

**Please take a moment to familiarize yourself with the  
Ear Institute of Texas (EIT) office policies and procedures.**

**Appointments:** All patients are scheduled by appointment only and the time is scheduled exclusively for you. Appointments are scheduled with the intent to see you at the scheduled time. However, since this is a surgical practice as well, emergencies sometimes occur, and patients are provided the necessary time for treatment. Therefore, delays may occur.

Two business days prior to your scheduled appointment, EIT staff will place a reminder call. Please call back to confirm your appointment. Patients who do not call back to confirm the appointment are subject to having the appointment cancelled and another patient booked in that appointment slot. Please note that it is best to call the main office number (210) 696-4327. If you call back the number listed on caller-id, you may be directed to a back office line that does not go to voice mail or that line may indicate a busy signal.

EIT does maintain a waiting list for patients who have a scheduled appointment but who would prefer an earlier appointment. In the event of a cancellation, those patients on the waiting list will be contacted and offered the opportunity to be scheduled for the earlier appointment.

**New patient Forms:** For your convenience new patient forms are available on the EIT website. If these forms are not completed prior to your appointment, please plan to arrive 15-20 minutes prior to your scheduled appointment to allow time to complete the office forms. Depending upon the nature of your visit, you may need to complete additional forms. It is not necessary to complete the “Dizziness” and “Tinnitus” questionnaires unless you are experiencing or have experienced those symptoms.

EIT realizes these forms require considerable information. However, medical history and documentation regarding your history and symptoms is important for the clinical providers to manage your care. We apologize for any inconvenience.

**Clinical Providers:** Due to the nature of our practice, EIT staff schedules patients for the soonest possible appointment. EIT employs Physician Assistants and Nurse Practitioners to support the physician with the volume of patients requiring medical care each day. These clinical providers are highly qualified and trained specifically by Dr. Jackson to treat the medically complex patients seen in this office. As we schedule patients for the first available appointment, patients may be scheduled with any of our clinical providers.

The physician supervises the care of each and every patient but does require assistance to ensure patients are cared for in a timely manner. In some instances, the Physician Assistant or Nurse Practitioner may begin evaluation of a patient on Dr. Jackson’s schedule. However, the patient will still be seen by Dr. Jackson if expected.

**Cancellations/Late Arrival:** We reserve your appointment exclusively for you. In order that we may serve all of our patients, we ask that if you need to cancel your appointment, you provide notice not less than 24-hours prior to your scheduled appointment. For appointments cancelled with less than a 24-hour notice, a cancellation fee will be charged.

If you are going to be late for your scheduled appointment, please contact the office as soon as possible. Dependent upon the schedule, late patients may be moved to a later appointment, as close to the originally scheduled appointment as possible.

**Identification:** For your protection, valid photo identification will be requested at the time of your appointment. If you do not have valid picture identification with you at the time of your appointment, it will be necessary to reschedule the appointment.

Additionally, EIT will require a copy of the front and back sides of your current insurance card(s). Should you not have this available, it will be necessary to indicate you are a private-pay patient necessitating that you are responsible for all charges related to the appointment, at the time the services are provided.

**Diagnostic Testing:** New patients to EIT should expect to receive a hearing test to evaluate most conditions that we treat, even if the patient is not specifically complaining of hearing loss or hearing associated problems. The hearing test may be performed because the balance nerve is located in the ear and may be a cause of dizziness or imbalance. If you are unsure why you are having a hearing test, please speak with one of our Doctors of Audiology.

**Medical Records:** It is important that EIT maintains a current and accurate medical record on your behalf. Therefore, at the time of each appointment, EIT staff will ask you if any information has changed (e.g. name, address, guarantor, insurance, telephone, medications, new medications, symptoms or conditions). It is your responsibility to ensure any updates are provided. We appreciate your cooperation in keeping us informed so that we may better serve you.

**Payment for Services:** Payment for services is required at the time services are provided. For your convenience we accept: Master Card, Visa, American Express, cash, and local checks. Payment options may be available through the EIT billing office. Please contact our insurance department to discuss payment plan options.

