BASIC INFORMATION

Full Name ____
First Middle Last Suffix

Sex ○ Male ○ Female ○ Unknown Date of Birth ______/______/______

Primary Phone ○ Home ○ Mobile ○ Work Phone Number ______________________

Email ______________________ SSN# ______________________

Address 1 ______________________ Address 2 ______________________

City ______________________ State ____________ Zip ____________

Marital Status ______________________ Maiden Name ______________________

Drivers License State ______________________ Drivers License # ______________________

DEMOGRAPHICS

Hispanic or Latino? ○ YES ○ NO Ethnicity ____________ Race ____________ Language ____________

EMERGENCY CONTACT

Relationship to Contact ____

Full Name ____
First Middle Last Suffix

Primary Phone ○ Home ○ Mobile ○ Work Phone Number ______________________

Email ____

Address 1 ______________________ Address 2 ______________________

City ______________________ State ____________ Zip ____________

FINANCIAL INFORMATION

Responsible Party

Who will be financially responsible for you? ○ Myself ○ Someone else
If you checked "Someone else", please fill out the following.

Relationship to contact ____

Full Name ____
First Middle Last Suffix

Primary Phone ○ Home ○ Mobile ○ Work Phone Number ______________________

What method of payment? ○ Insurance ○ Self pay

If you have health insurance please fill out the following.

PRIMARY INSURANCE INFORMATION

Insurance Company ______________________ Policy Holder ______________________

Insurance Plan ______________________ Insurance Phone Number ______________________

Group Number ______________________

Insurance Company Address ______________________ Address 2 ______________________

City ______________________ State __________ Zip __________

Relationship to Primary Policy Holder ______________________

If YOU are not the primary policy holder, please fill out the following.

Full Name ______________________
First Middle Last Suffix

Sex ○ Male ○ Female ○ Unknown Date of Birth ______/______/______

Policy ID Number ______________________ SSN# ______________________

Policy Holder Address ______________________ Address 2 ______________________

City ______________________ State __________ Zip __________

If you are unable to provide your insurance information please provide a reason before proceeding.

SECONDARY INSURANCE POLICY

If you do not have a secondary policy please leave this information blank.

Insurance Company ______________________ Policy Number ______________________

Insurance Plan ______________________ Insurance Phone Number ______________________

Group Number ______________________

Insurance Company Address ______________________ Address 2 ______________________

City ______________________ State __________ Zip __________

Relationship to Secondary Policy Holder ______________________

ADDITIONAL INFORMATION

Please list your preferred pharmacies in the order of preference

Pharmacy Name ______________________ Pharmacy Address (& zip code) ______________________

Pharmacy Name ______________________ Pharmacy Address (& zip code) ______________________

Pharmacy Name ______________________ Pharmacy Address (& zip code) ______________________

How did you hear about us?

____

HIPAA Release of Information Authorization

Date: ___________________________

Patient Name: ____ DOB: _________________________

Patient Phone Number: _____________________________ Type: cell / work / home

Patient Email: ____

May we leave a voicemail? Yes / No

Consent for access to protected healthcare information

I, ______________________________ (patient name), give consent to the staff at Atkins Expert Sinus Care to release my medical information (appointments, labs/imaging results, treatments, medications, surgeries, etc) with the person(s) listed below. Atkins Expert Sinus Care may release my medical information in person, by telephone, mail, email, fax, or other means. I may withdraw this consent at any time by notifying Atkins Expert Sinus Care in writing. Any communication prior to such notice will be considered to have been authorized by me.

Patient Signature:____ Date:___________________

Name:_______________________________ DOB:_____________ Relationship:_________________

Name:_______________________________ DOB:_____________ Relationship:_________________

Name:_______________________________ DOB:_____________ Relationship:_________________

Name:_______________________________ DOB:_____________ Relationship:_________________

Name:_______________________________ DOB:_____________ Relationship:_________________

Clinic Cancellation, Rescheduling and No Show Policy

Our goal is to provide innovative, quality medical care in a timely manner. In order to do so we have had to implement a no-show / cancellation / rescheduling policy. This policy enables us to better utilize available appointments for our patients in need of medical care.

Late Cancellation of an appointment:
Canceling an appointment within 24 hours inconveniences those individuals who need access to medical care. Our office understands that emergencies happen and will not charge a fee for emergency cancellations. Non-emergent late cancellations will result in the following fees listed below.

