PATIENT INFORMATION PLEASE FILL FORM COMPLETELY

Race and Ethnicity questions are required to be asked to the patient by the Federal Government

Patient Name: _____ Date of Birth _____

Age: _____ Sex: F ____ M ____ Marital Status: M ____ S ____ D ____ W ____ Other _____

Employed _____ Retired _____ Unemployed _____ Student _____

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American
☐ Native Hawaiian/Pacific Islander ☐ Other Race ☐ White

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined to answer

Primary Language: _____

Primary Address: _____ City and State: _____

Patient's Phone (Primary) ( ) _____ Patient's Phone (Cell) ( ) _____

Email Address: _____

Please check your preference on how to contact you: ☐ Primary Phone ☐ Cell Phone

Can we leave test results on your phone? ☐ Yes ☐ No Who can we leave results with? _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Referring Physician: _____

Is this visit related to a Work Accident: _____ Auto Accident: _____

or Other Accident _____

Pharmacy Name: _____ Phone: _____

INSURANCE INFORMATION:

Primary Insurance Company: _____

Subscriber's Name: _____ Relationship to Patient: _____

Date of Birth: _____ ID#: _____ Group#: _____

Secondary Insurance Company: _____

Subscriber's Name: _____ Relationship to Patient: _____

Date of Birth: _____ ID#: _____ Group#: _____

I consent to medical treatment for myself, my child or the above named minor, for which I am legally responsible. I authorize the release of any medical information to any insurance for the purpose of filing my medical/surgical claim. I authorize payment on behalf of myself, and/or my dependents to be made directly to George Georgakakis, M.D., PA. I further understand that I am financially responsible for any services deemed Non Covered by my insurance company, and deductibles, co-pays and co-insurance is due at the time of service. I further understand that I will be financially responsible for any and all costs and fees relating to the collection of my debt.

Signature: _____ Date: _____

FINANCIAL & TREATMENT CONSENT

I hereby authorize said assignee to release all information necessary to secure payment. I certify that the information given by me for payment by my insurance plan(s) is correct. I authorize any holder of medical or other information about me to release to the above plan or its intermediaries or carriers any information needed for this or any related insurance claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for medical services to the physician or organization furnishing the services or authorize such physician to submit a claim to the above insurance company for payment to me. **I understand that I am financially responsible for all charges whether paid by my insurance, including any deductibles and co-pays, and that payments are due at the time services are rendered. I understand and agree that in the event that I fail to make payments for services rendered to me, my name and account may be turned over to an attorney or a collection agency, and I agree to pay collection agency fees of 30% plus patient account balance, court costs, and/or reasonable attorney's fees that may be incurred in the collection of any outstanding balance.**

I hereby voluntarily consent to outpatient care at George Georgakakis, M.D., P.A., encompassing routine diagnostic procedures (scopes), examination and medical treatment.

I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the physicians and their assistants, including audiologists, medical assistants or their designees as is necessary in the physician's judgment.

Patient Signature: _____ Date: _____

MEDICARE CONSENT

I certify that the information given by me in applying for payment under Title SVIII and /or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician(s) services. I understand that I am responsible for my health insurance deductibles and coinsurance.

Patient Signature: _____ Date: _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Policies, which states how we may use and/or discuss your health information. This notice is posted in our lobby for you to read. We will gladly give you a copy to take with you, if you so request. Please sign this form to acknowledge advisement of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have been advised of the office's Notice of Privacy Practices.

Please print your name here: _____

Signature: _____ Date _____

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient, but it could not be obtained because:

☐ The patient refused to sign.

☐ Due to an emergency situation, it was not possible to obtain an acknowledgement. We weren't able to communicate with the patient.

☐ Other (please provide specific details).

Employee Signature: _____ Date _____

AUTHORIZED REPRESENTIVE FORM

Note: This form is used to confirm a Patient's permission that the health provider may discuss or disclose their Protected Health Information to a particular person who acts as their Authorized Representative. Use of the Protected Health Information is strictly limited to that purpose.

SECTION A: PATIENT INFORMATION

By signing this form in section E below, I understand and agree that _____ ("Provider") may release my Personal Health Information (PHI) as defined in Section B below to my Authorized Representative named in Section C.

Patient Name: _____

Address: _____

Telephone Number: _____ Chart No: _____

Please Note: This authorization does not provide your "Authorized Representative" with any authority, either implied or direct, over any treatment or direct care decisions. If you wish to designate a health care partner/proxy or a clinical personal health care representative or if you want to set up a living will or power of attorney, please discuss this with your attorney or health care provider. Also, the provider will not condition treatment, benefits payments, enrollment or eligibility for benefits on the execution of this form.

SECTION B: TYPE OF INFORMATION

*Personal Health Information (PHI), including, but not limited to, identification of treating providers of care, diagnosis, procedures, demographic information.