**Insurance:** EIT accepts various insurance plans. Each insurance plan has its own unique stipulations, coverage limits and requirements for the plan participant (you the patient). The staff at the EIT will verify your benefits prior to the time of your appointment. However, due to the various plan types, and the variations in coverage, we ask that you take the time to discuss your visit with your insurance provider or your employer's benefits manager, so that you are aware of your responsibilities and all applicable fees for which you will be responsible for at the time of your appointment.

At the time of your appointment you may be required to undergo diagnostic testing which may or may not be covered by your insurance provider. Any charges not covered by your insurance provider will be your responsibility. You will be required to pay these charges at the time services are provided.

**HMO:** If your insurance is through an HMO, it is your responsibility as the patient to coordinate all necessary referrals prior to your appointment, including a determination as to whether or not the physician is a "participating physician" with your individual HMO insurance plan. If EIT is not a participating provider, it will be your responsibility to pay all charges at the time services are provided.

**Prescription Refills:** Please provide at least 72-hours notice, if possible. You should first contact your pharmacy and ask them to contact our office for the authorization to refill. Some prescription requests are sent electronically. For those refills, the pharmacy will contact EIT through electronic means. Once the refill has been authorized, your pharmacy will be notified, generally within 24-hours (excluding weekends and holidays).

**Clinical Questions:** Please call the main office number at (210) 696-4327 to leave a message. Calls left on the answering machine at night, on the weekends, or on a holiday will be documented the next business day. Clinical questions will be documented on a message log and routed to the appropriate clinical provider. Please provide the numbers where you may be reached, both day and evening. Your call will be returned at the first opportunity.

**Parking:** There is plenty of free parking available for our patients. Please note that some spaces are clearly marked as "reserved". Please do not park in those spaces. Please do not park in the designated handicapped spaces unless you have a handicapped placard or license plate.

*Thank you for being our valued patient.*

**NOTICE OF PRIVACY PRACTICES – HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)**

**RELEASE OF INFORMATION – MEDICAL PROVIDERS AND YOUR RIGHTS**

(\_\_\_\_\_) Your confidential information could potentially be transmitted to those who are not authorized to receive such information.  
initial The Ear Institute of Texas uses its best efforts to avoid such disclosure. I have been advised of this potential and authorize the Ear Institute of Texas to utilize facsimile to transmit my Protected Health Information (“PHI”), which may include, without limitation, contact information and medication history.

I hereby authorize the Ear Institute of Texas to release my PHI to the referring physician or to another physician or health care provider or facility associated with my care and treatment, or as otherwise permitted by applicable rules, regulations or laws. I understand and agree that the release of any such information may be transmitted, without limitation; telephonically, by facsimile, electronically, by mail, courier, or by overnight delivery services.

Further I hereby authorize the Ear Institute of Texas to obtain my PHI from the referring physician or another physician or health care provider or facility associated with my care and treatment including medication history from any pharmacy and that any such PHI information may be transmitted to the Ear Institute of Texas, without limitation, telephonically, by facsimile, electronically, by mail, courier, or by overnight delivery services.

You may ask to see or receive a copy of your medical records and other health information. If you want a copy, you will need to put your request in writing, there could be a small fee to cover the cost of printing and postal services. It may take up to but not exceed 30 days.

You may request to change any incorrect information in your file or add information to your file if you think something is missing or incomplete.

If you believe your privacy rights have been violated, you may file an OCR complaint with us or the Secretary of Health and Human services. Under HIPAA, we cannot retaliate against anyone for filing a complaint.

You have the right to request a copy of this notice from us at any time.

**RELEASE OF INFORMATION – FAMILY AND OTHERS**

(\_\_\_\_\_) In accordance with HIPAA regulations, the Ear Institute of Texas may not discuss your condition, care, or treatment plan with family members or other individuals unless that person(s) is authorized by you to access any such PHI information in regard to your condition, care or treatment plan. Any such authorization must be obtained by the Ear Institute of Texas, from you or your legally authorized representative, prior to the release of any such information.  
initial

However, pursuant to the regulations, this privacy provision may be waived dependent upon your medical condition.

