PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item**. It is important for your doctor to know you have carefully reviewed every area of this form.

DATE _____

Patient's Last Name _____ First _____ MI ____ Sex: __ Male __ Female

Address _____ City_____ ST_____ Zip_____ Married Single Widowed

Email _____ Social Security #_____ Date of Birth _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ Job Title _____

Primary Physician _____ Referring Physician _____

Pharmacy Preference (include location) _____

Responsible Party/Guardian Information (If patient is a minor or disabled)

Responsible Party Name _____Date of Birth _____S.S. #_____

Address _____ City _____State _____ Zip _____

Home Phone _____ Cell Phone _____

Employer _____ Work Phone _____

DO YOU HAVE MEDICAL INSURANCE ___ YES ___ NO

NAME OF INSURANCE COMPANY _____ INSURED S.S.#_____

Primary Insured's Name _____ Sex: M F Birth date _____

Insured's Address _____ City _____ State _____ Zip _____

Group # _____ ID # _____ Relationship to patient _____

SECONDARY INSURANCE _____ INSURED S.S#_____

Insured Name _____ Sex: M F Birth date _____

Insured's Address _____ City _____ State _____ Zip _____

Group # _____ ID # _____ Relationship to patient _____

Preferred alternate contact name (spouse, family member, etc)_____ Phone _____

REASON FOR TODAY'S VISIT: _____

Are you on any blood thinners (Aspirin, Plavix, Coumadin, etc.)? ____Y ____ N

If so, please list below along with any other medications you are taking at this time, including over-the-counter.

CURRENT MEDICATIONS:

Name of Medication	Dosage	How Often

May we electronically obtain additional medication history from your pharmacy? ____Y ____ N

ARE YOU ALLERGIC TO ANY MEDICATION? ____ Yes ____ No If yes, please list below:

Name of Medication	Type of Reaction

PAST HEALTH HISTORY:

List any **significant medical problems** (ie. heart disease, diabetes, kidney or lung problems, cancer, etc) or write "none"

_____

_____

_____

List any surgeries you have had (including dates) or write "none" _____

_____

_____

List any prior problems with anesthesia (being numbed or put to sleep) or surgery or write "none" _____

_____

List reasons for any prior hospitalizations not related to surgery or write "none" _____

_____

_____

Prior Tonsillectomy _____ Yes _____No Approximate date/age _____

Prior Adenoidectomy ____Yes _____ No Approximate date/age _____

Do you have any bleeding problems?_____ If so, please list _____

Have you been tested for allergies in the past? ____ Yes ____ No

Name of Doctor _____ Where? _____ When? _____

List all allergies from testing _____

Have you ever received allergy shots? ____ Yes ____ No When?_____ How Long?_____

Have you had prior blood testing, CT or MRI Scans, sleep study, or any other diagnostic test pertaining to today's visit? If so, please give details to the receptionist.

Assignment of Insurance Benefits

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/ or dependents. I also agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/ or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I further authorize the clinic, in its discretion, to disclose such information to its insurance carrier or carriers when requested by such carrier.

I_____ hereby authorize_____
(Name of Insured) (Name of Insurance Company)

To pay and hereby assign directly to **Ear, Nose & Throat Center of Conway, Jeffrey P. Kirsch, M.D., P.A.,** all benefits, if any, otherwise payable to for his/her services as described on the attached forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to **Ear, Nose & Throat Center of Conway, Jeffrey P. Kirsch, M.D., P.A.** will be credited to my account, in accordance with the above assignment.

_____ _____
(Authorized Signature of Subscriber) (Date)

CONSENT FOR PROCEDURES

As part of the practice of otolaryngology, various office procedures are at times necessary. While most of these are relatively minor in scope and often part of the routine examination process for certain disorders, it is nonetheless mandatory that patients understand the risks and benefits of these interventions. Specific procedures performed at our office for which broad consent from our patients is needed, include but are not limited to:

1. **Nasal endoscopy (with/without debridement)** – a procedure in which a sterilized rigid or flexible endoscope is placed into the nose after the nasal membranes are anesthetized using spray-type anesthetic. The risks of this intervention are negligible, and primarily include inadvertent trauma to the nasal membranes and/or mild nasal bleeding. This consent will also cover cauterization or packing performed with endoscopic guidance in order to control nasal bleeding. Diagnostic nasal endoscopies are also needed at frequent intervals following endoscopic sinus surgeries, and these will often entail postoperative debridement of blood, crusts, and devitalized tissue. Such endoscopic debridement is a necessary part of achieving optimal healing following various sinonasal surgical interventions.

2. **Flexible fiberoptic laryngoscopy** – a procedure in which a sterilized flexible scope is inserted through the nose after applying spray-type anesthetic and used to evaluate the lower throat areas. Specifically, this allows adequate visualization of the larynx (voice box) and other lower throat structures which structures which are not readily visible when viewing the posterior throat through the mouth. Risk is again limited to bleeding from trauma induced by the scope.

3. **Biopsy or lesion excision involving various head and neck structures** – All biopsies are generally performed with either topical or local anesthetic. The risk of any biopsy generally centers around bleeding, although scarring, poor-healing, infection, or other wound-related problems could occur. The incidence of these is quite minimal. If more aggressive biopsies or removal of lesions are needed, these usually end up being scheduled in the operating room setting at our local hospital or surgical center. In some cases following biopsy, the pathologic findings may warrant additional and/or more formal or extended surgical interventions to be performed at a later date.

4. **Cerumen or debris removal** – including removal of various types of debris other than "earwax" from the ear canals. The risks of such interventions generally center around bleeding, which is usually minimal and due to cerumen ("earwax") being adherent to the delicate skin within the ear canals.

5. **Myringotomy with or without tube placement** – a procedure used to treat fluid, infections, or abnormal pressure within the middle ear space by creating a small hole in the eardrum. We customarily use a topical phenol anesthetic for this. Risks of this type intervention generally include bleeding, permanent holes or perforation involving the eardrum, ear drainage and extrusion ("coming out") of tubes which could require further tubes in the future. Ear tube insertion is one of the most commonly performed minor surgical procedures in United States.

6. **Fine needle aspiration cytology (needle biopsy)** – a procedure in which a small needle is passed through the skin and into various deeper structures of the head and neck. This is mainly performed to obtain cellular material in evaluating various types of neck, lymph node, thyroid or salivary gland masses. The procedure carries with it very minimal risks which generally include mild bruising or bleeding at the needle puncture site. Such bleeding usually responds promptly to pressure over several minutes. The risks of infection with this procedure is negligible.

I authorize Jeffrey P. Kirsch, M.D./ Patrick L. Fraley, M.D. to perform any or all indicated minimally invasive office interventions (on myself or on my dependent/child) during today's or subsequent office visits. I understand that such interventions will only be performed as deemed necessary by Dr. Kirsch/ Dr. Fraley and that these interventions are customarily billed to myself or my insurance plan separately from a general office visit. I understand that risks and complications as noted above could occur, and that listed risks or complications are in no way indicative of all potential complications which could occur. I also acknowledge that I have the right to refuse any intervention offered, and I accept the risks of any such refusal. My informed consent for recommended or needed interventions is thus obtained.

Patients Signature_____ **Date**_____

Print Name_____

FINANCIAL NOTICE TO PATIENTS REGARDING ENDOSCOPIES, BIOPSIES, OR OTHER PROCEDURES

Over the last several years, insurance companies have increasingly shifted more financial responsibility to patients in the forms of higher deductibles or coinsurances. Similarly, some in-office procedures such as endoscopies or biopsies that were previously covered with the office visit are now being applied to deductibles. Our billing for these procedures is not being performed any differently and continues to follow standard protocols – the only difference is in how they are being reimbursed.

While not all insurance plans apply these procedures to your deductible, we have noted an increasing number of insurers adopting this policy. Your individual insurance company continues to determine the allowed amount reimbursed to us for any procedures.

Please keep in mind that these procedures are usually beyond the services available through your primary physician, and this is often the reason you were referred to us. No procedures are performed that we do not feel are necessary to make a diagnosis or determine the appropriate treatment. As the patient, you have the right to decline any treatment or procedure performed in our office for any reason.

If you would like to check or have us check with your insurance prior to having any in-office procedure performed, we invite you to do so. As a courtesy to all of our patients and to minimize waiting times, we may not be able to talk with your insurance and perform the procedure on the same day.

You may also receive a bill from another entity for services such as radiology, pathology, or laboratory. Since we do not perform these services, we neither take part in nor have any control over their billing or collection. Any questions regarding those services should be directed to the entity performing the service.

I have read and hereby acknowledge the above-noted statement, as evidenced by my signature:

_____

Patient or Patient's Representative

Date_____

"NOTICE OF PRIVACY PRACTICES" CONFIRMATION AND GENERAL AUTHORIZATION

I HEREBY CERTIFY THAT I HAVE REVIEWED AND UNDERSTAND THE "NOTICE OF PRIVACY PRACTICES" DOCUMENT FOR THE EAR, NOSE AND THROAT CENTER OF CONWAY.

I hereby give my authorization for the Ear, Nose and Throat Center of Conway to use or disclose my Protected Health Information to carry out treatment, payment, or any other health care operations.

I understand that my Protected Health Information is as follows:

Information that is oral or recorded in any form that relates to my past, present, or future, physical or mental health condition, my past, present, or future health care treatment, or the payment of my past, present, or future health care treatment, that is or could reasonably identify me and is transmitted in an electronic form or maintained in any form.

This Protected Health Information could include information that this Health Care Provider created, received from me, received from another Health Care Provider, received from a Health Plan, Health Care Clearing House, Insurance Company, Employer, or any other source, and could include demographic information about me.

I specifically give this Health Care Provider authorization to use or disclose my Protected Health Information to other health care providers, group health plans, and business associates to provide for my medical care, treatment, and evaluation; the payment of my medical care, treatment, and evaluation; and to provide information for utilization and quality care purposes.

I understand that I have the right to revoke my authorization; however, it shall not be considered revoked to the extent my Health Care Provider has relied on it. I understand that once this information has been disclosed to third parties, there may not be any safeguards to prevent the third party from further disclosing the Protected Health Information.

This authorization shall remain in effect until I revoke it in writing by contacting the Privacy Official, Jeffrey P. Kirsch M.D. I may also reach him by phone at 501.932.7600. I understand the Health Care Provider can condition my treatment or evaluation on my signing this authorization.

I understand that I have the right to request in writing to inspect and copy my Protected Health Information. There are a few exceptions to this rule. My health Care Provider must approve or deny my request within 30 days and in the case of a denial, provide me an explanation of the reason. My Health Care Provider may charge a reasonable fee for copying, preparation, and postage (if mailed to me), which must be prepaid.

I also authorize the following individuals to have unimpeded and/or full access to my Protected Health Information:

_____	_____
Name	Relationship
_____	_____
Name	Relationship

Accepted by:

_____	_____
Patient – Printed Name	Patient – Signature

_____
Date

_____
Personal Representative of Patient (if patient is a minor or unable to legally give consent)