Carolina Eye, Ear, Nose & Throat Associates, LLC

2016 Sumter Street
Columbia, SC 29201
Phone (803) 744-2700
Fax (803) 744-7979

Clinic Record

Patient Name ______________________ Chart # __________

Parent/Spouse Name ______________________

Patient Social Security # ______________________

Address: ______________________

City ______________________ State __________ Zip __________

Age __________ Date of Birth __________ Male or Female __________

Home Telephone __________

Emergency Contact __________ Phone __________ Pt. Relation __________

Alternate Contact __________ Phone __________ Pt. Relation __________

Referring Physician ______________________ Telephone __________

Primary Care Physician ______________________ Telephone __________

Insurance Information:

Primary Carrier ______________________

Name of Insured ______________________ Date of Birth __________

ID # ______________________ Group # __________

Insureds Employer ______________________

SSN __________

Secondary Carrier ______________________

Name of Insured ______________________ Date of Birth __________

ID # ______________________ Group # __________

Insureds Employer ______________________

SSN __________

Pharmacy Name and Phone Number: ______________________

I agree that the above information is true and correct and will submit any new information or changes if asked.

Patient's Signature ______________________ Date __________

Carolina Eye, Ear, Nose & Throat Associates, LLC

Medical History Questionnaire

Name: ________________________________ Date: ______________

HISTORY OF PRESENT ILLNESS/REASON FOR REFERRAL

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REVIEW OF SYSTEMS

Do you **currently** have any problems in the following areas? If yes, please explain.

	YES	NO	Explanation of Problem
Chronic fever, weight loss/gain/fatigue	___	___	___________
Ear/nose/throat problems (ie: sinus congestion, Hearing loss, sore throat, dry mouth)	___	___	___________
Heart/vascular problems (ie: chest pain, high Blood pressure, irregular heart beat)	___	___	___________
Respiratory problems (ie: shortness of breath, Asthma, chronic cough)	___	___	___________
Gastrointestinal problems (ie: abdominal pain, Heartburn, diarrhea, vomiting)	___	___	___________
Urinal problems (ie: pain or discomfort, blood In urine)	___	___	___________
Skin problems (ie: rashes, excessive dryness, Eczema, cancer)	___	___	___________
Musculoskeletal problems (ie: muscle aches, Joint pain)	___	___	___________
Neurological problems (ie: numbness, weakness, Headaches, paralysis)	___	___	___________
Psychiatric problems (ie: depression, anxiety, Nervousness)	___	___	___________
Eye problems			
Loss of vision	___	___	___________
Blurred vision	___	___	___________
Double vision	___	___	___________
Dryness	___	___	___________

Eyes cont'd

	YES	NO	Explanation of Problem
mucous discharge	____	____	____
redness	____	____	____
sandy/gritty feeling	____	____	____
itching/burning	____	____	____
tearing	____	____	____
light sensitivity	____	____	____
floaters/flashes	____	____	____
pain/soreness	____	____	____
chronic infection(s)	____	____	____
sty/chalazion	____	____	____

MEDICAL HISTORY (PAST/PRESENT)

List all medical conditions (High Blood Pressure, Heart related, Diabetes, Respiratory/Breathing, Arthritis, Bleeding disorders, Neurological, Allergies, etc.)

____

List past surgeries and dates ______________________________

List any hospitalizations and reason ______________________________

List all medications and dosages ______________________________

List any eye diseases, conditions or surgeries (cataract, glaucoma, crossed eye, lazy eye, drooping lids, retina, etc.) ______________________________

Do you have any medication allergies? YES ____ NO ____

If yes, please list ______________________________

Any allergies to Iodine? YES ____ NO ____ / Latex? YES ____ NO ____ / Adhesives? YES ____ NO ____

SOCIAL HISTORY

Current occupation ______________ If retired, prior occupation ______________
Do you drive? ________ Do you wear glasses? ________ Contacts? ________
Do you drink alcohol? ________ How much? ________ How often? ________
Do you smoke/use tobacco? ________ Are you a past smoker/tobacco user? ________
When did you start smoking/using tobacco? ________ When did you quit? ________
How many packs of cigarettes or cans/day? ________
Have you ever used illegal drugs (Marijuana, Cocaine, etc.)? ______________

FAMILY HISTORY

Please include family relation (e.g. brother, mother, aunt, etc.)

Eye conditions (cataract, glaucoma, cornea, retinal detachment) ______________

Medical conditions (High blood pressure, diabetes, heart conditions, cancer, thyroid, etc.) ______________

Patient's Signature ______________ **Date** ________
Physician's Signature ______________ **Date** ________
I have reviewed the patient's history detailed above and have added comments where indicated. Otherwise, there are no changes.