**Therefore I do hereby authorize the Ear Institute of Texas to release my PHI to the following person(s):**

Name	Relationship
Name	Relationship

**If no persons are listed above, the Ear Institute of Texas will not disclose your PHI to anyone, except as permitted within this document or as otherwise permitted by applicable law.**

**RELEASE OF INFORMATION – MARKETING**

(\_\_\_\_\_) Here at the Ear Institute of Texas, Voice & Swallowing Institute of Texas, and the Hearing Institute of Texas we are trying to keep you informed as much as possible. Email and mail outs are ways we have found many people enjoy getting notifications and material on new developments pertaining to your health. We also offer patient portal on our website that can be accessed by you at anytime to view your patient history information.  
initial

General disclosure: Dr. Jackson functions as investor or in advisory role for the following companies: St. Raphael’s Surgery Center, Precision Neuromonitoring, and Cochlear Corporation.

**I have read this release before signing below and I fully understand the contents, meaning and impact of this release.**

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**Signature: Patient/Guarantor/Legal Guardian**

-----  
**Date**

-----  
**Print Name: Patient/Guarantor/Legal Guardian**

**ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND /OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE**

I hereby assign and convey directly to the Ear Institute of Texas and the Voice & Swallowing Institute of Texas as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort feason insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or medications provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

\_\_\_\_\_  
Signature: Patient/Guarantor/Legal Guardian

\_\_\_\_\_  
Date

# HEALTH HISTORY

Patient Name \_\_\_\_\_ Age: \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Chief Complaint/Reason for today's visit: \_\_\_\_\_

List <u>ALL</u> Hospitalizations/Surgeries	Year	Complications
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had: Pneumonia vaccination within the last 5 years? Y/N \_\_\_\_\_ Date \_\_\_\_\_ Flu shot in the last year? Y/N \_\_\_\_\_ Date \_\_\_\_\_

Have you had: Mammogram? Y/N \_\_\_\_/\_\_\_\_/\_\_\_\_ Date \_\_\_\_\_ Pap Smear? Y/N \_\_\_\_/\_\_\_\_/\_\_\_\_ Date \_\_\_\_\_ Colonoscopy? Y/N \_\_\_\_/\_\_\_\_/\_\_\_\_ Date \_\_\_\_\_

RESULTS: Mammogram \_\_\_ Normal \_\_\_ Abnormal Pap Smear \_\_\_ Normal \_\_\_ Abnormal Colonoscopy \_\_\_ Normal \_\_\_ Abnormal

\*\*\*ALLERGIES TO MEDICATION: None \_\_\_\_\_ Please list any known allergies \_\_\_\_\_

Have you ever had problems with anesthesia? Yes \_\_\_ No \_\_\_ If yes, what problems: \_\_\_\_\_

## Past Medical History

Have you ever had the following: (Circle "yes" or "no", leave blank if uncertain)

Meningitis.....	Yes No	Bleeding Tendency	Yes No	Hives or Eczema.....	Yes No	High Cholesterol.....	Yes No
Spine/Back Problem:	Yes No	High Blood Pressure...	Yes No	AIDS or HIV+.....	Yes No	Pacemaker.....	Yes No
Arthritis.....	Yes No	Low Blood Pressure...	Yes No	Stroke.....	Yes No	Please list <u>ALL</u> other illnesses, past or present: _____	
Epilepsy.....	Yes No	Heart Disease (Besides BP)	Yes No	Hepatitis A/B/C....	Yes No	_____	
Migraine Headaches.	Yes No	Asthma.....	Yes No	Kidney Disease.....	Yes No	_____	
Other Headaches.....	Yes No	Diabetes I or II.....	Yes No	Thyroid Disease....	Yes No	_____	
Cancer.....	Yes No	Type/Location: _____		Are you cancer free at this time?	Yes No	_____	
Cancer treatments (Check all that apply): Surgery _____ Radiation _____ Chemo _____							