*This information may include diagnosis and/or treatment for alcohol and/or drug abuse; AIDS/AIDS Related Complex (ARC) and HIV diagnosis and/or treatment; and diagnosis and/or treatment relating to other communicable diseases.

*This authorization does not cover disclosure of psychotherapy notes.

I understand that I have the right to limit the information that you release under this authorization. For example, I may limit my Authorized Representative's access to information about a particular healthcare provider or a particular diagnosis/disease. Any such limitations must be described below in writing. I understand that by leaving this section blank, I am creating no limitations on disclosure.

Limitations on Disclosure: _____

_____

_____

SECTION C: AUTHORIZED USE AND /OR DISCLOSURE; AUTHORIZED REPRESENTATIVE

I understand that the Provider's general policy is not to disclose my Personal Health Information to other parties, except those directly involved in my care, without my written authorization or as permitted or required by law. For this reason, I authorize you to discuss and disclose my Personal Health Information to the person(s) named below for the purpose of assisting with, facilitating the coordination or payment of my health plan benefits. I also understand that if my Authorized Representative is not a health care provider or another entity subject to Federal or applicable state privacy laws, my Personal Health Information may no longer be protected by those privacy laws and my Personal Health Representative may further disclose my Personal Health Information without my authorization. I acknowledge that my authorization is voluntary

AUTHORIZED REPRESENTATIVE #1

Name: _____ Relationship to patient: _____

Phone Number: _____

Address: _____

AUTHORIZED REPRESENTATIVE #2

Name: _____ Relationship to patient: _____

Phone Number: _____

Address: _____

SECTION D: EXPIRATION AND REVOCATION

This authorization to release information to my Authorized Representative will automatically expire two (2) years following the last treatment provided by you to me.

I understand that I have the right to revoke or end this authorization at any time. I understand that, if I do not wish the person(s) named in Section C to remain my Authorized Representative, I must revoke this authorization in writing by giving notice of my decision to the Provider listed below. I understand that my revocation of this authorization will not affect any action that you have taken, or any information that you have already released, based upon authorization before you actually received my request to revoke it.

Contact Person: _____

Address: _____

Telephone No: _____ Fax: _____

SECTION E: SIGNATURE / AUTHORIZATION

I have had full opportunity to read and consider the content of this Authorized Representative Form. I confirm that this authorization is consistent with my request of the provider. I understand that, by signing this form, I am confirming my authorization that the provider may use and/or disclose my Personal Health Information to the person(s) named in Section C for the purpose described above. I also confirm that a facsimile copy of this form is acceptable.

Patient Signature: _____ Date: _____

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize the use/disclosure of health information about me as described below:

Patient Name: _____ Patient Date of Birth _____

A. Organization authorized to provide the information: George Georgakakis, MD

B. Person(s) or Organization(s) authorized to receive the information:

Physician/Facility: _____

Address: _____

C. Specific description of the information that may be used or disclosed (including dates):

_____

_____

D. Specific description of how the information will be used:

_____

_____

1. I understand that this information will expire on
2. I understand that I may revoke this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notify our office in writing.
3. I understand that I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).
4. I may inspect or copy any information used or disclosed under this agreement.
5. I understand that if the person or organization that receives the information is not a healthcare provider or plan covered by federal privacy regulations, the information above may be redisclosed and would no longer be protected by these regulations.

_____ _____

Patient or Patient Representative Signature Date

_____ _____

Print Name of Patient or Patient Representative Relationship to Patient

NOTE: You have the right to know specifically what information you are authorizing for release (e.g., "results of a lab test performed on 1/4/03" or if your entire medical record is included, "all health information").

You have the right to know the name(s) or other identification of the person(s) or organization(s) authorized to release the information (e.g., the names of your health care provider).

You have the right to know who is going to use it and what it is going to be used for (e.g., John Smith, Ph.D./Research).

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

HIPAA Authorization for the Use/Disclosure of Protected Health Information

Dr. Georgakakis
Otolaryngology • Ear Nose & Throat
Hearing Health

PAST MEDICAL HISTORY

Patient Name: _____ Reason For Visit _____

HEAD-SINUSES:	Yes	No
FACIAL PAIN	☐	☐
HEADACHES	☐	☐
CONGESTION	☐	☐
HEAD/FACIAL TRAUMA	☐	☐
SINUS SURGERY	☐	☐

RESPIRATORY:	Yes	No
SHORTNESS OF BREATH	☐	☐
COUGH	☐	☐
ASTHMA	☐	☐
PNEUMONIA	☐	☐
BRONCHITIS	☐	☐

SKIN:	Yes	No
RASH	☐	☐
LESIONS	☐	☐
HIVES	☐	☐
HISTORY OF SKIN CANCER	☐	☐

ENDOCRINE:	Yes	No
DIABETES	☐	☐
OBESITY	☐	☐
HAIR LOSS	☐	☐
THYROID DISEASE	☐	☐

PSYCHIATRIC:	Yes	No
ANXIETY	☐	☐
SLEEP DISORDER	☐	☐
SNORING OR APNEA	☐	☐
MEMORY LOSS	☐	☐
DRUG ADDICTION	☐	☐
DEPRESSION	☐	☐

