Methodist Charlton Ear, Nose and Throat Associates

REGISTRATION FORM – PLEASE PRINT

환자 정보 (PATIENT INFORMATION)		
성(Last Name) / 이름 (First Name) / Middle Name	생년월일 (DOB: Month/Day/Year) _____/_____/_____	성별 (Sex) ☐ 남자 (M) ☐ 여자 (F)
보호자 이름 (Name of Guardian)	환자와의 관계 (Relationship) ☐ 부 (Father) ☐ 모 (Mother) ☐ 친척 (Relative) ☐ 친구 (Friend)	
주소 (Address) 시 (City) 주 (State) 우편번호 (Zip)		
전화번호 (Phone) 집 (Home) 직장 (Work) 휴대폰 (Cell)		
응급시 연락처 (Emergency Contact Name)	관계 (Relationship)	전화 (Phone)
이메일주소 (Email Address)	소셜번호 (Social Security Number)	결혼관계 (Marital Status) ☐ 미혼 (Single) ☐ 기혼 (Married) ☐ 이혼 (Divorced) ☐ 미망인 (Widow)
직장 이름 / 주소 (Employer Name / Address)		학생시 신분 (Student Status) ☐ Full Time ☐ Part Time
인종 (Race) ☐ Black/African American ☐ Asian ☐ Caucasian ☐ Hispanic or Latino ☐ Other (Please Specify:)		
집에서 사용하는 언어 (Primary Language Spoken in the Home) ☐ English ☐ Spanish ☐ Korean ☐ Other (please define:)		참전용사 (Veteran) ☐ Yes ☐ No 흡연여부 (Smoker) ☐ Yes ☐ No

Methodist
CHARLTON EAR, NOSE AND THROAT ASSOCIATES

다음 사항을 정확히 기입하여 주십시오.

병원을 방문하신 이유 (Reason to See the Doctor):

지난 21 일동안 미국외 나라를 방문한 적이 있습니까? (Have you traveled outside the United States within the past 21 days?) 네 (Yes) / 아니오 (No) 방문한 나라 (Where):

최근에 미국외 나라를 방문시 아픈 사람과 접촉한 적이 있습니까? (Have you recently been exposed to someone ill who has traveled outside the United States?) 네 (Yes) / 아니오 (No)

열이 101.5 ° F 를 넘어간 적이 있습니까? (Has you had a fever of 101.5 ° F or greater?)
네 (Yes) / 아니오 (No)

Print Name: _____ Signature: _____ Date: _____

Methodist Charlton Ear, Nose and Throat Associates

PATIENT HEALTH QUESTIONNAIRE (pg 1/2) – PLEASE PRINT

성 (Last Name) / 이름 (First Name) / Middle Name	생년월일 (DOB: Month/Day/Year) _____/_____/_____
언제 마지막으로 파상풍 주사를 맞았습니까? (When was your last Tetanus Shot)	올해 독감 주사를 맞았습니까? (Have you had the flu shot this year?) ☐ 예 (Yes) ☐ 아니오 (No)
언제 마지막으로 병원을 방문하셨습니까? (Last doctor's visit)	의사이름 (Doctor's Name):

병력 (Medical History) – 해당 사항을 모두 체크하세요

어릴적 겪었던 병 (Childhood Illness): ☐ 류마티스성 열 (Rheumatic fever) ☐ 볼거리 (Mumps)
☐ 성홍열 (Scarlet fever) ☐ 수두 (Chicken pox) ☐ 소아마비 (Polio) ☐ 홍역 (Measles)

병력: ☐ 당뇨병 (Diabetes Mellitus) ☐ 천식 (Asthma) ☐ 고혈압 (Hypertension) ☐ 심장병 (Heart Disease)
☐ 녹내장 (Glaucoma) ☐ 편두통 (Migraine) ☐ 궤양 (Ulcers) ☐ 고콜레스테롤 (High Cholesterol)
☐ 뇌졸증 (Stroke) ☐ 결핵 (Tuberculosis) ☐ 신장병 (Kidney Disease) ☐ 암 (Cancer) ☐ 우울증 (Depression)
☐ 관절염 (Arthritis) ☐ 갑상선 질환 (Thyroid Disease) ☐ 빈혈 (Anemia) ☐ 골다공증 (Osteoporosis)
☐ 알코올 중독 (Alcoholism) ☐ 발작 경련 (Seizures) ☐ 정신병 (Mental Illness) ☐ 간염 (Hepatitis)
☐ 이외 병명이 있으시면 모두 나열해 주세요 (Other):
_____

