Med Center Health

ENT

Today's Date:	Referring Provider:	Primary Care Provider:
Last Name:	First Name:	MI:
Preferred Name:	Name Suffix: Jr. Sr. I II III IV	

Pharmacy Information

Pharmacy Name:	Pharmacy Location:

Patient Information - A Picture ID and Insurance Card is Required of all Patients

Date of Birth:	Male/Female	SS#:	
Race:	Ethnicity:	Marital Status:	Language:

Address:

City:	**State:**	**Zip Code:**
Home Phone:	Work Phone:	Cell Phone:

Have you registered for our patient portal? **Give us your EMAIL** :

How would you like to be contacted: Home Phone Cell Phone Email Text Patient Portal

Employer:	Occupation:
Employer Address:	Employer Phone #:

Payment Responsibility - Patient, Parent, Guardian or Advocate

Name:	Relationship:
SS#:	DOB:

Address, if different from patient:

Insurance Information

Primary Ins:	Policyholder's Name:
Policyholder's DOB:	Policyholder's SS#:
Secondary Ins:	Policyholder's Name:
Policyholder's DOB:	Policyholder's SS#:

In Case of Emergency

Name:	Contact #:

What is the purpose of your visit today?

Please Circle Any of the Symptoms you have been experiencing

GENERAL: fatigue fever chills night sweats

EYES: eye pain double vision blurred vision changes in vision

HENT: nasal obstruction nasal congestion nose bleeding nasal discharge hearing loss

CARDIOVASCULAR: chest pain irregular heartbeats lower extremity edema

RESPIRATORY: shortness of breath wheezing cough

GASTROINTESTINAL: nausea vomiting diarrhea constipation

GENITOURINARY: dysuria nocturia urinary hesitancy

INTEGUMENT: rash itching skin dryness changes to existing lesions

NEUROLOGICAL: muscular weakness incoordination memory difficulties

MUSCULOSKELETAL: joint pain joint swelling muscle pain

ENDOCRINE: loss of hair heat intolerance weight gain weight loss

PSYCHIATRIC: anxiety depression mood swings

HEME LYMPH: easy bleeding easy bruising lymph node enlargement or tenderness

ALLERGIC-IMMUNOLOGIC: sneezing eye irritation

Signature: **Date Signed:**

Med Center Health

ENT

Patient Name: _____

Height: **Weight:** **DOB:**

LIST ALL MEDICATIONS

MEDICAL HISTORY

Have you ever had or do you have any of the following medical problems?

Please circle all that apply

Alcoholism	Diabetes	Liver Problems
Anemia	Emphysema	Lung Problems
Arthritis	Glaucoma	Lupus
Asthma	Hearing Loss	Mental Illness
Birth Defect	Heart Attack\Angina	Stroke
Bladder Disease	Heart Failure	Seizures
Bleeding Disorder	High Blood Pressure	Sexually Transmitted Disease
Cancer	Kidney Problems	Thyroid Disease

List all food/medication allergies: _____

Date of your last flu shot: _____

List any medical problems not listed above: _____

Lisa all surgeries you've had: _____

FAMILY HISTORY

Has anyone in your family had any of the following medical problems? Please indicate relative

F=Father, M=Mother, G=Grandparent, S= Sibling

__Alcoholism	__Diabetes	__Liver Problems
__Anemia	__Emphysema	__Lung Problems
__Arthritis	__Glaucoma	__Lupus
__Asthma	__Hearing Loss	__Mental Illness
__Birth Defect	__Heart Attack\Angina	__Stroke
__Bladder Disease	__Heart Failure	__Seizures
__Bleeding Disorder	__High Blood Pressure	__Sexually Transmitted Disease
__Cancer	__Kidney Problems	__Thyroid Problems