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Physician's medical history review dates

Date ________ Changes ______________

Date ________ Changes ______________

Date ________ Changes ______________

Carolina Eye, Ear, Nose & Throats Associates, LLC

Authorization Release Statement

Name of patient ______________________________ Date of Birth ______________________

SS# ______________________________________

☐Yes ☐No **DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHO?**

Per my request, I hereby authorize Carolina Eye, Ear, Nose and Throat Associates, LLC to communicate my medical information and/or billing information to the following individuals:

1. Name __________________________________ Phone # __________________________

   Relationship ____________________________ Alternate # _______________________

2. Name __________________________________ Phone # __________________________

   Relationship ____________________________ Alternate # _______________________

3. Name __________________________________ Phone # __________________________

   Relationship ____________________________ Alternate # _______________________

☐Yes ☐No I give permission to leave messages on my answering machine/voice mail.
Phone # ____________________
(I would like test results or appointment information left on my answering machine/voice mail)

☐Yes ☐No I give permission to call my place of employment.

☐Yes ☐No I give permission to leave messages on my voice mail at work.

☐Yes ☐No I give permission for Carolina Eye, Ear, Nose and Throat Associates, LLC to release information to my employer or my school regarding absences or immunizations.

Rights of Patient

I understand that I have the right to revoke this authorization at anytime and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending written notification to the Privacy Officer or Administrator. I understand that revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that the information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditional on signing. This authorization shall be in effect until revoked by the patient.

Signature of patient or personal representative ______________________________________

Description of personal representative's authority ____________________________________

FINANCIAL POLICY

PAYMENT METHOD

We accept payment by Cash, Checks, and Credit Cards (VISA / Mastercard / Discover / Debit Cards)

INSURANCE RESPONSIBILITY

As a service to our patients, we will file a claim to your primary and, if applicable, your secondary insurance carrier on your behalf.

We will work with you to have your insurance carrier pay for any charges they should pay, but you are ultimately responsible to make sure we are paid for the treatment you receive. Those patients that have good knowledge of their insurance policy and coverage typically receive quicker reimbursement for covered services. Any outstanding insurance claims 45 days or older from the date of service will be reverted to the patient's responsibility to pay.

PATIENT RESPONSIBILITY

Should you have no insurance coverage, you will be responsible to pay the entire amount of your services at the time of your service.

Should you have insurance coverage, we will attempt to collect that balance from your carrier as explained above. Any money owed by the patient to include insurance over 45 days; any outstanding co-pays, co-insurance or deductible that remains unpaid for a period of 90 days may be referred to an outside collection agency. This may result in your being discharged from the practice.

RETURNED CHECKS

We will charge your account a $30.00 fee for any check returned to us by the bank for any reason. We will attempt to collect the original amount of check plus the fee. If our attempts fail, we will send the fraudulent check to the magistrate for collection.

CO-PAYS, CO-INSURANCE, NO SHOW FEES & CANCELLATION FEES

Patients are responsible for their co-pay, co-insurance, or deductible at the time of their service. A $50.00 no show or cancellation fee will be charged if not cancelled within 24 hours in advance.

Assignment of Insurance and Release & Assignment of Benefits

Please remember that insurance is considered a method of reimbursing the patient for fees paid directly to the provider and is not a substitute for payment. Some companies will pay fixed allowances for certain procedures and others pay a percentage of the charge. It is the patient's ultimate responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company. If we are filing your claim we will allow (45) forty five days from the billing date for the carrier to process your claim and make payment accordingly. If payment from your insurance company is not received within the time frame specified above, we will notify you to clear your account. Insurance claim filing is only done as a courtesy to the patient and does not dismiss the patient's responsibility for the charges. I certify that I have read and understand fully the provider's billing policy and agree to its terms. I also agree to make payment in full and/or satisfactory arrangements when asked to do so as specified above.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, Private Insurance, Worker's Compensation, and other health plans. This assignment applies to all charges outstanding as of the date of signature and will remain in effect for all current and future charges until revoked in writing. A photocopy as of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by the insurance carrier. I hereby authorize said assignee to release all information or necessary to secure payment. Should the account be referred to any collection agency for collection, the undersigned shall pay reasonable attorneys's fees and collection expense.

Acknowledgment of Receipt of Privacy Practices

I hereby acknowledge that I have been given an opportunity to review the privacy practices at Carolina Eye, Ear, Nose & Throat Associates, LLC. I understand that I may obtain a copy of this notice of privacy practices. This notice has been issued and considered effective on the date signed. We will keep this signed form on file for a minimum of six (6) years.

Patient Signature ______________________________ Date __________

Parent/Guardian Signature (if minor) ______________________________ Date __________

Witness______________________________ Date __________