Peoria Ear Nose and Throat Group
7301 N Knoxville Ave, Peoria, IL 61614

PATIENT INFORMATION

Name:	Date of Birth:
Address One:	Social Security #:
Address Two:	Sex:
City:	Language:
State: Zip:	Race:
Primary Physician:	Ethnicity:
Referring Physician:	Patient Email:
Home Phone#:	Emergency Contact:
Work Phone#:	Emergency Phone#:
Cell Phone#:	Emergency Relationship:

GUARANTOR INFORMATION

Name:	Date of Birth:
Address One:	Social Security#:
Address Two:	
City:	Employer:
State: Zip:	Employer Address:
Home Phone#:	Employer City:
Work Phone#:	Employer State: Zip:
Cell Phone#:	

INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
Certificate#:	Certificate#:
Group Number:	Group Number:
Group Name:	Group Name:
Copay:	Copay:
Subscriber Name:	Subscriber Name:
Subscriber DOB:	Subscriber DOB:

I hereby request that all medical and/or surgical benefits including medical benefits to which I am entitled and government sponsored programs, private insurance, and any other health plan be sent directly to: PEORIA EAR, NOSE AND THROAT GROUP, S.C.

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 I am financially responsible for all charges whether or not paid by insurance. If collection is required, I understand and agree that I will be liable for all costs of collection, including but not limited to, attorney's fees and court costs. I hereby authorize said assignee to release all information necessary to secure payment.

_____ _____

Signed (patient or parent/guardian if minor) Date

PEORIA EAR, NOSE AND THROAT GROUP, S.C.
INFORMATION FOR YOUR PHYSICIAN

NAME _____ **DOB** _____ **TODAY'S DATE** _____

WHAT PROBLEM BRINGS YOU HERE TODAY?

_____

_____

HOW LONG HAVE YOU HAD IT?

_____

_____

MEDICATIONS/DIETARY SUPPLEMENTS

_____

_____

_____

PREVIOUS OPERATIONS (Dates, hospital and name of surgeon)

_____

_____

_____

MEDICAL HISTORY – PLEASE CHECK AL THE MEDICAL PROBLEMS YOU NOW HAVE OR HAVE HAD IN THE PAST:

_____ Heart problems
_____ Kidney problems
_____ Lung problems
_____ Thyroid problems
_____ High blood pressure
_____ Low blood pressure
_____ Diabetes
_____ Hypoglycemia (low blood sugar)
_____ High cholesterol or triglycerides
_____ Headaches
_____ Overweight by 25 lbs +
_____ Speech problems
_____ Problems with teeth/bite

_____ Eye infections or diseases
_____ Cancer
_____ Neurological disease
_____ Mononucleosis (Mono)
_____ Asthma
_____ Glaucoma
_____ Digestive problems
_____ Hearing problems
_____ Meningitis
_____ Herpes Zoster (shingles)
_____ Anemia (low blood count)
_____ Rheumatic fever
_____ Allergies

_____ Nose or sinus problems
_____ Throat problems
_____ Hoarseness or voice problems
_____ Stroke
_____ Venereal Disease (VD, Syphilis, Gonorrhea)
_____ Ringing or noises in ear
_____ Loss or change in sense of smell
_____ Swallowing problems
_____ Enlarged lymph nodes
_____ Neck masses
_____ Fibromyalgia
_____ Hepatitis B or C

HAVE YOU HAD ALLERGY OR SENSITIVITY TO MEDICINES, LATEX OR OTHER SUBSTANCES?
☐ NO ☐YES LIST: _____

DO YOU USE TOBACCO NOW: ☐ NO ☐YES	TYPE & DAILY AMOUNT	# OF YEARS	IN THE PAST?	QUIT WHEN	TYPE & DAILY AMOUNT	# OF YEARS

DO YOU USE ALCOHOLIC BEVERAGES? ☐ NO ☐YES	TYPE	WEEKLY AMOUNT	HOW LONG?

DO YOU DRINK COFFEE, TEA OR SOFT DRINKS WITH CAFFEINE? ☐ NO ☐YES	WEEKLY AMOUNT	HOW LONG?

FEMALES ONLY: ARE YOU PREGNANT, PLANNING A PREGNANCY, OR NURSING A CHILD? ☐ NO ☐YES

FAMILY HISTORY: ANESTHESIA COMPLICATIONS/BLEEDING OR BRUISING PROBLEMS/OTHER?

