HEARTLAND OTOLARYNGOLOGY

Patient's Last Name _____ First Name_____ Middle Initial ____

SSN _____ Date of Birth _____ Age _____ Sex: F M

Address _____ City _____ State _____ Zip _____ County_____

Marital Status: Single Married Divorced Widowed Separated

Home Phone _____ Day Phone _____ Cell Phone _____

E-mail Address _____

Employer: _____ Employer Address: _____

Name of Spouse/Parent/Legal Guardian _____ DOB _____ SSN _____

Name & Address of Primary Care (Family) Physician / Pediatrician _____

Referring Physician Name & Address (if different) _____

Primary Medical Insurance

Policy Holder Name _____ Policy Holder SSN _____ Policy Holder DOB _____

Plan Name _____ Policy Holder # _____ Patient's Policy # _____

Group Name (if applicable) _____ Group Number (if applicable) _____

Ins. Co. Address _____ Ins. Co. Phone Number _____

Effective Date _____ Co-pay Amount _____ Deductible _____

Secondary Medical Insurance

Policy Holder Name _____ Policy Holder SSN _____ Policy Holder DOB _____

Plan Name _____ Policy Holder # _____ Patient's Policy # _____

Group Name (if applicable) _____ Group Number (if applicable) _____

Ins. Co. Address _____ Ins. Co. Phone Number _____

Effective Date _____ Co-pay Amount _____ Deductible _____

Emergency Contact: _____ Phone #: _____

Doctor you are here to see _____

I WILL BE PAYING BY: CASH CHECK CREDIT CARD

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical and or surgical information necessary to process an insurance claim and request that payment of benefits be made to Heartland Otolaryngology / Jose L. Ruiz, M.D. unless my account has been paid in full. I understand that I am financially responsible for all charges whether or not paid by Insurance. **I have received Heartland Otolaryngology's notice of privacy practice.**

Responsible Party Signature: _____ ***Date:*** _____

Patient Name: _____ **DOB:**_____ **Date:**_____

ALLERGIES?

Medication Allergies	Type of Reaction		Medication Allergies	Type of Reaction

Have you ever had an allergy test? ☐ Yes ☐ No

Have you ever taken allergy shots? ☐ Yes ☐ No

If yes, are you still taking them? ☐ Yes ☐ No How much relief from shots? ☐ minimal ☐ partial ☐ significant

LIST ALL MEDICATIONS YOU ARE TAKING (Prescription, over-the-counter or herbal) ☐ **None**

Medication	Dosage	How often taken		Medication	Dosage	How often taken

Pharmacy Name (Include Address &/or Phone)_____

MEDICAL / SURGICAL HISTORY: **HAVE YOU EVER BEEN *DIAGNOSED* WITH ANY OF THE FOLLOWING?**

☐ **No Past Medical History**

Cardiovascular:		**Surgery/Management**
Coronary Artery Disease	☐ **Yes**	_____
Elevated cholesterol (hyperlipidemia)	☐ **Yes**	_____
High Blood Pressure (hypertension)	☐ **Yes**	_____
Gastrointestinal:		
Hepatitis	☐ **Yes**	_____
Hernia	☐ **Yes**	_____
Gastroesophageal Reflux	☐ **Yes**	_____
Genitourinary:		
Prostate enlargement (Prostatitis)	☐ **Yes**	_____
Kidney Stones (Nephrolithiasis)	☐ **Yes**	_____
Acute Renal Failure	☐ **Yes**	_____
Ear / Nose / Throat: (HEENT)		
Cataracts	☐ **Yes**	_____
Glaucoma	☐ **Yes**	_____
Chronic ear infections (otitis media)	☐ **Yes**	_____
Hearing loss	☐ **Yes**	_____
Sinus problems (chronic sinusitis)	☐ **Yes**	_____
Nasal polyps	☐ **Yes**	_____
Nasal allergies	☐ **Yes**	_____
Recurrent tonsillitis	☐ **Yes**	_____
Tinnitus	☐ **Yes**	_____
Vertigo	☐ **Yes**	_____
Hematologic :		
Anemia	☐ **Yes**	_____
Immunologic:		
Allergies Type: _____	☐ **Yes**	_____
Food Allergies Type: _____	☐ **Yes**	_____
HIV / AIDS	☐ **Yes**	_____

Infectious Disease:		**Surgery/Management**
Mononucleosis	☐ **Yes**	_____
STD Type: _____	☐ **Yes**	_____
Metabolic/endocrine:		
Diabetes Type: _____	☐ **Yes**	_____
Thyroid deficiency (hypothyroidism)	☐ **Yes**	_____
Thyroid excess (hyperthyroidism)	☐ **Yes**	_____
Neoplastic:		
Cancer Type: _____	☐ **Yes**	_____
Neurologic:		
Migraine	☐ **Yes**	_____
Obstetric:		
Pregnancy Date(s): _____	☐ **Yes**	_____
Psychiatric:		
Adjustment Disorder - Anxiety	☐ **Yes**	_____
Major Depression	☐ **Yes**	_____
Pulmonary:		
Asthma	☐ **Yes**	_____
COPD/Emphysema	☐ **Yes**	_____
Sleep Apnea	☐ **Yes**	_____
Tuberculosis	☐ **Yes**	_____
Miscellaneous:		
Anesthesia Reaction	☐ **Yes**	_____
Miscellaneous PEDIATRIC:		
Complications during Pregnancy	☐ **Yes**	_____
Complications during Delivery	☐ **Yes**	_____
NICU stay >48hrs:_____	☐ **Yes**	_____
Preterm birth	☐ **Yes**	_____

If YES to any of the above Diagnosis was surgery performed?

What_____ **Where/When**_____ **By Who**_____

FAMILY HISTORY:

ADD/ADHD	☐ **Yes**	Hearing deficiency	☐ **Yes**
Alcoholism	☐ **Yes**	Hyperlipidemia	☐ **Yes**
Allergies	☐ **Yes**	Hypertension	☐ **Yes**
Alzheimer's Disease	☐ **Yes**	Irritable Bowel Syndrome	☐ **Yes**
Asthma	☐ **Yes**	Learning disability	☐ **Yes**
Blood disease	☐ **Yes**	Mental illness	☐ **Yes**
CAD (Coronary Artery Disease)	☐ **Yes**	Migraines	☐ **Yes**
CAD-Premature	☐ **Yes**	Obesity	☐ **Yes**
Cancer Type: _____	☐ **Yes**	Osteoarthritis	☐ **Yes**
CVA (Stroke)	☐ **Yes**	Osteoporosis	☐ **Yes**
Depression	☐ **Yes**	PVD	☐ **Yes**
Developmental delay	☐ **Yes**	Renal disease	☐ **Yes**
Diabetes	☐ **Yes**	Seizure disorder	☐ **Yes**
Eczema	☐ **Yes**	Other: _____	

Tobacco Use? ☐ **Yes** ☐ **No** ☐ **Former**

Type of Tobacco	Packs/ Day	For ? Years	Yr. Quit?
Cigarettes			
Other: (list type)			

Do you consume alcohol? ☐ **Yes** ☐ **No** ☐ **Former**

Type of Alcohol	Frequency?	Amt?	Last Drink?

Exposed to second hand smoke? ☐ **Yes** ☐ **No**
Caffeine Consumption? ☐ **Yes** ☐ **No** **Type: _____ Amount per day? _____**

REVIEW OF SYMPTOMS: Check any of the following problems you have recently had:

General health problems
☐fatigue ☐fever ☐night sweats ☐unintentional weight loss ☐sleeping problems ☐weight gain

Eye problems
☐double vision ☐itchy eyes ☐swelling ☐redness

Ear problems
☐ear drainage ☐hearing loss ☐ear infections ☐dizziness ☐itchy ☐noise exposure ☐ringing /noise in ears ☐ear pain ☐tinnitus

Nose & Sinus problems
☐chronic congestion ☐mouth breathing ☐nosebleeds ☐frequent sneezing ☐runny nose ☐post-nasal drip

Mouth & Throat problems
☐difficulty swallowing ☐snoring ☐sore throat ☐hoarseness ☐sores in mouth ☐ulcers

Heart or circulation problems
☐heart murmur ☐leg cramping ☐swelling of ankles ☐chest pain ☐blacking out ☐irregular heartbeat

Lung or respiratory problems
☐shortness of breath ☐wheezing ☐ cough

Stomach problems
☐abdominal pain ☐diarrhea ☐heartburn ☐nausea ☐vomiting

Brain or Nervous system problems
☐headache ☐seizures ☐weakness ☐numbness ☐facial pain

Glands & Hormone problems
☐intolerance to heat ☐increased appetite ☐neck enlargement ☐intolerance to cold

Blood or Lymph nodes problems
☐bleeds excessively after injury ☐bruises easily

Allergy problems
☐food intolerances ☐insect bites

Skin
☐rash ☐itchy ☐latex allergies ☐swelling ☐urticaria / hives

What is the reason you are here today? _____

How would you prefer the doctor to address you? Mr. Ms. Mrs. Dr. First Name Nickname: _____

Patient Name: _____ DOB: _____

Responsible Party Signature: _____ Date: _____

FINANCIAL AGREEMENT

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. WE WILL REQUEST TO PHOTOCOPY YOUR INSURANCE CARD(S) FOR YOUR FILE.

- **APPOINTMENTS** – 24 hours notice must be provided in the event you cannot keep an appointment. Should you not provide this notice, a cancellation fee of $25 may then be added to your account.

- **REFERRALS** – If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral, YOU WILL BE REQUESTED TO SIGN A FINANCIAL WAIVER. It is then your responsibility to provide us with the referral within 48 hours or you will be personally responsible for that day's services.

- **CO-PAYMENTS** – By law we MUST collect your carrier designated co-pay and or co-insurance. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit. Should you not pay at the time of service and we subsequently send you a statement, an administrative fee of $20 may be added to your account.

- **OUT OF NETWORK PLANS** – You will be responsible for any balance your plan indicates as due on their explanation of benefits form. We will adjust the charges to coincide with your plan's UCR (Usual, Customary and Reasonable) charges. All patients will be responsible for their co-insurance and deductible.

  Private Insurance Authorization for Assignment of Benefits/Information Release: I, the undersigned, authorize payment of medical benefits to Heartland Otolaryngology for any services furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize any holder of medical information about me to release to my insurance company (or their agent) information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

- **SELF-PAY PATIENTS** – Full Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.

- **MEDICARE** – We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one.

  Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits be made on my behalf to Heartland Otolaryngology for any services furnished to me. I authorize any holder of medical information about me to release to the CMS (and its agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluating and administering claims of benefits.

- **DIVORCED/SEPERATED PARENTS OF MINOR PATIENTS** – The parent who consents to the treatment of a minor child is responsible for payment of services rendered, Heartland Otolaryngology will not be involved with separation or divorce disputes.

You are responsible for the timely payment of your account. Should it become necessary for us to use an outside agency to collect payment from you, you will be additionally responsible for whatever charges we incur as a result of this.

WE ACCEPT CASH, CHECKS, MASTERCARD, DISCOVER OR VISA.

THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share with us special concerns.

Patient's Name: _____ DOB: _____

Responsible Party Signature: _____ Date: _____

Print Name: _____ Relationship: _____

HIPAA AUTHORIZATION FORM

Patient's Full Name | **Patient's Social Security Number/Medical Record Number**

Address | **Patient's Date of Birth**

City, State Zip Code | **Patient's Telephone Number**

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me:
   _____DR. JOSE L. RUIZ – HEARTLAND OTOLARYNGOLOGY_____
2. The following person (or class of persons) may receive disclosure of protected health information about me:

   His/her/its Name

   Address

   City, State Zip Code
3. The specific information that should be disclosed is (please give dates of service if possible):

_____

_____

UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:

YES, DISCLOSE THIS INFORMATION *_____

NO, **DO NOT** DISCLOSE THIS INFORMATION * _____

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
5. I may revoke this authorization by notifying HEARTLAND OTOLARYNGOLOGY in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
6. My purpose/use of the information is for _____ .
7. This authorization expires on _____, 200___, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: _____.

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. You will be required to pre-pay for the copies; then your copies will be mailed along with an invoice.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING – note that signature is required in two places.*

Signature of Individual* (The person about whom the information relates)	**Date of Individual's Signature**	**Date of Birth or Social Security Number**

OR, if applicable –

Signature of Guardian* or Personal Representative of Patient's Estate	**Date of Guardian's/Personal Representative's Signature**	**Description of Authority to Act for the Individual**

Official Use Only

Received By	**Date**	