

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

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Head & Neck Surgery
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Sierra MacDonald, Au.D., CCC-A
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Rachel Horne, Au.D., CCC-A
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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: _____

Responsible Party

Permanent Address

Name: _____ Street: _____
Date of Birth: _____ SSN: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Phone: _____
Work Phone: _____ **Billing Address (If Different)**
Cell Phone: _____ Street: _____
E-mail Address: _____ City: _____ State: _____ Zip: _____

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

PARENTS: MARRIED DIVORCED SEPARATED FOSTER CARE

REVIEWED BY: _____ DATE: _____

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Please be advised that we are a specialty care practice and some services performed in the office may be charged in addition to an office visit.

These charges are separate from your co-payment and may apply to your co-insurance and/or deductible depending on your insurance plan.

These services include but are not limited to:

- Any type of scope
- Control of nose bleeds
- Removal of foreign bodies
- Wax removal
- Sinus debridement
- Biopsies
- Excisions
- Audio services
- Somnoplasty
- Tympanostomy
- Videostrobe

Patient's Name: _____ **DOB:** _____

Parent/Guardian Name: _____

Signature: _____ **Date:** _____