## Patient Social History

Occupation: \_\_\_\_\_  
Marital Status: Single: \_\_\_\_\_ Married: \_\_\_\_\_ Separated: \_\_\_\_\_ Divorced: \_\_\_\_\_ Widowed: \_\_\_\_\_  
Do you have children: Yes \_\_\_ No \_\_\_ If yes, how many? \_\_\_\_\_ Lives with you?..... Yes No  
Do you smoke? Yes \_\_\_ No \_\_\_ I quit \_\_\_ years ago If you have smoked: \_\_\_ packs of cigarettes per day for \_\_\_ years.  
Do you drink alcohol? Yes \_\_\_ No \_\_\_ No, but I used to \_\_\_  
If yes, how often? Daily: \_\_\_/day 1 or more times a week: \_\_\_/week 1 or more times a month: \_\_\_/month Rarely \_\_\_

## Family Medical History

Please circle any of the following which have occurred in an immediate family member (parent, sibling, and children only - not by marriage/adoption)  
For any circled, list relation (mother, father, etc.) and specific condition/symptoms below; if none, check here \_\_\_\_\_

Epilepsy	Relation:___	Asthma	Relation:___	Stroke	Relation:___	Migraines	Relation:___
Ear Problems	Relation:___	Kidney Disease	Relation:___	Thyroid Disease	Relation:___	Heart Disease	Relation:___
High Blood Pressure	Relation:___	Low Blood Pressure	Relation:___	Hemophilia	Relation:___	Diabetes	Relation:___

Is there a history of hearing loss, dizziness, or ear problems in the family? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please describe relation and condition: \_\_\_\_\_

Current Medications  None  See attached list

Please list all medications. If more space is needed, please attach an additional sheet of paper

Name	Dose	Frequency	Name	Dose	Frequency
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Preferred Pharmacy: \_\_\_\_\_ Location: \_\_\_\_\_ Phone # \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

For pediatric patients only:  
Birth History: Full term \_\_\_ Premature \_\_\_ (\_\_\_ weeks early) Vaginal Delivery \_\_\_ Caesarian Section \_\_\_  
Complication at Birth: Yes / No Required ICU care \_\_\_ Required ventilator \_\_\_ Had jaundice \_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Review of Systems: Please indicate any personal history below:

**Constitutional / General**

Fever..... Yes No  
Weight Loss..... Yes No  
Night Sweats..... Yes No  
Excessive Fatigue..... Yes No

**Eyes**

Wear Glasses..... Yes No  
Infections..... Yes No  
Injuries..... Yes No  
\*Glaucoma..... Yes No  
\*Cataracts..... Yes No  
If yes, operated? (right/left) Yes No  
\*Macular Degeneration..... Yes No  
Itchy/watery eyes..... Yes No

**Ear**

Wear Hearing Aids..... Yes No  
Hearing Loss..... Yes No  
If yes, circle one of the following:  
*Left / Right / Both Sides*  
Ear Pain..... Yes No  
Ringing in the Ears..... Yes No  
If yes, circle all that apply:  
*Left / Right / Both Sides*  
*Rarely / Occasional / Constant*  
Dizziness..... Yes No  
If yes, circle all that apply:  
*Spinning Vertigo / Lightheadedness / Imbalance*  
Exposure to Loud Noise..... Yes No  
If yes, list: \_\_\_\_\_

**Nose, Throat, and Mouth**

Nose Bleeds..... Yes No  
Nasal Congestion..... Yes No  
Inability to Smell..... Yes No  
Sinus Problems..... Yes No  
Sinus Headaches..... Yes No  
Sore Throat..... Yes No  
Hoarseness..... Yes No  
Difficulties Swallowing..... Yes No  
Speech Delay/Difficulties..... Yes No  
Pain Swallowing..... Yes No

**Respiratory**

Chronic Cough..... Yes No  
\*Emphysema..... Yes No  
Shortness of Breath..... Yes No  
\*Bronchitis..... Yes No  
\*Pneumonia..... Yes No  
Lung Cancer..... Yes No  
Blood Sputum..... Yes No

**Cardiovascular**

Chest Pain or Angina..... Yes No  
Irregular Pulse..... Yes No  
\*Heart Murrur..... Yes No  
Swelling in Feet or Hands..... Yes No  
Leg Pain While Walking..... Yes No

**Musculoskeletal**

Broken Bones..... Yes No  
Arm or Leg Weakness..... Yes No  
Back Pain..... Yes No  
Arm or Leg Pain..... Yes No  
Joint Pain or Swelling..... Yes No

**Integumentary**

Skin Disease..... Yes No  
Skin Cancer..... Yes No

**Gastrointestinal**

Indigestion/Pain with Eating..... Yes No  
Nausea..... Yes No  
Vomiting..... Yes No  
\*Liver Disease..... Yes No  
Jaundice..... Yes No  
Abdominal Pain..... Yes No  
\*Ulcers or Gastritis..... Yes No  
Colon Cancer..... Yes No  
Heartburn..... Yes No  
Reflux..... Yes No

**Genitourinary**

Urinary Tract Infections..... Yes No  
Blood in Your Urine..... Yes No  
Incontinence..... Yes No  
Prostate Cancer (males)..... Yes No  
\*Endometriosis (females)..... Yes No  
Uterine/Cervical Cancer..... Yes No

**Hematologic/Lymphatic**

\*Anemia..... Yes No  
\*Hemophilia..... Yes No  
Persistant Swollen Glands..... Yes No  
Swollen Lymph Nodes..... Yes No  
Blood Transfusion..... Yes No  
If yes, when? \_\_\_\_\_

**Psychiatric**

\*Anxiety..... Yes No  
\*Depression..... Yes No  
\*Bipolar Disorder..... Yes No  
Other Psychiatric Disorder.. Yes No  
If yes, please list: \_\_\_\_\_

**Endocrine**

Increased Appetite..... Yes No  
Excessive Thirst/Urination... Yes No  
Hormone Problems..... Yes No

**Allergic/Immunologic**

\*Immunological Disorders..... Yes No  
Food Allergies..... Yes No  
\*Inhalant (Nasal) Allergies.... Yes No  
\*Previously allergy tested?.... Yes No

**Neurological**

Fainting Spells/Black Outs.... Yes No  
\*Seizures..... Yes No  
Problems with Memory..... Yes No  
Disorientation..... Yes No  
Difficulty with Your Speech... Yes No  
Inability to Concentrate..... Yes No  
Double or Blurred Vision..... Yes No  
Face Weakness..... Yes No  
Poor Coordination in  
Arms and/or Legs..... Yes No  
Weakness in Arms or Legs... Yes No  
Numbness, tingling or  
increased sensitivity in your  
feet? ..... Yes No  
Pain, burning or feelings  
of pins/needles in your feet? Yes No  
\*Neuropathy ..... Yes No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information may be detrimental to my health. It is my responsibility to inform this office of any changes in my medical status/condition. I hereby authorize the healthcare staff to perform any necessary services I may require.

Signature of Patient, Parent or Guardian

Date

**Doctor's Review**

Signature of Doctor

Date

# The Ear Institute of Texas, P.A.

(210) 696-HEAR (4327) (210) 798-2509 Fax  
18518 Hardy Oak, Ste 300  
San Antonio, Texas 78258

DATE: \_\_\_\_\_ CHART # \_\_\_\_\_

## PATIENT INFORMATION

Full Legal Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Birth date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone: Home:( ) \_\_\_\_\_ Work:( ) \_\_\_\_\_ Cell:( ) \_\_\_\_\_

E-mail: \_\_\_\_\_ Social Security Number \_\_\_\_\_

Marital Status: \_\_\_\_\_

**Employer** \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**How did you find us:** \_\_\_\_\_ Friend, Other, Web-Page, Insurance Provider List, Phone Book, Doctor's Referral

**Referring Physician's Name** \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Is your referring physician an Ear, Nose, Throat Specialist? Yes \_\_\_\_\_ No \_\_\_\_\_

