Farris Memorial ENT

1706 E Joyce Blvd, Ste. 1, Fayetteville, AR 72703

Patient Information

Patient Name_____

Birthdate _____/_____/_____ **Age**_____ **Sex:** ❑ **M** ❑ **F** **SSN#**_____

Address_____**City**_____**State**_____**Zip Code**_____

Home phone:_____ **Cell Phone:**_____

Employer:_____ **Work Phone:**_____

Email address:_____@_____ **How is the best way to contact you: With letter? Patient portal?**

Please check one: ❑ Married ❑Single ❑Widowed ❑other **Spouse Name:**_____

Ethnicity (Origin)**:** ❑ Not Hispanic or Latino
❑ Hispanic or Latino

Spouse: DOB:_____SSN#_____

Spouse: Phone:_____ Employer:_____

Race:❑White ❑African American ❑Asian ❑Native Hawaiian/Other Pacific Islander ❑Native American Indian/Alaskan ❑Other Race

Preferred (primary) Language:_____ _____

Referring Physician:_____ **Primary Care Physician:**_____

Preferred Pharmacy & Location: _____

Who is bringing in minor patient today: _____

If patient is a minor please give us parent/guardian's information below.

Father's/Guardian Name_____**DOB**_____**SSN**_____

Address if different from child's_____**City**_____**State**_____**Zip Code**_____

Home Phone Number ( )_____ **Cell Phone Number ( )**_____

Employer _____ **Work Phone ( )** _____

Mother's/Guardian Name _____ **DOB**_____**SSN**_____

Address if different from child's_____ **City**_____**State**_____**Zip Code**_____

Home Phone Number ( )_____ **Cell Phone Number ( )**_____

Employer _____ **Work Phone ( )**_____

Please **turn this form over** and complete page two of this form. We need a signature at the bottom of page two to be able to treat you today.

Is this visit related to an Accident/Injury? ❑ YES ❑ NO

If YES, please supply date of accident/injury_____ Accident Time:_____ ❑ AM ❑PM
If YES, was this accident/injury automobile related? ❑ YES ❑ NO

If auto related please list auto insurance coverage: _____

Is this visit to be filed with Worker's Comp? ❑ YES ❑ NO

If YES to Worker's Comp, Please supply Company Name and Contact Person _____

_____

All worker's comp patients must have written proof from their employer stating this claim is approved for w/c payment and where to send bills.

Please give insurance identification cards to the receptionist to be photocopied/ Scanned and placed in your permanent record. <u>If you don't have your card please fill out information below</u>:

Name of Primary Insurance Company_____

Address_____City _____State _____Zip Code_____

Policy/Group number_____ I.D. number_____

Name of Insured_____SSN of Insured_____

Insured's Employer_____Address_____

City_____State_____Zip Code_____

Name of Secondary Insurance_____

Address_____City_____State_____Zip Code_____

Policy/Group number_____I.D. number_____

Name of Insured_____ SSN of Insured_____

Insured's Employer_____ Address _____

City_____State _____Zip Code _____

Consent to Treat/Assignment of Benefits

By signing below I, or my authorized representative on my behalf, authorize Dr. Paul Farris and or his staff to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries. I understand that it is the responsibility of my individual treating healthcare providers to explain to me the reason for any particular diagnostic examination, test or procedures, the available treatment options and the common risks and anticipated burdens and benefits associated with these options as well as alternative courses of treatment

I authorize the release of any medical information necessary to process insurance claims and payment of medical benefits to provider or supplier. I authorize the release of all or part of the patient's medical records to physician's office(s) in the event that the doctor needs to refer outside of Farris Memorial ENT for medical treatment.

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I certify that all information provided is true and correct to the best of my knowledge. I will notify you of any changes in the above information. The undersigned hereby authorizes any insurance payments be assigned directly to Dr. Paul Farris for services rendered.