Rescheduling appointments:
Rescheduling is moving a currently scheduled appointment to a new date to be seen. Rescheduling an appointment for the 3rd time will result in the following fees listed below.

No Show Policy:
A “no-show” is someone who missed an appointment without canceling it in an adequate manner. No-shows inconvenience those individuals who need access to medical care. A failure to be present at the time of a scheduled appointment will be recorded in the patient’s charges as a “no-show”.

The following are Atkins Expert Sinus Care’s fees:

Office Visit	$25.00
Allergy Test	$50.00
CT scan	$50.00
Allergy Test with CT scan	$100.00
Allergy SLIT	$75.00

Thank you for your understanding and cooperation.
By signing below you are acknowledging that you have read, understand, and accept our cancellation policy.

____
Patient Name (Printed)

____ ________________
Patient Signature Date

____ ________________
Witness Date

RECEIPT NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT

Please read and review our HIPAA Privacy Practices which are included in this packet before signing.
I, ____, have read a copy of Texas Sinus Center notice of Privacy Practices.

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process claims. I permit a copy of this authorization to be used in place of an original. I hereby authorize Texas Sinus Center PA to apply for benefits on my behalf for covered services. I request that payment from my insurance company be made to Texas Sinus Center. I certify that the information I have reported with regard to my insurance coverage is correct. I understand that I am responsible for payment of all medical services rendered. Any payments sent to me by my insurance company will be forwarded to the Texas Sinus Center to be applied toward my account should a balance exist.

Signature____ Date__________________________________
(Please circle: Patient Parent or Guardian)

FINANCIAL POLICY

All co-pays for office visits are due at the time of the visit. We will process your claim for services.

When your insurance company has processed your claim you will be expected to pay any outstanding balance(s).
All outstanding balances owed by you or your family must be paid before any additional services are rendered.

Our providers schedules are generally full weeks in advance therefore, we ask that you call to cancel or reschedule 3 days prior to your appointment.

We charge $25.00 for failing to notify us of cancellation or not showing for follow up appointments .
We charge $50.00 for failing to show for an Allergy Test or CT appointment.

Please be aware that our office charges for the following services.

Minimum $5.00 for Medical records and cost is based on the amount of records requested
Minimum $25.00 for Family Leave, Extended leave paperwork

NOTE: Absolutely no family leave, school or work excuses or forms will be granted 90 days after your surgery or it had been longer than 90 days since your last appointment.

___ /___ /___ ______________________________________ ______________________________________
Date Responsible Party (Print Name) Responsible Party (Signature)

CONSENT TO ACCESS MEDICATION RECORDS

For some patients it is possible for us to download your current medications from an online pharmacy database. Doing so helps us keep our records up to date and helps decrease prescribing errors.

I hereby give Texas Sinus Center permission to access my online pharmacy records to add a list of my medications to my records.

Signature:____ Date: __________________________

ADVANCED BENEFICIARY NOTICE

Diagnostic Procedures

It is the goal of the Texas Sinus Center to offer you the best treatment plan based on the most accurate diagnosis. To obtain this diagnosis our providers may recommend procedures or tests to be performed during your visit. These procedures may include, but are not limited to:

- Nasal Endoscopy – an in office surgical procedure using a sterile small camera to examine the nose.
- Laryngoscopy – an in office surgical procedure using a sterile small camera to examine the throat.

Depending on your insurance company's rules and regulations, you may be financially responsible for some or all of the cost of these procedures. These procedures are billed as SURGERY CHARGES, but there is NO SURGERY involved. This can be confusing when you get your bill. Call our office if you have questions regarding your bill.

___________ I understand that my co-pay is for a routine office visit. Additional diagnostic procedures (billed as office surgery) and tests are NOT included in a routine office visit and will result in additional charges. I will assume financial responsibility for charges that may be billed to me as a result of any diagnostic procedures / tests performed. Depending on my specific benefit plan the procedure / test charges may be applied to an annual deductible or co-insurance.

OR

___________ I do NOT authorize any procedures / tests to be performed during this visit, and by doing so, I understand that this may limit the information the doctor has available to determine the diagnosis and subsequent treatment.

CONSENT TO USE EMAIL AND CELL PHONE TEXTING

Texas Sinus Center uses email and texting as a way to communicate with our patients for the following reasons.

