EAR INSTITUTE OF TEXAS

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

VOICE & SWALLOWING INSTITUTE OF TEXAS

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

(_____) 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):

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Name **Relationship**

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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.

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Signature: Patient/Guarantor/Legal Guardian **Date of Birth**

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

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: _____

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

List ALL 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)***

Mamogram

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/ Did you use any other form of tobacco/nicotine: Yes No What type:_____How much:_____ For how long:_____

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:_____

No change since my last visit. Signature: _____ Date: _____ 10.16.19

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 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

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 SCHEUDLED 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:** _____