약에 부작용있으시면 모두 나열해 주세요 (Drug Allergies):

지금 복용하고 계신 약들을 모두 나열해 주세요 (Current Medications including non-prescription medications and supplements):

입원 경력 (Hospitalizations):

수술 경력 (Surgeries):

Social History

직업 (Occupation):_____ 주당근무시간 (Hours per week):_____ 직업만족도 (Satisfied with job): ☐ 상 ☐ 중 ☐ 하

주량 (Alcohol): _____drinks per week 커피/차 (Coffee/Tea): _____ cups per day

담배 (Tabacco): Smoking: _____cigarettes per day # Years:_____ Year quit:_____
Chewing: _____cans per week # Years:_____ Year quit:_____

Recreational drugs 사용여부:
특별한 식이요법을 하고 계십니까?
운동은 규칙적으로 하고 계십니까?

가족병력 (Family History) F: 아버지 M: 어머니 S: 형제자매 C: 자녀 R: 다른친척
해당 사항을 모두 체크하세요.

☐ 당뇨병 (Diabetes): F M S C R
☐ 알코올 중독 (Alcoholism): F M S C R
☐ 심장병 (Heart Disease): F M S C R
☐ 천식 (Asthma): F M S C R
☐ 당뇨병 (Diabetes): F M S C R
☐ 빈혈 (Anemia): F M S C R
☐ 녹내장 (Glaucoma): F M S C R
☐ 편두통 (Migraine): F M S C R
☐ 갑상선 질환 (Thyroid Disease): F M S C R
☐ 고혈압 (Hypertension): F M S C R
☐ 관절염 (Arthritis): F M S C R
☐ 고지혈증 (High Cholesterol): F M S C R
☐ 발작 경련 (Seizures): F M S C R
☐ 골다공증 (Osteoporosis): F M S C R
☐ 뇌졸증 (Stroke): F M S C R
☐ 암 (Cancer): F M S C R 암명 (Caner Name): _____

Chart #:_____ Reviewed by _____ Date _____

Methodist Charlton Ear, Nose and Throat Associates

PATIENT HEALTH QUESTIONNAIRE (pg 2/2) – PLEASE PRINT

전체리뷰 (System Review): 최근 3 개월동안 겪어 왔던 모든 증상에 대해 체크하세요 (Check any of the following which you have had in the last 3 months)

일반사항 (General)	**알르레기 / 면역계통 (Allergies / Immune)**	**청력계통 (Ears)**	**신경계 (Neurologic)**
☐ 열/오한 (Fever/chills)	☐ 계절성 알르레기 (Seasonal allergies)	☐ 귀 통증(Ear pain)	☐ 두통(Headache)
☐ 피로 (Fatigue)	☐ 만성 알르레기 (Year round Allergies)	☐ 귀 먹먹함 (Popping – pressure)	☐ 어지럼증(Dizziness)
		☐ 이명 (Ringing in ears)	☐ 간질(Seizures)
위장계통 (Gastrointestinal)	**후각계통 (Nose)**	☐ 귀 염증 (Ear infections-frequent)	☐ 무감각(Numbness or tingling)
☐ 속쓰림 (Heartburn)	☐ 축농증 (Sinus trouble)	☐ 청력 손실 (Hearing loss)	☐ (Muscle weakness)
☐ 멀미/구토 (Nausea / vomiting)	☐ 콧물흘림 (Runny nose)	☐ 어지러움 (Dizziness)	☐ 기절(Passing out)
☐ 식욕감퇴 (Loss of appetite)			
☐ 몸무게 감소 (Weight loss)	**후두계통 (Throat)**	**눈계통 (Eyes)**	**피부계통 (Skin)**
☐ 삼키기 장애, 연하곤란 (Difficulty swallowing)	☐ 후두통증 (Sore throat)	☐ 눈 간지러움 (Eye irritation and itching)	☐ 두드러기 (Rash / hives)
☐ 복통 (Abdominal pain-chronic)	☐ 쉰 목소리(Hoarseness)	☐ 눈통증 (Eye pain)	☐ 아토피성 피부염 (Psoriasis / Eczema)
☐ 설사(Diarrhea)		☐ 눈병 (Eye infections)	☐ 피부반점 (New moles)
☐ 혈변 (Bloody or Tarry stools)	**호흡계통 (Respiratory)**	☐ 시력변화 (Vision changes)	
☐ 황달(Jaundice)	☐ 기침 (Cough)		**심장계 (Cardiac)**
☐ 간염(Hepatitis)	☐ 숨가쁨 (Shortness of breath)	**혈액계통(Hematology)**	☐ 가슴통증 (Chest pain)
☐ 대장게실(Diverticulosis)	☐ 천식 (Asthma / wheezing)	☐ 멍 (Bruising)	☐ 발목 부종 (Swollen ankles)
☐ 대장염(Colitis)	☐ 폐렴 (Pneumonia)	☐ 출혈 (Bleeding)	☐ 부정맥 (Irregular pulse)
	☐ 기관기염 (Bronchitis)	☐ 수혈 (Blood transfusions – lifetime)	☐ 도보시 다리통증 (Leg pain when walking)
		☐ 임파선 부종 (Enlarged lymph nodes)	☐ 심잡음 (Heart murmur)