Signed_____Date _____

Farris Memorial ENT, PA

PATIENT NAME: _____ DATE: _____

Past Medical History

Do you have, or ever had, any of the following? Please circle

Allergies	Yes/No	Hearing problems	Yes/No
Anesthesia Difficulties	Yes/No	***Heart problems *Please specify below***	Yes/No
Arthritis	Yes/No	High Blood Pressure	Yes/No
Asthma or breathing problems	Yes/No	HIV or AIDS	Yes/No
Bleeding disorders	Yes/No	***Kidney Disease *Please specify below***	Yes/No
Cancer *Please specify below	Yes/No	***Neurological Disorder *Please specify below***	Yes/No
Coronary Artery Disease	Yes/No	Seizures	Yes/No
Diabetes	Yes/No	Snoring/Sleep Apnea problems	Yes/No
Emphysema	Yes/No	Stroke	Yes/No
Hepatitis	Yes/No	***Thyroid Problems *Please specify below***	Yes/No
Latex Allergy	Yes/No	Dementia/Alzheimer's	Yes/No

Please list any other serious or chronic illness not covered by above:

*

_____

_____

_____

Prescription Medications: ☐NONE

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

OVER →

ALLERGIES: Please List any medications that you are allergic to:

_____

_____

Past Surgical History

Procedure	Date	Location

Family History

Mark any disease known to have occurred in the family with the appropriate initial: **M**-mother, **F**-father, **GM**-grandmother, **GF**-grandfather, **A**-Aunt, **U**-uncle, **B**-brother, **S**-Sister, **C**-cousin

Dementia/Alzheimers		Cancer		Hearing Problems		Obesity	
Asthma		Stroke		High Cholesterol		Blood Clots	
Alcoholism		Depression/Mental Illness		High Blood Pressure		Kidney Problems	
Heart Disease		Developmental problems		Diabetes		Seizures	
Migraines		Sickle Cell					

Alcohol use: Yes/No If yes, how much and how often:_____

Vaping use: Yes/No

Tobacco use: Type: ☐ never smoked ☐ cigarettes/cigars ☐ smokeless tobacco

Year started: _____ Year stopped:_____

How much : _____per day/per week

Name of person completing this form if not patient:_____

FARRIS MEMORIAL ENT, PA

OFFICE POLICY RULES

Dear Patient:

Thank you for choosing us as your health care provider. Our main concern is that you receive the proper treatments needed to restore your health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to ask.

We ask that all patients read and sign our Office Policy Rules as well as complete our Patient Information Form Prior to seeing the doctor.

Payments for services are due at the time services are rendered unless prior arrangements are made with the office manager. Insured patients will need to pay either their deductible, co-pay or co-insurance amounts due. If we are in a contract agreement with your insurance company, and you have a specialist co-payment or allowed amount, then that amount can be paid. Just a reminder, not all co-payments apply to specialist. Please check with your insurance concerning this prior to services.

By Law we are required to have the patient, prior to being seen, sign a consent for use or disclosing protected health information to carry out treatment, payment, or healthcare operations. By signing this form you are hereby agreeing to this consent.

As a courtesy to our patients we file most primary insurance carriers. If you wish to file the claim yourself, please advise the front office staff prior to being seen. If for some reason we cannot file your insurance claim, we will send you a standardized insurance form in the mail within 7 to 10 business days for you to forward to your insurance carrier.

We attempt to file most secondary insurance carriers except Champus/Champva/Tricare. If for some reason we cannot file with your secondary insurance company, we will send you the claim form to file with them upon your oral or written request. You will need to attach our form to a copy of your primary insurance carrier's Explanation of Benefits and mail it to your secondary insurance carrier. There is a $5 charge for any reprints of insurance forms.

However, you must understand that:

1) Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract, our relationship is with you, not your insurance company.

2) **All charges are your responsibility whether your insurance company pays or not. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover**.

3) Fees for surgery (ies), along with unpaid deductibles and co-payments are due prior to surgery date.

4) If the insurance company does not pay your balance in full within 60 days from the date services were rendered, we require that you pay the balance due or make regular monthly payments on your account.

5) Returned checks are subject to a $25 NSF fee. Balances older than 60 days past due without a regular monthly payment will be subject to interest charges of .50 per month to help cover postage

6) Overpayment or Refunds will be mailed back to the patient after a 10 business day waiting period. Amounts under $5 will be applied as a credit to the patients account.

7) **Be aware that certain procedures may not be included in your Office Visit co-pay/allowed amount and will be an additional charge. These include but are not limited to: video scope of the nose/throat, hearing test, nasal cautery/pack, biopsy, foreign body removal**.

Please remember that there are other patients that could use an appointment time. We ask that you call us as early as possible if you need to cancel your appointment. No-show appointments could be subject to the rate of a normal office visit charge. Please call if you have to cancel or reschedule an appointment.

Again, thank you for choosing our office as your health care provider. We appreciate your trust in us and we honor the opportunity to serve you. Your signature below will be for the intent of all services from this date forward.

