EAR INSTITUTE OF TEXAS

The Ear Institute of Texas, P.A.

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

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)

_____ _____
Name **Relationship**

_____ _____
Name **Relationship**

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: _____ Date of Birth: _____/ _____/ _____

Chief Complaint/Reason for today's visit: _____

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

Do you experience tinnitus (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)*

Pacemaker	Yes No	Bleeding Tendency	Yes	No	Asthma	Yes	No	Diabetes I or II	Yes	No
Meningitis	Yes No	High Blood Pressure	Yes	No	Hives or Eczema	Yes	No	High Cholesterol	Yes	No
Spine/Back Problems	Yes No	Low Blood Pressure	Yes	No	AIDS or HIV+	Yes	No	**Please list ALL other illnesses,**		
Arthritis	Yes No	Heart Disease (Besides BP)	Yes	No	Stroke	Yes	No	past or present: _____		
Epilepsy	Yes No	If yes, what type (Circle all that apply):	Hepatitis A/B/C		Yes No			_____		
Migraine Headaches	Yes No	A.Fib; Coronary Artery Disease;	Kidney Disease		Yes No			_____		
Other Headaches	Yes No	Heart Attack;Valve Issues; Other:_____	Thyroid Disease		Yes No					
Cancer	Yes No	Cancer treatments (Check all that apply): Surgery _____ Radiation _____ Chemo _____								

Type/Location: _____ Are you cancer free at this time? Yes No

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:_____

How did you hear about us? (Circle one) Friend Internet Ad Doctor:_____ Other::_____

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PATIENT INFORMATION

DATE: _____ CHART # _____

Full Legal Name _____ Sex _____ Age _____ Date of Birth: _____/ _____/ _____

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 _____ Sex _____ Age _____ Date of Birth: _____/ _____/ _____

Social Security _____/ _____/ _____ 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 _____

Work Phone Number: ( ) _____ Home Phone Number: ( ) _____

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		
Rarely / Occasional / Constant		
Ear Pain	Yes	No
Ringing in the Ears	Yes	No
If yes, circle one of the following:		
Left / Right / Both Sides		
Rarely / Occasional / Constant		
Dizziness	Yes	No
If yes, circle one of the following:		
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 Weakness	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	N0

Hematologic/Lymphatic

*Anemia	Yes	No
*Hemophilia	Yes	No
Persistent 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	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	Yes	No
Arms and/or Legs	Yes	No
Weakness in Arms or Leg	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: _____

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 **or not arriving in time to complete your paperwork prior to the scheduled appointment time**) 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 (canceled in less than 72-hours prior to your scheduled time) and $500.00 (if canceled 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 employs mid-level providers (physician assistant and/or nurse practitioner) to support him in caring for the high volume of patients requiring medical care each day. The mid-level providers are highly qualified and trained by the doctor 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: _____