1. Medication Refills - We frequently communicate with patients about routine matters such as prescription status, medication refills etc.
2. Distribute Forms & Handouts - Patient registration documents, surgery information and medical handouts.
3. Communicate with you following procedures.
4. Important News - We send out 3-4 emails a year about important issues related to sinus/allergy problems.

If you give us your permission to use your email and text for the above, please sign, date and leave your email address and cell phone number below.

If you do not wish to receive emails or texts from us just leave the form blank. Please be reassured that we will never sell, rent or distribute your information to any third party.

Email address: ____ Texting #:_________________________

___ /___ /___ ______________________________________ ____

Date Responsible Party (Print Name) Responsible Party (Signature)

Name ________________________________

Date of Birth ________________________________

PLEASE TELL US ABOUT TODAY'S PROBLEM(S) & SYMPTOM(S)

Please describe the reason for visit____

When did your symptoms begin? _____ day(s) ago _____ week(s) ago _____ year(s) ago

Were there any precipitating events or circumstances that contributed or caused your problem: ______________________________

____

How many times a year do you get sick? _____ 1-2 times _____ 3-4 times _____ 5+ per year.

My symptoms are experienced (pick one) _____ constantly _____ intermittently

My symptoms are? (circle one) Mild | Mild to Moderate | Moderate | Moderate to Severe | Severe

What medications have you taken **FOR THIS PROBLEM**?
(Please list all antibiotics, over the counter and prescription medications used for **this problem**.)

Medication	Dose/Frequency	Medication	Dose/Frequency
1. ____________________	____________	4. ____________________	____________
2. ____________________	____________	5. ____________________	____________
3. ____________________	____________	6. ____________________	____________

How did you respond to the medication(s) and/or treatment(s) you've taken for this problem?

_____ These medications did not help.
_____ I only improved slightly with these medications.
_____ These medications helped for a while but are not longer working.
_____ These medication helped.

MEDICATIONS *Please list all medications you are **CURRENTLY** taking (not listed elsewhere):*

Medication	Dose/Frequency	Medication	Dose/Frequency
1. ____________________	____________	4. ____________________	____________
2. ____________________	____________	5. ____________________	____________
3. ____________________	____________	6. ____________________	____________
7. ____________________	____________	8. ____________________	____________

Allergies to Prescription Medication

Please list all known prescription medication allergies as well as the type of reaction type and severity:

Allergy: ____________________________ Reaction: _________________________________ Severity: _________

Allergy: ____________________________ Reaction: _________________________________ Severity: _________

Allergy: ____________________________ Reaction: _________________________________ Severity: _________

PAST MEDICAL HISTORY (Check all that apply)

Head

- ❏ Trauma

Eyes, Ears, Nose, Mouth

- ❏ Blindness
- ❏ Cataracts
- ❏ Glaucoma
- ❏ Wears glasses/contacts
- ❏ Hearing aids
- ❏ Allergic Rhinitis
- ❏ Sinus infections
- ❏ Dentures

Cardiovascular

- ❏ Aneurysm
- ❏ Angina
- ❏ Blood clots
- ❏ Dysrhythmia
- ❏ High blood pressure
- ❏ Murmur
- ❏ Heart attack
- ❏ Other heart disease

Respiratory

- ❏ Asthma
- ❏ Bronchitis
- ❏ COPD
- ❏ Pleuritis
- ❏ Pneumonia

Gastrointestinal

- ❏ Cirrhosis
- ❏ GERD
- ❏ Gallbladder disease
- ❏ Heartburn
- ❏ Hemorrhoids
- ❏ Hepatitis
- ❏ Hiatal hernia
- ❏ Jaundice
- ❏ Ulcer

Genitourinary

- ❏ Hernia
- ❏ Incontinence
- ❏ Kidney stones
- ❏ Other kidney disease
- ❏ Sexually transmitted disease
- ❏ Urinary Infections

Musculoskeletal

- ❏ Arthritis
- ❏ Gout
- ❏ M/S injury

Skin

- ❏ Dermatitis
- ❏ Mole(s)
- ❏ Other skin condition(s)
- ❏ Psoriasis

Neurological

- ❏ Epilepsy
- ❏ Seizures
- ❏ Severe headaches, migraines
- ❏ Stroke
- ❏ TIA

Psychiatric

- ❏ Bipolar disorder
- ❏ Depression
- ❏ Hallucinations, delusions
- ❏ Suicidal ideation
- ❏ Suicide attempts