SOCIAL HISTORY

Occupation: _____

Are you currently using tobacco products? _____ How Much: _____ How Long? _____

Are you exposed to secondhand smoke? _____ How Often? _____ How Long? _____

Med Center Health

ENT

Consent, Assignment of Benefits & Financial Agreement

Consent to Diagnostic Tests, Medical Treatment and Procedures:
I do voluntarily consent to care involving diagnostic tests, medical treatment and procedures by the physicians/practitioners of Commonwealth Health Corporation, d/b/a ENT of Bowling Green, their assistants and designees, and other employees of ENT of Bowling Green as is necessary or advisable in their judgment. This consent includes testing for communicable diseases, including but not limited to Human Immunodeficiency Virus (HIV), hepatitis or any other blood-borne infectious disease if ordered for a diagnostic purpose or due to occupational exposure of a health care worker. I acknowledge no guarantee has been made to me as to the results of examination and treatment.

Assignment of Benefits and Financial Agreement:
I certify all information given by me is correct and I accept responsibility for the charges for the care provided. I agree to the assignment of all third-party benefits to ENT of Bowling Green and to any physician, practitioner, organization or independent contractor who provided products or services, and agree to pay all charges not covered by third-party payers. If I am covered by an ERISA plan, with this assignment I specifically authorize my providers to receive copies of all notifications and information that I am legally entitled to receive under the terms of my insurance/health plan and to act on my behalf to appeal benefit determinations. I acknowledge any claim for benefits from a third party payer may be filed by ENT of Bowling Green as a courtesy to me. However, I am primarily responsible for monitoring the filing process and making certain the claim is filed in compliance with the provisions specified by the applicable third party payer. The filing of the claim by ENT of Bowling Green in no way releases me from liability for any portion of the bill not paid by a third party payer for any reason. This writing is intended to be the complete and exclusive statement of the terms and conditions regarding my assignment of benefits and supersedes all previous communications, representations or agreements, whether oral or written. Any terms or conditions proposed by me or on my behalf that differ from or are in addition to the terms of this agreement are rejected and shall not become part of this agreement.

Unless other payment arrangements are approved by ENT of Bowling Green, the account balance is due upon demand. Failure to pay for the services may result in the placement of an account with a collection agency or attorney for collection. All amounts due, as shown in the final statement and/or amended final statement, shall bear interest from the due date until paid at a per annum rate of eight percent (8%). In the event there is a judgment, the amount due shall accrue interest at the judgment rate of six percent (6%) until paid in full. Further, I agree to pay all costs of collection including court costs, interest, attorney fees and collection agency fees.

Contact Information:
I agree ENT of Bowling Green, Commonwealth Health Corporation and their agents, attorneys or collection agencies may contact me regarding medical information or information about my account or for the purposes of collection by telephone at any number provided by me including wireless telephone numbers, and via text messaging or e-mail to any e-mail address provided. Methods of contact may include the use of pre-recorded or artificial voice messages and/or automated dialing.

Release of Information:
I authorize the release of all or part of my records, including information stored in ENT of Bowling Green's corporate-wide database, to my physician(s), whose name I provided at the time of registration, and to any physician or practitioner who has or will provide services to me. I authorize the release of statistical information as required by any local, state or federal agency or managed care program. I authorize the release of my HIV test results to health care personnel in the event of an occupational exposure.

I authorize ENT of Bowling Green and any other holder of medical or other information to release information about me (including medical information concerning psychological or psychiatric conditions, alcoholism and/or drug related conditions and HIV or other blood-borne infectious diseases) as required to complete any claim for benefits due to services rendered to me to any person or corporation which is or may be responsible for all or part of the total charge incurred. The persons or corporations to which this information may be released includes, but is not limited to insurance companies, the Social Security Administration, its intermediaries and carriers, state agencies and workers' compensation carriers, as well as the review organization employed by my employer or the employer of the insured member of my family and any corporation engaged by ENT of Bowling Green to make collection of any unpaid charges. I further authorize my employer to release to ENT of Bowling Green or any agency engaged for the purpose of collecting any unpaid charges, verification of my employment status, including the amount of salary or wages and the number of hours worked.