**Primary Care/ Family Physician** \_\_\_\_\_ Phone Number ( ) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

## INSURANCE INFORMATION (Disregard if patient is same as policy holder)

**Primary Insurance Company** \_\_\_\_\_ Group # \_\_\_\_\_ ID # \_\_\_\_\_

Policy Holder \_\_\_\_\_ Policy Holder's Social Security \_\_\_\_\_

Policy Holder's Date of Birth \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**Secondary Insurance Company** \_\_\_\_\_ Group # \_\_\_\_\_ ID # \_\_\_\_\_

Policy Holder \_\_\_\_\_ Policy Holder's Social Security \_\_\_\_\_

Policy Holder's Date of Birth \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

## GUARANTOR OR RESPONSIBLE PARTY FOR PATIENT'S FINANCIAL OBLIGATIONS, \*\*\*NOT YOUR INSURANCE

### COMPANY\*\*\*

Full Legal Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security Number \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer's Phone Number ( ) \_\_\_\_\_ Home Phone Number ( ) \_\_\_\_\_

Alternate Phone Number ( ) \_\_\_\_\_

## IN CASE OF EMERGENCY:

Contact Person \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number: Work ( ) \_\_\_\_\_ Home ( ) \_\_\_\_\_

**Federal Statistical Information:** Primary Language: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

## Patient Information

(\_\_\_\_\_) **Payment Policy:** Payment is required at the time of service unless prior arrangements were made in advance. Payment includes any and all applicable co-pays, co-insurance or deductibles. For your convenience, The Ear Institute of Texas accepts Visa and MasterCard. There is a \$35.00 service fee for returned checks. Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider.

(\_\_\_\_\_) **Insurance:** The Ear Institute of Texas bills participating insurance companies as a courtesy to our patients. You are expected to submit payment for all applicable co-pays, co-insurance or deductibles at the time services are rendered, based on the requirements of your individual insurance plan. If payment is not received from your insurance company, the total balance due will be your responsibility. **Due to various insurance provisions, we ask that you verify your individual benefits with your insurance provider. The Ear Institute of Texas acts only in an advisory capacity when sharing insurance benefits.**

(\_\_\_\_\_) **Missed Appointments:** The Ear Institute of Texas is committed to providing quality services to as many patients as possible. Resources are assigned for each individual patient. Missed appointments represent a cost to the Ear Institute of Texas and are an inconvenience to other patients who could have been scheduled for that time.

We require a 24-hour notice to cancel your scheduled appointment. Failure to provide a 24-hour notice to cancel your scheduled appointment **will result in a “no-show” fee of \$50.00.** A no-show fee must be paid prior to being seen at your next visit. Please note that insurance companies do not pay for no-show fees and therefore will not be billed for that charge.

Due to the resources allotted for Vestibular testing, you will be charged a **\$75.00 cancellation fee if you do not provide cancellation notice at least 2 business days prior to your testing appointment;** or, if you elect to cancel the testing up to and including the time of your scheduled appointment.

A cancellation policy applies to our surgical patients as well. Any scheduled surgery must be cancelled at least 72-hours prior to the scheduled surgery date. **Failure to provide at least a 72-hour notice of cancellation will result in a “no-show” fee of \$250. Cancellations less than 24-hours will result in a “no-show” fee of \$500.**

(\_\_\_\_\_) **Physician Assistant:** The Ear Institute of Texas employs physician assistants to support the physician with the volume of patients requiring medical care each day. The physician assistant is highly qualified and trained specifically by Dr. Jackson to treat the medically complex patients seen in this office. Dependent upon the daily schedule, patients may be seen by either the physician assistant, or by the physician.

The physician supervises the care of each and every patient but does require assistance to ensure patients are cared for in a timely manner. In some instances, the Physician Assistant may begin evaluation of a patient on Dr. Jackson’s schedule. However, the patient will still be seen by Dr. Jackson if requested.