EARS-HEARING:	Yes	No
HEARING LOSS	☐	☐
RINGING IN THE EARS	☐	☐
LOSS OF BALANCE	☐	☐

NOSE:	Yes	No
BLEEDING	☐	☐
RUNNY NOSE	☐	☐
LOSS OF SMELL	☐	☐
PRESSURE	☐	☐
POSTNASAL DRAINAGE	☐	☐

THROAT:	Yes	No
SORE	☐	☐
HOARSENESS	☐	☐
LOSS OF TASTE	☐	☐
SNORING	☐	☐
TONSILLITIS	☐	☐

GI:	Yes	No
DIFFICULTY SWALLOWING	☐	☐
HEARTBURN	☐	☐
REFLUX	☐	☐
NAUSEA	☐	☐
VOMITING	☐	☐
HIATAL HERNIA	☐	☐

GU:	Yes	No
PROSTATE	☐	☐
KIDNEY STONE	☐	☐
DIALYSIS	☐	☐
GOUT	☐	☐

EYES:	Yes	No
DOUBLE VISION	☐	☐
ITCHING	☐	☐
VISION LOSS	☐	☐
PAIN	☐	☐
BURNING	☐	☐
DRY EYES	☐	☐
GLAUCOMA	☐	☐

CONSTITUTIONAL SYMPTOMS:	Yes	No
FATIGUE	☐	☐
FEVER	☐	☐
CHILLS	☐	☐
NIGHT SWEATS	☐	☐
WEIGHT LOSS OR GAIN	☐	☐

NEUROLOGICAL:	Yes	No
PASSING OUT	☐	☐
DIZZINESS	☐	☐
NUMBNESS	☐	☐
STROKE	☐	☐
SEIZURES	☐	☐
TREMORS	☐	☐

CARDIOVASCULAR:	Yes	No
HYPERTENSION	☐	☐
HIGH CHOLESTEROL	☐	☐
PAST HEART ATTACKS	☐	☐
PACEMAKER	☐	☐

HEMATOLOGIC-LYMPHATIC:	Yes	No
HIV/AIDS	☐	☐
ANEMIA	☐	☐
IMMUNE PROBLEMS	☐	☐
PULMONARY EMBOLISM	☐	☐

MUSCULOSKELETAL:	Yes	No
JOINT PAIN	☐	☐
ARTHRITIS	☐	☐
JAW PAIN	☐	☐
HIP / KNEE REPLACEMENT	☐	☐
OSTEOPOROSIS	☐	☐
LUPUS	☐	☐

Any other medical conditions: _____

Past surgical history: ☐ Yes ☐ No If yes, please list the procedures and dates: _____

Family history of medical problems: ☐ Yes ☐ No If yes, please list and indicate family member: _____

List all allergies: ☐ No Allergies: _____

List all medications you are currently taking (including all over the counter medications and vitamins): ☐ None

_____

Are you currently using tobacco products? ☐ Yes ☐ No If yes, quantity smoked per day: _____

If you quit, how often did you smoke before (per day)? _____ For how long? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, amount: _____ How often: _____

Do you currently have or have you in the past had a problem with substance abuse? ☐ Yes ☐ No

Patient / Representative Signature: _____ Date: _____

PATIENT AUTHORIZATION FOR MARKETING – ALL PRODUCTS AND SERVICES

To our Patients:

From time to time, our practice would like to tell patients about products and services that we think may be of interest to them.

When we give patients promotional gifts of nominal value, or recommend products or services in face-to-face communication, we do not require the patient's written authorization. However, we do require a patient's written authorization before sending other kinds of marketing communications if our practice receives financial remuneration for sending the communications.

If you would like to receive information about products and services from our practice, please complete and sign the authorization form below.

Authorization

Patient Date of Birth: _____ Patient Chart No: _____

I hereby authorize the practice to use my name and address and other information about my health to provide marketing communications to me. I also authorize the practice to disclose such information to a business associate for purposes of sending marketing communications to me.

I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA Privacy regulations. I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by the practice's Privacy Official at the doctor's address shown above.

I understand that if I revoke this authorization, my revocation will not affect any actions taken by the practice before receiving my written revocation. I understand that I may refuse to sign this authorization, and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan or eligibility for benefits.

This authorization expires on the following date or when the following event occurs: _____