to you, to your primary care provider or referring physician regarding your treatment, or as required by law. More specifically, we are permitted to use and disclo.se your health information for the following purposes:

1. ***Treatment.*** We are permitted to use and disclose your health information to provide you with medical treatment or services. For example, we are permitted to disclose medical information about you to doctors, technicians, or other Practice personnel who are involved in your care at the Practice.
2. ***Payment.*** We are permitted to use and disclose medical information about you in order to bill and receive payment for the services you receive at the Facility. For example, in order to receive payment from your insurance company, we might need to provide specific health information to your health insurance plan about your diagnosis or health services you received at the Practice. We are permitted to tell your health insurance plan about a treatment or service you are going to receive and your diagnosis in order to obtain pre-authorization or to determine whether your plan covers the treatment or service.
3. ***Appointment Reminders.*** Unless you request that we do not, we are permitted to use your health information to provide you with appointment reminders.
4. ***As required or permitted by law.*** Under certain circumstances, we are required to report specific health information to legal authorities, such as law enforcement officials, court officials, or government agencies. For example, we are permitted to disclose your health information in relation to cases of abuse, neglect, domestic violence or certain physical injuries, or to respond to a subpoena or court order.
5. ***For public health activities.*** We are, at times, required to report your health information to authorities to help prevent or control disease, injury, or disability. This might include disclosing information in your medical record to report certain diseases, injuries, birth or death information to the Health Department, information of concern to the Food and Drug Administration, or information related to child or vulnerable adult abuse or neglect.
6. ***For research.*** If you are participating in a research protocol, please notify the Practice. Your medical information will not be released for a research project unless you consent in writing or, in the case of pre-study evaluation, an authorized Institutional Review Board has issued a waiver of authorization for review of records at the Practice.

7. ***To avoid a serious threat to health or safety.*** As required by law and standards of ethical conduct, we are permitted to release your health information to the proper authorities if we believe, in good faith, that such release is necessary to prevent or minimize a serious and approaching threat to your, the public's, or another individual's health or safety.

8. ***For military, national security, or incarceration/law enforcement custody.*** If you are involved with the military, national security or intelligence activities, or you are in the custody of law enforcement officials or an inmate in a correctional institution, we are permitted to release your health information to the proper authorities so they may carry out their duties under the law. We are permitted to release medical information about you to authorized federal officials so that they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

9. ***For Workers' Compensation.*** We are permitted to disclose your health information to the appropriate persons in order to comply with the laws related to workers' compensation or other similar programs.

Your Health Information Rights

You have several rights with regard to your health information. Specifically, you have the right to:

1. ***Inspect and copy your health information.*** With a few exceptions, you have the right to inspect and obtain a copy of your medical record. However, this right does not apply to psychotherapy notes or information gathered for judicial proceedings. If you wish to inspect and/or copy the health information in your medical record, please notify the Privacy Contact at the Practice.

2. ***Request to amend your health information.*** If you believe the health information within your medical record is incorrect, you may ask us to amend the information. You will be asked to make such requests in writing to the Practice at the address at the top of this Notice and to include the requested amendment along with a reason as to why your health information should be amended. We are not required, however, to honor your request if we did not create the information you are requesting be amended or if it is our professional opinion that the information in your record is accurate and complete. We will respond to your request in writing within 60 days of the date of receipt of your written request for amendment of your information.

3. ***Request restrictions on certain uses and disclosures.*** You have the right to ask for restrictions on how your health information is used or to whom your information is disclosed, even if the restriction affects your treatment or our payment or health care operation activities. However, we are not required to agree to your requested restriction.

4. ***Obtain a paper copy of this Notice.*** Upon your request, you may at any time receive a paper copy of this Notice. Copies of our Notice are available at the Registration desk at the Practice.

This Notice of Privacy Practices is effective June 1, 2013 based on a revision of privacy practices originally implemented. We must follow the privacy practices described in this Notice. However, the Practice reserves the right to change its privacy practices described in this Notice at any time, and to apply these changes retroactively. Changes to our privacy practices would apply to all health information we maintain.

If you have any questions or concerns regarding your privacy rights or the information in this Notice, please contact the Privacy Contact at the address above.

I authorize the following people to have access to my personal health information:

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

_____ _____ _____

Signature Print Name Date

I have been given a token ID number to access my personal health information over the secure portal at WebMD and give my permission for Advanced ENT Physicians and Surgeons of CNY to make these records available to me through this secure portal.

_____ _____ _____

Signature Print Name Date

Details about patient information in Health6 ConnectionsMr and the consent process:

1. How Your Information Will be Used. Your electronic health information will be used by Advanced ENT Physicians and Surgeons only to:

- Provide you with medical treatment and related services .
- Evaluate and improve the quality of medical care provided to all patients.

NOTE: The choice you make in this Consent Form does NOT allow health insurers to have access to your information for the purpose of deciding whether to give you health·insurance or pay your bills. You can make that choice in a separate Consent Form that health insurers must use.