Chart #:_____ Reviewed by _____ Date _____

Methodist Charlton Ear, Nose and Throat Associates

환자의료정보 공개 동의서
(Patient Preference Regarding Communication of Health Information)

「건강보험의 이전과 책임에 관한 법률 (HIPAA)」에 의거하여 환자의 프라이버시를 보호하기 위해서, 당사자 이외 환자가 지정한 제 3 자 (가족인이나 대리인)에게 환자 본인의 의료정보를 접근 혹은 공개를 허용할 경우 이 동의서에 서명이 필요합니다. 또한 공개 방식으로 NextMD 에서 지정한 연락정보에 의해 전화메세지, 메일통보, 이메일을 선택할수 있습니다.

In order to better protect your privacy under HIPAA (Health Insurance Portability and Accountability Act), we have created this consent form for releasing medical information to family members and other people of choosing. This will also be used for consent to leave you detailed telephone messages at the mentioned phone numbers, mail your lab results to your home and also send secure email results to your personal email address once enrolled in NextMD. Many times we have patient's family members call requesting medical information and legally we are not allowed to release that information without the patient's written consent. The purpose of this document is to protect your privacy.

환자가족 및 대리인 지정 (Communication to Family Members, Spouses or Other)

아래 지정한 사람에게 나의 조건과 치료방법에 관한 예약, 질문 등에 관한 의료정보를 공유하는것을 허락합니다.

I, 본인 이름 (Name)_____ 생년월일 (DOB) _____, hereby give my permission for the release of medical information regarding appointments and questions about my condition and treatments to the following person:

이름 (Name):_____ 관계 (Relation): _____ 전화번호 (Phone): _____

이름 (Name):_____ 관계 (Relation): _____ 전화번호 (Phone): _____

이름 (Name):_____ 관계 (Relation): _____ 전화번호 (Phone): _____

_____ 위에 지정한 가족, 친척, 또는 대리인 **이외** 어떤분에게도 본인의 어떠한 의료정보를 접근 혹은 공유를 허락치 않은 경우 여기에 체크하시기 바랍니다. (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).)

NextMD 를 통한 의료정보교환 (Electronic Communication via NextMD (Secure Electronic Medical Records))

_____ 네, NextMD 의 Patient Portal 을 통하여 의료정보를 교환하기를 원합니다. 검사 결과와 같은 확인할 정보가 있을시에 이메일로 연락해 드립니다. 이 이메일에는 보완이 된 웹사이트로 접속할 수도록 링크가 제공되어지며, 이 링크를 통해 본인이 정한 user name 과 password 로 검사 결과를 인터넷에서 확인하실 수 있습니다.

아래에 본인이 사용하고자 하는 이메일을 적어 주시기 바랍니다.
Email address: _____

_____ 아니오, NextMD 를 통한 인터넷상에서 의료정보를 교환하기를 원하지 않습니다. 이 경우 검사 결과는 예약을 통해 의사를 직접 만나서 확인하시거나 메일로 결과를 보내드릴 수 있습니다. 메일 확인시 최대 10 일 시간이 소요될 수 있습니다.

전화를 통한 의료정보교환 (Communication via the Telephone)

환자 의료정보 또는 예약 확인 등을 아래에 있는 전화번호의 음성메세지로 연락해 드립니다.

_____(회사/휴대폰/집전화) _____(회사/휴대폰/집전화)

동의서 서명 (Consent and Agreement)

위의 환자의료정보 공개 동의서에 설명되어진 가이드라인을 잘 이해하고 동의합니다.

서명 (Signature): _____ 날짜 (Date): _____

Methodist Charlton Ear, Nose and Throat Associates

환자의료정보 공개 동의서

(Financial Policy)

「건강보험의 이전과 책임에 관한 법률 (HIPAA)」에 의거하여 환자의 프라이버시를 보호하기 위해서

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

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
MEDICAL GROUP

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)