Methodist

METHODIST CHARLTON EAR, NOSE, AND THROAT

*****YOU WILL NOT BE CHECKED IN UNTIL ALL INFORMATION IS FILLED OUT COMPLETELY!*****

PATIENT INFORMATION

Name		Date of Birth	Sex
Address	City	State	Zip
Home Phone Cell	Preferred? Home Cell	**TEXT MSG reminders (cell ONLY)?** Y N	
Email Address		**Social Security Number (REQUIRED)**	
Pharmacy: NAME AND LOCATION		PRIMARY CARE PROVIDER (PCP)	
Employer Name:		Employment Status: circle one Full Time Part Time Retired Student	
Race ○ Black/African American ○ Asian ○ Caucasian ○ Hispanic or Latino ○ Other *(Please Specify)*			
Ethnicity: ○ Hispanic or Latino ○ Not Hispanic ○ Decline to Provide		Marital Status ○ Single ○ Married ○ Divorced ○Widowed/er	
Primary Language Spoken in the Home ○ English ○ Spanish ○ Other (please define):		Veteran ○ Yes ○ No	

RESPONSIBLE PARTY/GUARANTOR INFORMATION IF DIFFERENT FROM ABOVE

NAME		Date of Birth	Relationship to Patient
Address	City	State	Zip
Phone Home/Cell	Work	**Social Security Number:**	

PRIMARY INSURANCE – MUST PROVIDE INSURANCE CARD- ************FILLOUT ONLY IF PATIENT IS NOT SUBSCRIBER**

Insurance Company Name		Phone Number	
Name of Insured or SELF	**Date of Birth**	Relationship to Patient	○ Self ○ Spouse ○ Parent ○ Other

SECONDARY INSURANCE IF APPLICABLE - MUST PROVIDE INSURANCE CARD- ************FILLOUT ONLY IF PATIENT IS NOT SUBSCRIBER**

Insurance Company Name		Phone Number	
Name of Insured or SELF	Date of Birth	Relationship to Patient	○ Self ○ Spouse ○ Parent ○ Other

EMERGENCY CONTACT

NAME		Phone number	Relationship to Patient
Address	City	State	Zip

Methodist Charlton Ear, Nose, and Throat
PATIENT HEALTH QUESTIONNAIRE (pg 1/2)

Patient's name_____
Date of Birth_____

Gender M / F Marital Status S M W D Sep

Reason for visit _____

When was your last Tetanus Shot: _____ Have you had the flu shot this year? ☐ Yes ☐ No

Medical History (Mark all that apply)

Childhood Illnesses	☐ Rheumatic fever	☐ Mumps	☐ Scarlet fever	☐ Chicken pox	☐ Polio	☐ Measles
Patient History	☐ Diabetes Mellitus	☐ Asthma	☐ Hypertension	☐ Heart Disease	☐ Glaucoma	☐ Migraine
☐ Ulcers	☐ High Cholesterol	☐ Stroke	☐Tuberculosis	☐ Kidney Disease	☐ Cancer	☐ Depression
☐ Arthritis	☐ Thyroid Disease	☐ Anemia	☐ Osteoporosis	☐ Alcoholism	☐ Seizures	☐ Mental Illness
☐ Hepatitis	☐ Other (please list)					

Drug Allergies: _____
Current Medications (including non-prescription medications and supplements):_____
_____
_____
_____
Last doctor's visit _____ **Doctor's name** _____
Hospitalizations_____
_____
Surgeries _____
_____

Social History
Occupation _____ Hours/week: _____ Satisfied with job: _____
Alcohol _____drinks per week Coffee / Tea _____cups/day
Tobacco: Smoking _____ cigarettes/day # Years:_____ Year quit:_____
Chewing _____cans/week # Years: :_____ Year quit: _____
Recreational drugs _____ Last used:_____
Do you follow a particular diet? (explain) _____
Do you exercise regularly? _____