2. What Types of Information about You Are Included. If you give consent, Advanced ENT Physicians and Surgeons may access ALL of your electronic health information available through the RHIO. This includes information created before and after the date of this Consent Form. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may relate to sensitive health conditions, including but not limited to:

- Alcohol or drug use problems/treatment
- Birth control and abortion (family.planning)
- Genetic (inherited) diseases or tests
- Any mention of HIV/AIDS
- Mental health conditions
- Sexually transmitted diseases

3. Where Health Information About You Comes From. Information about you comes from places that have provided you with medical care or health insurance ("Information Sources"). These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, theMedicaid program, and other ehealth organizations that exchange health information electronically. A complete list of current Information Sources is available from Health8 Connections™.You can obtain an updated list of Information Sources at any time by checking the Health8 Connections™ website at www.healtheconnections.org or by calling (315) 671-2241.

4: Who May Access Information About You, If You Give Consent. Only these people may access information about. you: doctors and other health care providers who serve on Advanced ENT Physicians and Surgeons' medical staff who are involved in your medical care; health care providers who are covering or on call for Advanced ENT Physicians and Surgeons' doctors; and staff members who carry out activities permitted by this Consent Form as described above in paragraph one.

5. Penalties for Improper Access to or Use of Your Information. There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call Advanced ENT Physicians and Surgeons at: 315-671-8796; or visit Health6Connections™ website: www.healtheconnections.org; or call the NYS Department of Health at 877-690-2211.

6. · Re-disclosure of Information. Any electronic health information about you may be re-disclosed by Advanced ENT Physicians and Surgeons to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. Some state and federal laws provide special protections for some kinds of sensitive health information, including HIV/AIDS, mental health information and drug and alcohol treatment. Their special requirements must be followed whenever people receive these kinds of sensitive health
information. HealtheConnections™ and persons who access this information through Health6 Connections™ must comply with these requirements.

7. Effective Period. This Consent Form will remain in effect until the day you withdraw your consent or HealtheConnections™ ceases all operations.

8. Withdrawing Your Consent. You can withdraw your consent at any time by signing a Withdrawal of Consent Form and· giving it to Advanced ENT Physicians and Surgeons. You can also change your consent choices by signing a new Consent Form at any time. You can get these forms on the Health6Connections™ website at www.healtheconnections.org, or by calling (315) 671-2241. Note: Organizations that access your health information through Health8 Connections™ while your consent is in effect may copy or include your information in their own medical records. Even if you
later decide to withdraw your consent, they are not required to return it or remove it from their.records.

9. Copy of Form. You are entitled to get a copy of this Consent Form after you.sign it.

Advanced ENT Physicians and Surgeons

Heal th9 Connections™ Consent Form Advanced ENT Physicians and Surgeons

In this Consent Form, you can choose whether to allow Advanced ENT Physicians and Surgeons to obtain access to your medical records through a computer network operated by HealtheConnections™, which is part of a statewide computer network. This can help collect the medical records you have in different places where you get health care, and make them available electronically to our office.

You may use this Consent Form to decide whether or not to allow Advanced ENT Physicians and Surgeons to see and obtain access to your electronic health records in this way. You can give consent or deny consent, and this form may be filled out now or at a later date. Your choice will not affect your ability to get medical care or health insurance coverage.
Your choice to give or to deny consent may not be the basis for denial of health services.

If you check the "I GIVE CONSENT" box below, you are saying "Yes, Advanced ENT Physicians and Surgeons' staff involved in my care may see and get access to all of my m.edical records through HealtheConnectionsTM."

If you check the "I DENY CONSENT" box below, you are saying, "No, Advanced ENT Physicians and Surgeons may not be given access to my medical records through HealtheConnections™ for any purpose."

HealtheConnections™ is a not-for-profit organization. It shares information about people's health electronically and securely to improve the quality of health care services. This kind of sharing is called ehealth or health information technology (health IT). To learn more about ehealth in New York State, read the brochure, "Better Information Means Better Care." You can ask Advanced ENT Physicians and Surgeons for it, or go to the website www.ehealth4ny.org.

Please carefully read the information on the back of this form before making your decision. Your Consent Choices. You can fill out this form now or in the future. You have two choices.

☐ **I GIVE CONSENT** for Advanced ENT Physicians and Surgeons to access ALL of my electronic health information through HealtheConnections™ in connection with providing me any health care services, including emergency care.

☐ **I DENY CONSENT** for Advanced ENT Physicians and Surgeons to access my electronic health information through HealtheConnections™ for any purpose, even in a medical emergency. NOTE: UNLESS YOU CHECK THIS BOX, New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through HealtheConnectionsTM.

Print Name of Patient	Patient DOB
Other Names used by Patient (e.g., Maiden Name)	
Signature of Patient or Patient's Legal Representative:	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient