

Otolaryngology  
Pediatric Otolaryngology  
Allergy  
Facial Rejuvenation  
Audiology  
Hearing Testing  
Hearing Aid Dispensing

Peter F. Agnello, M.D.  
Otolaryngology  
Head & Neck Surgery  
Board Certified  
American Board of Otolaryngology

Yoon C. Nofsinger, M.D.  
Otolaryngology  
Head & Neck Surgery  
Allergy  
Board Certified  
American Board of Otolaryngology  
Fellow  
American Academy of Otolaryngic Allergy

Nalin J. Patel, M.D.  
Pediatric Otolaryngology  
Laryngology  
Voice & Swallowing Disorders  
Board Certified  
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Janet L. Seper, M.D.  
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Amy L. Charrier, Au.D., CCC-A, FAAA  
Clinical Audiologist  
American Speech, Language & Hearing Association  
Fellow American Academy of Audiology  
Florida Academy of Audiology

Sierra MacDonald, Au.D., CCC-A  
Clinical Audiologist  
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Melissa Sirois, M.S., CCC-A, FAAA  
Clinical Audiologist  
American Speech, Language & Hearing Association  
Fellow American Academy of Audiology

Locations  
Tampa and Wesley Chapel

Dear Patient:

Welcome to Tampa Ear Nose & Throat Associates. We would like to take this opportunity to welcome you to our practice. This letter contains answers to some of the most commonly asked questions by patients entering our practice. We hope you find this information useful.

Our office hours are Monday through Friday from 9:00AM to 5:00PM. Our office phone number is 813-972-3353. In the event of an emergency outside of our normal business hours patients may call this number and the call service will contact the doctor on call for you.

We understand that in today's busy world occasionally situations come up that are beyond your control. In those instances, we request you extend us the courtesy of a 24-hour notice. This courtesy allows us to continue to operate efficiently and use the time that was reserved for you to help other patients in need. It is our policy that you call our office at least 24 hours prior to your appointment time. If you fail to contact our office in advance three times over the course of one year you will be discharged from the practice.

Patients should complete, sign and bring the following to your first appointment:

- Patient registration form
- Conditions of treatment form
- Health questionnaire
- Medication list
- Allergy patient information (if applicable)
- Allergy questionnaire (if applicable)
- Drivers license or state issued identification card
- Primary and secondary insurance cards

On subsequent visits our front office staff will review your demographic and insurance information with you to ensure we maintain your correct information on file. This allows us to submit your claim to your insurance carrier in a timely manner.

We are contracted with several insurance carriers for the benefit of our patients. You will want to check your benefits booklet or with the benefits department of your employer to verify if our physicians are listed as providers within your network. As part of our contract with the insurance companies we are legally required to collect any co-pays or deductibles from you at the time of service. We ask that you be prepared to pay your co-pay at the time of check out. We accept cash, check, American Express, Discover, MasterCard, and Visa.

**If your insurance requires a referral from your primary care physician, a written referral or authorization number must be in our office 48 hours prior to your visit or your appointment will be cancelled. Obtaining this authorization is the responsibility of the patient. Please contact your primary care physician as soon as possible to initiate this process.**

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It is our desire to have a mutually respectful relationship with our patients. As part of the relationship we feel it is important to set patient expectations appropriately:

- Patient telephone messages must first be reviewed by clinical staff prior to a return telephone call. In most cases, this process may take 4-6 hours. Please note, for messages left after 12PM, you may not receive a return phone call until the following business day.
- Please allow 2 working days for the clinic to process requests for prescription refills and 3 working days to process authorizations for diagnostic testing.
- Please allow 5-7 working days for the completion of any forms, letters, or records requests. There is a standard fee for any form completion including FMLA. This amount is per form and based on the number of pages per form. This amount is due at the time the forms are submitted to our office.
- Your medical records are strictly confidential. The Health Information Portability and Accountability Act (HIPAA) restricts us from releasing any information without your written permission.
- We expect our patients to maintain a good credit rating with our office. Failure to pay for medical services delivered in good faith will cause your account to be turned over to a third party collection agency and you will be discharged from the practice.

If you have any questions or need further clarification on any of our policies please contact our office for assistance. Thank you for allowing us to assist you with your healthcare needs.

Sincerely,

Tampa Ear Nose & Throat Associates

**Tampa Ear Nose & Throat Associates Patient Registration** *(please print clearly)*

**Patient Information**

Date: \_\_\_\_\_ Patient SSN: \_\_\_\_\_  
First Name \_\_\_\_\_ MI \_\_\_\_\_ Last: \_\_\_\_\_ Suffix: \_\_\_\_\_  
Sex: M / F Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Marital Status *(please circle)*: Single Married Divorced Widowed Legally Separated  
Primary Care Physician: \_\_\_\_\_ Pharmacy Name/Phone: \_\_\_\_\_

**Patient's Permanent Address**

**Patient's Billing Address *(If different)***

Street: \_\_\_\_\_ Street: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
E-mail Address: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

**Insurance Subscriber / Policy Holder Information**

Primary Carrier: \_\_\_\_\_ Secondary Carrier: \_\_\_\_\_  
Subscriber: \_\_\_\_\_ Subscriber: \_\_\_\_\_  
Subscriber DOB: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_  
Subscriber SSN: \_\_\_\_\_ Subscriber SSN: \_\_\_\_\_  
Subscriber ID #: \_\_\_\_\_ Subscriber ID #: \_\_\_\_\_  
Group ID#: \_\_\_\_\_ Group ID#: \_\_\_\_\_  
Subscriber's Employer: \_\_\_\_\_ Subscriber's Employer: \_\_\_\_\_

**Employment Status Patient / Parent or Guardian**

*Please circle:*      Employed      Self Employed      Retired      Disabled      Unemployed      Student  
Employer Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Emergency Contact Information**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**CONDITIONS OF TREATMENT BY  
TAMPA EAR NOSE & THROAT ASSOCIATES**

Patient \_\_\_\_\_ DOB: \_\_\_\_\_

**Permission for Treatment:** Permission is hereby granted for physicians, residents, employees or agents of Tampa Ear Nose & Throat Associates (collectively, the "Provider") to render the patient named above such medical and surgical treatment as is deemed necessary.

**Authorization for Release of Information:** The Provider (through its employees or other contracted agents) may disclose the patient's medical record account to:

1. Any person or corporation which is or may be liable for all or any portion of the patient's charges; including but not limited to insurance companies, health care service plans, and worker's compensation carriers to the extent necessary to determine insurance benefits, liability for payment and to obtain reimbursement.
2. Any referring physician to ensure continuity of medical care.

**Financial Agreement:** (Please initial as applicable)

\_\_\_\_\_ **Assignment of Insurance Benefits:** I request my insurance carrier to pay to Tampa Ear Nose & Throat Associates all benefits due me related to my pending claim for medical and surgical services. I agree to pay all applicable deductible and coinsurance amounts due and other fees for services rendered for which my insurance plan/HMO is not liable for payment to the Provider, and agree to pay the costs of collection including reasonable attorney's fees in the event of legal action to collect such amounts.

\_\_\_\_\_ **Medicare B Authorization:** I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to the billing agent of this physician or supplier, any information needed for this or a related Medical Claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or the party who accepts assignment.

\_\_\_\_\_ **Self-Paying Patient:** I have been informed that Tampa Ear Nose & Throat Associates does not have a contract to participate with my insurance plan or HMO, and the requested services have not been authorized by my insurance plan/HMO, as applicable. I am requesting medical services as a fee-for-service, self-paying patient. I agree that I am responsible for all charges incurred as a result of this visit, including but not limited to all medical/surgical professional services, laboratory, radiological, and any other ancillary services. I agree to pay the costs of collection including reasonable attorney's fees in the event of legal action to collect this account.

Patient/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

## PEDIATRIC HEALTH QUESTIONNAIRE

REASON FOR VISIT: \_\_\_\_\_

OTHER PHYSICIANS (WHO YOU WANT NOTES SENT TO): \_\_\_\_\_

CURRENT MEDICAL PROBLEMS: \_\_\_\_\_

BIRTH HISTORY:   NORMAL   ABNORMAL                   IMMUNIZATIONS UP TO DATE:   YES   NO

HOSPITAL ADMISSIONS, YEAR AND OPERATION: \_\_\_\_\_

### MEDICAL HISTORY

PLEASE NOTE: IT IS IMPORTANT FOR THIS SECTION TO BE FILLED OUT COMPLETELY BEFORE THE DOCTOR CAN SEE YOU

	YES	NO		YES	NO
<b>CONSTITUTIONAL</b>			<b>GASTROINTESTINAL</b>		
FEEDING DIFFICULTY	_____	_____	REGURGITATION	_____	_____
POOR WEIGHT GAIN	_____	_____	INDIGESTION/HEARTBURN	_____	_____
IRRITABLE	_____	_____	NAUSEA/VOMITING	_____	_____
<b>SKIN</b>			ABDOMEN PAIN	_____	_____
ITCHING	_____	_____	DIARRHEA	_____	_____
RASH	_____	_____	CONSTIPATION	_____	_____
HIVES	_____	_____	BLOODY STOOL	_____	_____
<b>ALLERGIES/IMMUNOLOGY</b>			<b>UROLOGIC</b>		
ASTHMA	_____	_____	BEDWETTING	_____	_____
SEASONAL ALLERGIES	_____	_____	UTI	_____	_____
<b>EARS/NOSE/THROAT/MOUTH</b>			<b>ENDOCRINE</b>		
HEARING LOSS	_____	_____	DIABETES	_____	_____
EAR INFECTIONS	_____	_____	THYROID DISEASE	_____	_____
SINUS INFECTIONS	_____	_____	<b>MUSCULOSKELETAL</b>		
NOSE BLEEDS	_____	_____	JOINT PAIN	_____	_____
RUNNY NOSE	_____	_____	<b>NEUROLOGICAL</b>		
SORE THROATS	_____	_____	SEIZURES	_____	_____
TONSILLITIS	_____	_____	CEREBRAL PALSY	_____	_____
SNORING	_____	_____	IVH	_____	_____
MOUTH BREATHING	_____	_____	<b>PSYCHOLOGICAL</b>		
RESTLESS SLEEP	_____	_____	ANXIOUS	_____	_____
<b>EYES/HEAD</b>			DEPRESSED	_____	_____
VISION LOSS	_____	_____	STRESSED	_____	_____
HEADACHES	_____	_____	HYPERACTIVE	_____	_____
DIZZINESS	_____	_____	<b>HEME/LYMPHATIC</b>		
<b>RESPIRATORY</b>			ANEMIA	_____	_____
WHEEZING	_____	_____	BRUISE EASILY	_____	_____
COUGH	_____	_____	BLEEDING	_____	_____
<b>CV</b>			SWOLLEN GLAND	_____	_____
CHEST PAIN	_____	_____	BLOOD TRANSFUSIONS	_____	_____
SHORT OF BREATH	_____	_____			
<b>SOCIAL HISTORY</b>			<b>FAMILY HISTORY</b>	<b>YES</b>	<b>NO</b>
GRADE: _____	DAYCARE:   YES	NO	DIABETES	_____	_____
ACTIVITIES: _____			HEARING LOSS	_____	_____
			ALLERGIES	_____	_____

PARENTS:   MARRIED   DIVORCED   SEPARATED   FOSTER CARE

REVIEWED BY: \_\_\_\_\_ DATE: \_\_\_\_\_