Family History: (If any relative has suffered any of the following, mark and indicate which relative)
F – Father M – Mother S – Sibling C – Child R – Other Relative

☐ Diabetes	F M S C R	☐ Thyroid Disease	F M S C R	☐ Alcoholism	F M S C R
☐ Hypertension	F M S C R	☐ Heart Disease	F M S C R	☐ Arthritis	F M S C R
☐ Asthma	F M S C R	☐ High Cholesterol	F M S C R	☐ Seizures	F M S C R
☐ Anemia	F M S C R	☐ Osteoporosis	F M S C R	☐ Glaucoma	F M S C R
☐ Stroke	F M S C R	☐ Migraine	F M S C R	☐ Cancer	F M S C R

Chart # _____ Reviewed by _____ Date _____

Methodist Family Health Centers
PATIENT HEALTH QUESTIONNAIRE (pg 2/2)

Patient's name_____
Date of Birth_____

Systems Review: Check any of the following which you have had in the last 3 months

General	Breast	Cardiac	Neurologic
☐ Fever or chills	☐ Tenderness	☐ Chest pain	☐ Headache
☐ Fatigue	☐ Discharge	☐ Swollen ankles	☐ Dizziness
		☐ Irregular pulse	☐ Seizures
Nutritional	**Respiratory**	☐ Leg pain when walking	☐ Numbness or tingling
☐ Weight loss	☐ Cough	☐ Heart murmur	☐ Tremor
	☐ Shortness of breath	☐ Varicose veins	☐ Muscle weakness
Skin	☐ Asthma / wheezing	☐ Phlebitis	☐ Passing out
☐ Rash / hives	☐ Pneumonia		
☐ Psoriasis / Eczema	☐ Bronchitis	**Urinary**	**Endocrine**
☐ New moles		☐ Painful urination	☐ Heat or cold intolerance
	Gastrointestinal	☐ Loss of urinary control	☐ Thirst
Eyes	☐ Heartburn	☐ Frequent urination	☐ Frequent urination
☐ Eye irritation and itching	☐ Nausea / vomiting	☐ Urination>2x nightly	
☐ Eye pain	☐ Loss of appetite	☐ Decreased force or flow	**Psychiatric**
☐ Eye infections	☐ Difficulty swallowing	☐ Blood in urine	☐ Sleeping difficulty
☐ Vision changes	☐ Abdominal pain (chronic)	☐ Kidney stones	☐ Depression
	☐ Change in bowel habits	☐ Urine infections	☐ Nervousness
Ears	☐ Constipation		☐ Memory loss
☐ Ear pain	☐ Diarrhea	**Genital**	☐ Moodiness
☐ Popping – pressure	☐ Bloody or Tarry stools	☐ Irritation/Infection	☐ Mental illness
☐ Ringing in ears	☐ Gallbladder trouble	☐ Discharge	☐ Phobias
☐ Ear infections (frequent)	☐ Jaundice	☐ Sexual difficulties	
☐ Hearing loss	☐ Hepatitis		**Hematology**
☐ Dizziness	☐ Diverticulosis	**Musculoskeletal**	☐ Bruising
	☐ Colitis	☐ Joint pain	☐ Bleeding
Nose	☐ Hemorrhoids	☐ Back pain	☐ Blood transfusions (lifetime)
☐ Sinus trouble	☐ Hernia	☐ Bone fracture	☐ Enlarged lymph nodes
☐ Runny nose		☐ Joint injury	
		☐ Gout	**Allergies / Immune**
Throat		☐ Foot pain	☐ Seasonal allergies
☐ Sore throat		☐ Cold / numb feet	☐ Frequent illnesses
☐ Hoarseness			

FEMALES

Menstrual Flow		
☐ Regular	Days of flow	Length of cycles
☐ Irregular	☐ Pain / bleeding during or after sex	
☐ Pain / cramps		
Obstetric history		
Number of pregnancies	Number of children	
Birth control method	Miscarriages	
Birth control pill name		
Menopause symptoms		
Flushing		
Health Maintenance		
Date of last Pap smear	normal / abnormal	
Date of last mammogram	normal / abnormal	