Information Received:

_____ I acknowledge receipt of the NOTICE OF PRIVACY
(initial) PRACTICES.

_____ This authorization is valid until revoked in writing.
(initial)

_____ My medical/financial information may also be released to the
(initial) following persons.

_____

_____

Primary Care Physician: _____

If you were sent to us by another physician, please list the physician: _____

Print patient name: _____

_____ _____ _____ _____
Signature *Date* *Time* *Relationship (if not patient)*

_____
Witness

Original - Chart *Copy - Patient*

ENT of Bowling Green
CONSENT, ASSIGNMENT OF BENEFITS, & FINANCIAL AGREEMENT
03-461009 9/19

Med Center Health
ENT

Treatment with Controlled Substances

Patient Name: _____ DOB: _____

The physician/practitioner has discussed with me the option of treating my condition/pain with a controlled substance. By accepting the prescription for the controlled substance(s) that was prescribed to me, I acknowledge I understand there are inherent risks and benefits associated with treating my condition/pain with a controlled substance. These risks include developing drug tolerance and dependence.

It is my responsibility to take the medicine as prescribed and not more frequently than prescribed. I am not to share this medication with anyone else, including family members. The use of controlled substances can depress my senses and impact driving and work safety. It is discouraged during pregnancy, and may harm the unborn child. There is a potential for overdose, and if I suspect I have had an overdose I should call 911 or go to the emergency room as soon as possible.

The medication should be stored in a safe place, out of the reach of children, and should be properly disposed of after expiration. Any requests for refills must be made during weekday hours before the prescription has expired and may require an office visit.

I give permission for my entire prescription history to be obtained from my pharmacy.

_____ _____
Witness Patient Signature or Person Authorized to Consent for Patient

_____ _____ _____
Date Time Relationship to Patient

Med Center Health®

It is the policy of Med Center Health Physician Practices to monitor and manage appointment no-shows. This is necessary to ensure we are able to provide timely access for all patients. High numbers of vacant appointments delay care to all patients.

We understand that it is sometimes necessary to cancel and reschedule and that emergencies occur. If you have an appointment with one of our providers, your appointment must be cancelled or rescheduled at least 24 hours prior to the scheduled appointment time. Any patient who fails to arrive for a scheduled appointment without canceling or rescheduling that appointment at least 24 hours will be considered a “no-show.”

As a courtesy, an appointment email is sent out five (5) days prior to your visit; a phone call is sent out two (2) days prior; a text is sent the day of the appointment.

Our policy is that at two (2) “no-shows,” the patient is sent a warning letter with the dates of their missed appointments. At three (3) “no-shows,” the patient is sent a discharge letter from the practice and must seek care at another location.

Thank you,

Med Center Health Physician Practices

Med Center Health®

CONSENT TO PHOTOGRAPH, FILM, VIDEOTAPE AND/OR INTERVIEW FOR PUBLIC USE, INCLUDING SOCIAL MEDIA

The undersigned does hereby authorize Med Center Health (MCH), its subsidiaries, agents, and/or other persons to photograph, film, video tape and/or interview _____ *(print name)* of _____(*print department)* and agree that MCH may use or permit other persons to use the negatives, prints, images, name, story and information prepared therefrom for such purposes and in such manner as may be deemed necessary to transmit a story for public information and/or commercial presentation, including use on MCH/Subsidiaries' websites and social media platforms.

The undersigned has the right to request cessation of recording or filming. The undersigned may revoke this consent provided that the revocation is in writing signed by the undersigned and received by MCH within 24 hours of the recording or filming.

The undersigned expressly understands and agrees that no liability of any nature shall be attached to Med Center Health, Commonwealth Health Corporation, The Medical Center, and their respective employees in acting upon this authorization and request. A photocopy of this consent form shall be considered as valid as the original.

By signing this form, you acknowledge that you have read, understand and agree to be bound by the terms set forth in this form.

_____ Witness's signature

_____ Signature

_____ Date

_____ Phone Number

_____ Email

_____ Date _____ Time

Because the above is a minor, _____ years of age, the above consent is given on their behalf by:

_____ Witness's signature

_____ Legal guardian

_____ Date

_____ Date _____ Time

Purpose (Marketing Dept Only): _____