Patient Signature:_____ (OR guardian/parent/legal representative)

Date:_____

OVER →

Farris Memorial ENT

1706 E. Joyce, Suite 1, Fayetteville, AR 72703

Patient acknowledgement of Receipt of Privacy Notice

I understand that as part of the provision of healthcare service, Farris Memorial ENT creates and maintains healthcare records and other information describing among other things, my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and will provide me the new Notice of Privacy Practices if there are any changes.

I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be uses or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

This acknowledgement is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or healthcare operations without my prior written authorization, except as otherwise provided by law.

2. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or healthcare operations be restricted. I also understand that the Practice and I must: agree to any restrictions in writing on the use and disclosure of my Protected Heath Information, and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which I have been previously agreed upon.

_____ _____

PATIENT'S NAME DATE

_____ _____

PATIENT'S SIGNATURE DATE OF BIRTH

(Please list the names of the individuals with whom we may discuss your protected health information)

Name	Relationship to patient

This authorization is given freely with the understanding that: any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law. A photo copy or fax of this authorization is as valid as this original. I may revoke this authorization at any time, except where information has already been released. This revocation must be in writing. Farris Memorial ENT, its employees, officers, and physician are hereby released from any legal responsibility or liability for disclosure of the protected health information to the extent indicated and authorized herein.

Patient Portal Use Agreement - Farris Memorial ENT

Patient name:_____

Farris Memorial ENT provides this site in partnership with eClinicalWorks for the exclusive use of its patients. The patient portal is designed to enhance patient-physician communications and improve patient care and satisfaction.

We strive to keep all of the information in your records correct and complete. If you identify any discrepancy on your record, you agree to notify us immediately. Additionally, by using the patient portal, the user agrees to provide factual and correct information.

The patient portal provides the following services:
- Access to view and print your Personal Health Record (PHR)
- Review of the patient's visit summary, medication list, treatment history
- Email secure messages for non-urgent needs
- View lab results that have been sent to you
- Medication refill requests
- Update your demographic information

___ My email address for the patient portal is: _____

___ I prefer not to sign up for the patient portal.

The patient portal is not designed to provide internet based diagnostic services. Also the following limitations apply:

- No internet based triage or treatment requests can be made. Diagnosis can only be made and treatment rendered after the patient schedules and sees the provider.
- No emergent communications or services are provided. Any emergent conditions should be seen by urgent care appointment, the Emergency Department of the local hospital, or by calling 911.
  DO NOT USE THE PORTAL TO COMMUNICATE IN AN EMERGENCY
- You cannot request re-fill medication not currently prescribed by your physician.
- No requests for narcotic patient medication will be accepted.

The patient portal is provided as a courtesy to our valued patients. If abuse or negligent usage is suspected, Farris Memorial ENT reserves the right at our own discretion to terminate patient portal offering, suspend user access, or modify services offered through the patient portal.

Protecting Your Private Health Information and Risks

Farris Memorial ENT understands the importance of privacy in regards to your health care and will continue to strive to make all information as confidential as possible. Your private information, including email addresses, will never be sold or shared, without your written consent.

The patient portal is provided in partnership with our software vendor. The data is provided through a secure web portal which uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log in to the portal site.

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect and we will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors: the secure message must reach the correct email address, and only the correct individual (or someone authorized by that individual) must be able to get access to it.

If you pick up secure messages from a website, you need to keep unauthorized individuals from learning your password. If you think someone has learned your password you should promptly go to the website and change it. Please make sure to provide us with your correct email address and you must inform us if it ever changes.

Please read our HIPAA policy for information on how personal health information (PHI) is used at Farris Memorial ENT. All new and established patients have signed a HIPAA Notice of Privacy Practices Acknowledgement and have been given a copy of our HIPAA Privacy Policy. If you do not recall having signed a HIPAA acknowledgement or need to reacquaint yourself with our HIPAA policy, a printed or electronic copy in format will be provided to you for your review.

I acknowledge that I have read and fully understand this consent form. I have been given the risks and benefits of patient portal use and agree that I understand the risks associated with online communications between my physician and patient, and consent to the conditions outlined herein. I acknowledge that using the patient portal is entirely voluntary and will not impact the quality of care I receive from Farris Memorial ENT should I decide against using the patient portal. In addition, I agree to adhere to the policies set forth herein, as well as any other instructions or guidelines that my physician may impose for online communications. I understand that my email address is required for Farris Memorial ENT to enable my secure patient portal account, and provide instructions regarding how to use the account. I authorize Farris Memorial ENT to utilize my email address for this purpose only.

Patient signature _____ (OR guardian/parent/legal representative)