MALES

Prostate exam date
PSA Test date
MALE & FEMALE
Have you had a colonoscopy? ☐ Yes ☐ No Date:
Results: ☐ Normal ☐ Polyps ☐ Other

Chart #_____ Reviewed by_____ Date_____

Methodist
MEDICAL GROUP

General Patient Consent for Care Form

General Consent to Care:
I, the undersigned, for myself or a minor child or another person for whom I have authority to sign, hereby consent to medical care and treatment, as ordered by a provider, while such medical care and treatment is provided through Methodist Medical Group on an outpatient/ office visit basis. This consent includes my consent for all medical services rendered under the general or specific instructions of a provider; including treatment by a mid-level provider (Nurse Practitioner or Physician Assistant), and other health care providers or the designees under the direction of a physician, as deemed reasonable and necessary.

I agree and acknowledge that Methodist Medical Group is not liable for the actions or omissions of, or the instructions given by the physicians/providers who treat me while I am a patient. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations at Methodist Medical Group facilities.

Telemedicine
I understand that telemedicine (defined as the use of medical information exchanged from one site to another via electronic communications for the health of the patient, including consultative, diagnostic, and treatment services) may be employed to facilitate my medical care. All electronic transmission of data will be restricted to authorized recipients in compliance with the Federal Health Insurance Portability and Accountability Act (HIPPA) and applicable state privacy laws.

To the Patient:
You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

Signed Consent

I hereby give my consent to treat minor child/children below, which is under the legal age of eighteen years of age, to receive medical care and/or treatment from the providers of Methodist Medical Group. Any care deemed medically necessary may be provided with our without my presence:

Child: _____ Date of birth _____

Child: _____ Date of birth _____

Child: _____ Date of birth _____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ [ ] *Patient under 18 years of age* _____
Signature of Patient or Legal Guardian **Date**

_____ _____
Printed Name of Patient or Legal Guardian **Relationship to Patient**

This consent to medical treatment will expire 12 months from the date signed until revoked in writing

Methodist
MEDICAL GROUP

Patient Preference Regarding Communication of Health Information

In order to better protect your privacy under HIPAA, we have created this consent form for releasing medical information to family members and other people of your choosing. This will also be used for consent to leave you detailed telephone messages at the phone numbers listed below, mail your lab results to your home and also send secure email results to your personal email address once enrolled in MyChart. We are legally not allowed to release medical information to patient family members without the patient's written consent. The purpose of this document is to protect your privacy.

Communication to Family Members, Spouses or Other:

I, (print patient name) _____ DOB _____, hereby give my permission for the release of medical information regarding appointments and questions about my condition and treatments to the following person(s):

Name: _____ Relation: _____ Phone: _____ Emergency Contact Only: (Y/N) _____

Name: _____ Relation: _____ Phone: _____ Emergency Contact Only: (Y/N) _____

___ Check here if you do not give permission for additional family members, relatives or close personal friends to have access to any information regarding my medical condition(s).

Communication for Appointment Reminders and Appointment Follow-Ups:

Methodist Family Health Center (MFHC) may need to use your name, phone number, email address ("Contact Information"), and your clinical records to contact you with appointment reminders and information about treatment alternatives, If this communication is made by phone and you are not available, a message will be left on your voice mail or with the person answering the phone. By signing this form, you are consenting for MFHC to contact you with appointment reminders and information and to leave messages on a voice mail or with individuals at you home. Information that we use or disclosed based on this consent may be subject to re-disclosure by anyone who has access to the reminder and my no longer be protected by federal privacy rules.

You have the right to refuse to give MFHC your consent to use your telephone number and/or email address for appointment reminders and treatment alternatives. If you chose to give your consent, you have the right to revoke it, in writing, at any time in the future. If you refuse to give MFHC this consent or revoke it in the future, it will not affect the treatment we provide to you.

