



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



CONSENT TO TREAT AND PATIENT RESPONSIBILITIES

Patient Name: _____ Date of Birth: _____

If the patient is a minor, please complete the following:

Your name: _____ Telephone #: _____

Your address: _____

Relationship to patient: _____ Parent _____ Guardian _____ Other (explain) _____

I hereby consent to the provision of care, diagnosis and/or treatment by the Ear Institute of Texas, the Voice & Swallow Institute of Texas and/or the Hearing Institute of Texas. This consent shall apply to physicians, non-physician providers, audiologists, and any other employee working under the direction of the physician, or other professional medical care provider, to provide medical care for me (or to the patient). This consent includes contact and discussions with other health care professionals for care and treatment as well as your health insurance plan company.

I understand that I have the right to refuse any diagnostic testing or other recommendations by my health care provider.

PATIENT RIGHTS

- To be treated with courtesy and respect and protection of your privacy.
- To prompt and reasonable response(s) to questions and requests.
- To know who is providing your medical care and/or testing at the time of your visit.
- To be provided information concerning diagnosis and treatment.
- To impartial access to medical treatment or accommodations regardless of race, national origin, religion, sexual orientation, gender identity, or handicap.
- The right to privacy and confidentiality of all records pertaining to your treatment.
- To have access to senior management for complaints, compliments, or other clinic related matters.

Signature: _____ Date Signed: _____

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.

EMERGENCY CONTACT(s): Contact Person Name: _____ Relationship: _____
Emergency Contact Phone Number(s): Mobile: _____ Work: _____ Other: _____

General disclosure: Dr. Jackson functions as investor or in advisory role for the following companies: 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.

Signature: Patient/Guarantor/Legal Guardian Date of Birth

Print Name: Patient/Guarantor/Legal Guardian Date

HEALTH HISTORY

Patient Name Age: Birthdate / /

Chief Complaint/Reason for today's visit:

Do you experience tinnitus (ringing in your ears)? Yes No Do you experience dizziness? Yes No

Table with 3 columns: List ALL Surgeries, Year, Complications

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

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

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)

Table listing various medical conditions like Meningitis, Spine/Back Problems, Arthritis, etc. with Yes/No columns.

Patient Social History

Occupation: Marital Status: Single: Married: Separated: Divorced: Widowed: Do you have children: Do you smoke? Do you drink alcohol? If yes, how often?

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

Table for family medical history with columns for condition and 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

Table for listing current medications with columns for Name, Dose, Frequency.

Preferred Pharmacy: Location: Phone #

Primary Care Physician:

No change since my last visit. Signature: 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: Doctor's Referral, Phone Book, Insurance Provider List, Web-Page, Friend, Other _____

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 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 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

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

I understand that providing incorrect information may be detrimental to my health. Please inform this office of any changes in your 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

Revised 2.16.18

PATIENT INFORMATION

Patient Policy: Payment is required at the time of service unless prior arrangements were made. Payment includes any and all applicable co-pays, co-insurance, or deductibles. For your convenience, this office accepts Visa, MasterCard, Debit cards, cash and local checks. There is a \$35.00 service fee for returned checks. () Initials

Services Not Covered: 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 responsible for payment of these charges at the time the services are provided. () Initials

Insurance: This office 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 the various insurance plans, we ask that you verify your individual benefits with your insurance provider. This office provides your plan information as a courtesy only and is not responsible for interpretation of your individual plan. I hereby authorize this office to release all medical information to my health insurance provider in order to process my claim; and, I hereby assign all health insurance plan reimbursements to this office.** () Initials

Missed Appointments: This office is committed to providing quality services to as many patients as possible. Resources are assigned for each individual patient. Missed appointments (including being 15-minute or more late for your scheduled appointment) represent a cost to this office and are an inconvenience to other patients who could have been scheduled for your assigned time slot. **WE REQUIRE A 24-HOUR NOTICE TO CANCEL YOUR SCHEDULED APPOINTMENT, 48-HOURS TO CANCEL YOUR VESTIBULAR TESTING AND 72-HOURS TO CANCEL YOUR SURGERY.** () Initials

The cancellation fees are: \$50.00 for an appointment, \$75.00 for vestibular testing and \$250.00 for surgery (cancelled in less than 72-hours prior to your scheduled time) and \$500.00 (if cancelled less than 24-hours prior to your scheduled time). These fees may also apply to patients who are more than 15 minutes late for their scheduled appointment. () Initials

Mid-Level Providers: Dr. Jackson and Dr. Bain employ mid-level providers (physician assistant and/or nurse practitioner) to support them in caring for the high volume of patients requiring medical care each day. The mid-level providers are highly qualified and trained by the doctors to treat the medically complex patients seen by the doctors. Patients may be seen by either the physician or one of the mid-level providers. The individual doctor supervises the care of each of their patients but do require assistance to provide care in a timely manner. In some instances, the mid-level provider will begin evaluation of a patient on the doctor's schedule. You may request to see the doctor, if necessary. () Initials

Please initial each item above and sign/date this form prior to your first visit. Feel free to ask our reception staff or the office manager should you have any questions regarding the information contained within this form. Thank you for being our valued patient!

Patient/Guarantor/Legal Guardian Signature: _____

Date: _____

Printed Name: _____