Endocrine

- ❏ Goiter
- ❏ High cholesterol
- ❏ Low thyroid
- ❏ Thyroid disease
- ❏ Thyroiditis
- ❏ Diabetes typ: __1, __2

Heme/Onc

- ❏ Anemia
- ❏ Cancer

Infectious

- ❏ HIV
- ❏ STDs
- ❏ Tuberculosis (dz)
- ❏ Tuberculosis(exposure)

Other History

- ❏ Shots for allergies
- ❏ Drops for allergies
- ❏ Nasal Polyps
- ❏ Vertigo, dizzy
- ❏ Loss of smell

Other Comments

____

____

____

____

____

____

PAST SURGERY HISTORY (Check all that apply)

Common Surgeries

- ❑ Aneurysm repair
- ❑ Appendectomy
- ❑ Back surgery
- ❑ Gastric bypass
- ❑ Bilateral tubal ligation
- ❑ Breast mastectomy
- ❑ CABG
- ❑ Carotid stent
- ❑ Carpal tunnel
- ❑ Cataract/lens surgery
- ❑ Cesarean section
- ❑ Gallbladder
- ❑ Dilation & curettage
- ❑ Hemorrhoid surgery
- ❑ Hip arthroplasty
- ❑ Hip replacement
- ❑ Hysterectomy
- ❑ Inguinal hernia repair
- ❑ Knee
- ❑ LASIK
- ❑ Laminectomy
- ❑ Nasal surgery
- ❑ Heart stent
- ❑ Pacemaker/defibrillator
- ❑ Prostate surgery
- ❑ Prostatectomy
- ❑ Rotator cuff surgery
- ❑ Oophorectomy
- ❑ Skin cancer excision
- ❑ Spinal fusion
- ❑ Sinus surgery
- ❑ Prostate surgery
- ❑ Tonsillectomy/Adenoid
- ❑ Vasectomy
- ❑ Balloon Sinuplasty
- ❑ Sinus Surgery, year___
- ❑ Nasal fracture repair
- ❑ Clarifix
- ❑ Nasal Valve Repair
- ❑ Septoplasty
- ❑ Turbinate Surgery

Other Surgeries ____

____

SOCIAL HISTORY (Check all that apply)

Tobacco

- ❑ Smoke everyday
- ❑ Smoke some days
- ❑ Former smoker
- ❑ Heavy tobacco smoker
- ❑ Light tobacco smoker
- ❑ Never smoker
- ❑ Smoker, current status unknown
- ❑ Unknown if ever smoked

Alcohol

- ❑ Do not drink
- ❑ Drink daily
- ❑ Frequently drink
- ❑ Hx of Alcoholism
- ❑ Occasional drink

Drug Abuse

- ❑ IVDU
- ❑ Illicit drug use
- ❑ No illicit drug use

Cardiovascular

- ❑ Eat healthy meals
- ❑ Regular exercise
- ❑ Take daily aspirin

Safety

- ❑ Household Smoke detector
- ❑ Keep Firearms in home
- ❑ Wear seatbelts

Sexual Activity

- ❑ Exposure to STI
- ❑ Homosexual encounters
- ❑ Not sexually active
- ❑ Safe sex practices
- ❑ Sexually active

Birth Gender

__Male __Female

IMPLANTABLE DEVICES

Do you have an implantable device? NO / YES If YES, is this device active? NO / YES
If so what type of device? When was it implanted? Where and by whom?

____

____

FAMILY HISTORY

Health Status of Mother, Father, Brother, Sister

- ❑ Alive
- ❑ Deceased
- ❑ Unknown

Mark the following items with a (+) or (-) and if (+) please indicate whom with mother, father, brother, and /or sister.

General

- ❑ No Health Concern
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding Disorder
- ❑ CAD < age 55
- ❑ COPD
- ❑ Diabetes
- ❑ Heart Attack
- ❑ Heart Disease
- ❑ High Cholesterol
- ❑ Hypertension
- ❑ Mental Illness
- ❑ Osteoporosis
- ❑ Stroke

Cancer

- ❑ Breast CA
- ❑ Colon CA
- ❑ Other CA
- ❑ Ovarian CA
- ❑ Prostate CA
- ❑ Uterine CA

Other Family History

- ❑ Allergies

Other Comments

____

____

____

____

____