I CONSENT to the following forms of communication for appointment reminders and follow-up communication (*please initial all that apply*): _____ Email (If Applicable) _____ Phone _____ Text message (If Applicable) [1]
_____ Secure patient portal to be used in the manner described above.

Preferred Email Address _____ Preferred Telephone Number _____

If you consented to communication via the secure patient portal, you will be notified via email when there is secure information for you to review such as lab results. The email will provide a link that you will use to access the secure website. After clicking on the link, you will be required to log-in and provide your unique user name and password.

In choosing your email address, please consider privacy implications; for example, any other person that may have access to your email or any other person, such as your employer, that may have the right and/ or ability to review all email received at your work address.

____ (initial) I decline to give MFHC consent to use my Contact Information and clinical records to contact me with appointment reminders and information about treatment alternatives. I understand I may be requires to schedule a follow up appointment with the doctor for review my test results or it could take up to 10 business days to receive your results in the mail.

Consent and Agreement I have carefully reviewed this document and agree to fully comply with the guidelines defined herein for the communication of my health information.

_____ _____
Signature of Patient or Guardian Date

[1] Please note the text messaging service is a complimentary service provided by MTP, but standard messaging rates from your wireless carrier may still apply. If you have questions, please contact your wireless carrier.

Methodist
MEDICAL GROUP

Welcome Information

Thank you for choosing our practice to take care of your health care needs! We know that you have a choice in selecting your medical care and we strive to provide you with the best service possible. Here are a few of our office policies.

Registration: All patients must complete a patient information form before seeing their provider.

Charges: Full payment is due at the time services are rendered unless other payment arrangements have been made. For patients without insurance, payment is due at the time of service for both sick and well visits. Copays and balances are expected at the time of service. After 90 days, outstanding balances will be referred to a collection process. **In the event your health plan determines a service to be "non-covered", you will be responsible for all non-covered and allowable charges.** Delays in insurance processing occur when insurance information is not provided in a timely manner. Such delays may also result in insurance not covering care. Whenever insurance denies payment for a service, it is your responsibility to cover the charges, therefore, it is important to review your benefits with your insurance provider.

FMLA/ Paperwork: Any patient that needs paperwork completed by *Methodist Medical Group may be* assessed a processing fee. This must be paid in full before the paperwork can be picked up or faxed. Please inquire with our staff regarding specific fees prior to submission of your form(s).

NSF/ Closed Accounts: There will be a $35.00 charge added for returned checks.
Clinical Fees: There may be a processing fee for controlled medication refills and an additional fee to re-write if the prescription is not filled within the 21 day deadline. The voided prescription must be returned before a new prescription is issued.

There is a $25.00 fee for medical records up to 25 pages. Additional pages are $0.50 per page. All Medical Records are processed by HealthMark and take seven business days to process.

Appointments/ No Show: We request 24 hour notice for appointment cancellations. Patients with three (3) missed appointments and/ or no shows annually will result in dismissal from the practice. If you no show to your appointment you may be charged $25.00. These charges are not payable by your insurance company. You will be required to pay this charge before your next scheduled visit.

Insurance: Insurance cards must be available prior to each visit. Please notify our office if there is a change in your insurance plans or coverage. We file claims as a courtesy to our patients and are only responsible for filing claims to the contracted insurance company for the member. Any dispute for unpaid charges form the insurance company will be billed to the member. All patients must have a valid insurance ID card in order to utilize benefits.

Medication Refills: All prescription refill requests should be called into your pharmacy at least five (5) working days before the last pill taken to allow adequate time for approval. Refills will only be handled during normal business hours, Monday through Friday. Narcotic prescriptions will not be refilled after office hours or on weekends.
Referrals: Allow 5 to 7 working days to process routine referrals.