**Please sign and date this form prior to your first visit. Feel free to ask our reception staff or the office manager should you have any questions in regard to the information contained within this form. Thank you for being our valued patient.**

**Patient/Guarantor/Legal Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient printed name:** \_\_\_\_\_





**Voice & Swallowing Institute of Texas**  
**18518 Hardy Oak Blvd., Ste. 300**  
**San Antonio, TX 78258**

**EAT-10**

Swallowing issues, Dysphagia

Circle the appropriate response. To what extent are the following scenarios problematic for you?

0= No Problem

4= Severe Problem

My swallowing problem has caused me to lose weight	0	1	2	3	4
My swallowing problem interferes with my ability to go out for meals	0	1	2	3	4
Swallowing liquids takes extra effort	0	1	2	3	4
Swallowing solids takes extra effort	0	1	2	3	4
Swallowing pills takes extra effort	0	1	2	3	4
Swallowing is painful	0	1	2	3	4
The pleasure of eating is affected by my swallowing	0	1	2	3	4
When I swallow food sticks in my throat	0	1	2	3	4
I cough when I eat	0	1	2	3	4
Swallowing is stressful	0	1	2	3	4

Total: \_\_\_\_\_

Name (print) \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**Voice & Swallowing Institute of Texas**  
**18518 Hardy Oak Blvd., Ste. 300**  
**San Antonio, TX 78258**

**RSI**

Dysphagia, Reflux, Globus, Sore Throat

Within the last month, how did the following problems affect you? Circle the appropriate response:

0= No Problem

5= Severe Problem

Hoarseness or a problem with your voice	0	1	2	3	4	5
Clearing your throat	0	1	2	3	4	5
Excess throat mucus or postnasal drip	0	1	2	3	4	5
Difficulty swallowing food, liquids, or pills	0	1	2	3	4	5
Coughing after you ate or after lying down	0	1	2	3	4	5
Breathing difficulties or episodes	0	1	2	3	4	5
Troublesome or annoying cough	0	1	2	3	4	5
Sensations of something sticking in your throat or a lump in your throat	0	1	2	3	4	5
Heartburn, chest pain, indigestion, or stomach acid coming up	0	1	2	3	4	5

Total: \_\_\_\_\_

Name (print) \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**Voice & Swallowing Institute of Texas**  
**18518 Hardy Oak Blvd., Ste. 300**  
**San Antonio, TX 78258**

**VHI-10**

These are statements that many people have used to describe their voices and the effects of their voices on their lives. Circle the response that indicates how frequently you have the same experience.

0= never    1= almost never    2= sometimes    3= almost always    4= always

My voice makes it difficult for people to hear me	0	1	2	3	4
People have difficulty understanding me in a noisy room	0	1	2	3	4
My voice difficulties restrict personal and social life	0	1	2	3	4
I feel left out of conversations because of my voice	0	1	2	3	4
My voice problem causes me to lose income	0	1	2	3	4
I feel as though I have to strain to produce voice	0	1	2	3	4
The clarity of my voice is unpredictable	0	1	2	3	4
My voice problem upsets me	0	1	2	3	4
My voice makes me feel handicapped	0	1	2	3	4
People ask, "What's wrong with your voice?"	0	1	2	3	4

Total: \_\_\_\_\_

Name (print) \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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**Singing VHI-10**

**- FOR SINGERS ONLY -**

These are statements that many people have used to describe their singing and the effects of their singing on their lives. Circle the response that indicates how frequently you have had the same experience in the last 4 weeks.

0= never    1= almost never    2= sometimes    3= almost always    4= always

It takes a lot of effort to sing	0	1	2	3	4
I am unsure of what will come out when I sing	0	1	2	3	4
My voice “gives out” on me while singing	0	1	2	3	4
My singing voice upsets me	0	1	2	3	4
I have no confidence in my singing voice	0	1	2	3	4
I have trouble making my voice do what I want it to	0	1	2	3	4
I have to “push it” to produce my voice when singing	0	1	2	3	4
My singing voice tires easily	0	1	2	3	4
I feel something is missing in my life because of my inability to sing	0	1	2	3	4
I am unable to use my “high voice.”	0	1	2	3	4

Total: \_\_\_\_\_

Name (print) \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_