Please take a moment to familiarize yourself with the office policies and procedures

of the

Ear Institute of Texas and the Voice & Swallowing Institute of Texas ("EIT")

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 <u>your responsibility</u> 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

(_____) initial Your confidential information could potentially be transmitted to those who are not authorized to receive such information. 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

(_____) initial 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.

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.

General disclosure: Dr. Jackson functions as investor or in advisory role for the following companies: St. Raphael's Surgery Center, Precision Neuromonitoring, Astute Assistants, 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 feasor 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 ALL 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 Problems	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 ALL other illnesses,**		
Epilepsy.....	Yes	No	Heart Disease (Besides BP)	Yes	No	Hepatitis A/B/C....	Yes	No	**past or present:** _____		
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 ___

Immunizations: Up to date ___ Not Current ___

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 Murmur..... 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 Psychriatric 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 _____

FAX 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

(_____) initial **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.

(_____) initial **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.**

(_____) initial **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.**

(_____) initial **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: _____