Behavior: Physical and verbal abuse towards the office staff or other patients will not be tolerated. This includes disruptions affecting daily operations within the office as well as offensive behavior on the telephone with office personnel. Abusive behavior towards personnel will result in immediate dismissal from the practice.

After Hours: Our phone message will provide patients with a number to call our answering service for urgent needs after hours. The answering service will notify the physician on call.

Feedback: We appreciate all feedback provided. You will be receiving a patient satisfaction survey from Press Ganey. Please take time to complete this and let us know how we are doing.

Thank you for your understanding and agreeing to our Office Policies. We are committed to be an involved member of your Health Care Team working together for your health!

_____ _____

Signature of Patient or Guardian | Patient Date of Birth

_____ _____

Relationship to Patient, if not signed by the Patient | Date

Methodist
MEDICAL GROUP

Notice of Privacy Acknowledgement

Methodist Medical Group Notice of Privacy Practices provides information about how *Methodist Medical Group* may use and disclose your protected health information. You have the right to review the Notice before signing this acknowledgment. A copy of the current Notice is posted in the waiting room. The Notice contains the effective date and as provided in our Notice, the terms of our Notice may change.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for **treatment, payment and health care operations**, as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made disclosures on your prior consent.

This Privacy Acknowledgement does **not** give us consent to release records to anyone except to whom is mentioned. A signed medical release authorization form must be completed prior to us releasing records on your behalf.

Thank you for your understanding and agreeing to our Office Policies. We are committed to be an involved member of your Health Care Team working together for your health!

_____ _____

Signature of Patient or Guardian | Patient Date of Birth

_____ _____

Relationship to Patient, if not signed by the Patient | Date

Methodist
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Financial Policy

1. **Authorization to Release Information:**
I authorize **METHODIST MEDICAL GROUP** to furnish requested information from the patient's medical and other records to: (1) any insurance company or third party payer for the purpose of obtaining payment on account of (1) **METHODIST MEDICAL GROUP,** (2) any other person(s) or entities financially responsible for the patient's care or treatment, and (3) representatives of local, state, or federal agencies in accordance with law. Such information may include, but is not limited to, information concerning communicable diseases such as Acquired Immune Deficiency Syndrome ("AIDS"). I authorize the release of information from or the review of the patient's records for purposes of conducting medical audits, utilization reviews, or quality assurance reviews.

2. **Assignment of Benefits:**
We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment at the time of service. It is your responsibility to pay any deductible amount, coinsurance, or any other balance not paid for by your insurance at the time of service.

   If this account is assigned to an attorney for collection and or suit, the prevailing party shall be entitled to reasonable attorney's fees for costs of collection.

   I understand that I am responsible for providing **METHODIST MEDICAL GROUP** all insurance information at the time of registration to allow for verification of benefits, and that regardless of my assigned insurance benefits, I am responsible for the total charges for services rendered.

   I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance, and other health plans to **METHODIST MEDICAL GROUP**. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that in the event my health plan determines a service to be "non-covered", I will be responsible for all non-covered and allowable charges. I hereby authorize said assignee to release all information necessary to secure payment.

3. **Medicare / Medicaid Assignment of Benefits: (Do not complete unless you receive Medicare/Medicaid health care benefits)**
   a. I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize the release of information concerning me to the Social Security Administration or its intermediaries or carriers as well as any information needed for filing a Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign benefits payable for services to the physician or organization submitting a claim to Medicare for me.

      Initial _____

   b. I understand that Medicaid recipients are responsible for payment of any medical care or service received that is beyond the amount, duration and/or scope of the Texas Medicaid Program, as determined by the Medicaid Department or its health insuring agency. All payments for non-covered services are due and payable at the conclusion of each office visit unless prior payment arrangements have been made.

      Initial _____

_____ _____
Signature of Patient or Guardian (and relationship if not patient) Date

_____ [ ] Patient under 18 years of age
Witness

_____ _____
Translator (Print Name) Translator (Signature)