_____

PEORIA EAR, NOSE, & THROAT GROUP

THE SINUS, ALLERGY & HEARING CENTER OF EXCELLENCE
7301 N. KNOXVILLE AVE.
PEORIA, IL 61614
www.peoriaent.com
PH. 309-589-5900
FAX. 309-689-0312

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CONSENT FOR RELEASE OF MEDICAL RECORDS

AUTHORIZATION

I hereby consent to and authorize

_____

_____

(Name and address of Physician, Hospital, Facility or Agency)

To furnish to Peoria Ear, Nose & Throat Group, medical records and information pertaining to medical history, services rendered or treatment given to me for purposes of review and evaluation. This information may be delivered by mail, fax or electronic delivery. I further authorize Peoria Ear, Nose & Throat Group to deliver and receive copies of my medical records. I consent to allow Peoria Ear, Nose & Throat Group to disclose or receive any medical history pertaining to my care from/to appropriate healthcare providers.

_____ _____

PATIENT NAME DATE OF BIRTH

DURATION

This authorization shall become effective immediately and shall remain in effect while I remain a patient of Peoria Ear, Nose & Throat Group, or for three (3) years.

_____ _____

PATIENT OR PARENT/GUARDIAN SIGNATURE DATE

PEORIA EAR, NOSE & THROAT GROUP, S.C.

7301 NORTH KNOXVILLE AVE
PEORIA, ILLINOIS 61614

NOTICE OF PATIENT PREFERENCE FOR LABS AND TESTING

Print Patient Name: _____ **Date:** _____

Date of Birth: _____

In accordance with my current health insurance plan, any lab or testing should be performed at or go through:

Hospital: _____ Lab Service: _____

Pathology: _____
I understand that it is my responsibility to alert PENTG to any changes.

OFFICE FINANCIAL POLICY

There are numerous insurance networks in the Peoria market. Our physicians are not a part of all of these networks and, therefore, they have not agreed to accept a reduced fee from all insurance companies. Many insurance companies pay a different percentage of charges based on whether or not the physician is a part of the network. **It is the responsibility of the patient** to know and understand the benefits of his/her particular insurance plan.

Insurance coverage is a contract between the patient and the insurance carrier; however, the office will assist in every way in order to maximize your insurance benefits. The patient will be responsible for any deductible, co-insurance, co-pay and non-covered benefits according to the insurance plan. By law, the insurance carrier must remit payment or deny the insurance claim within 30 days of initial notice of claim. If an insurance problem occurs, the patient may be asked to assist the office in contacting the carrier and/or in filing a complaint with the State Insurance Commissioner.

The following information is office policy concerning payment for professional services:

1. **If our physician is not contracted with your insurance plan network, the patient will be required to remit full payment at the time of the office visit.**
2. All patients will be required to establish financial arrangements for payment of their account.
3. According to each contract that we have with an insurance company, we are required to collect the co-payment at the time of service, as well as payment of deductible and co-insurance upon receipt of Explanation of Benefits.
4. Clinical office visit charges only cover the cost of your appointment with the nurse, physician or physician's assistant (or combination thereof) on the day of your appointment. This charge does not cover any additional diagnostic testing, labs, scopes, CT scans, audiological or allergy testing or supplies or any other tests or procedures that may be appropriate before, during or after your visit with our medical provider. Your insurance company may or may not cover some or all of the costs of these additional tests or services and you have the right to accept or refuse any of

these services. However, refusing diagnostic testing, labs, scopes a CT scan or audiological services could limit the medical provider's ability to properly diagnose and treat your medical condition and may limit our ability to provide an appropriate surgical treatment or solution.

5. Each month patients will receive a statement for services which is due and payable by the payment due date on the statement. If payment is late, or if the patient has not previously made financial arrangements, a second invoice will be mailed stating that the account is in review, please call our office.
6. Any questions concerning the office financial policy or a patient's need for assistance should be immediately directed to the billing manager or practice manager.
7. If an insurance company has not settled a claim within 60 days, the patient will be notified and responsibility for the balance, which will transfer to the patient.
8. Accounts that have an outstanding balance for over 90 days may be sent to an outside collection agency. **If an account is sent to the collection agency, additional service fees will be added by the agency and the account must be settled through them.**

I have read this policy and hereby authorize my insurance benefits to be paid directly to this physician office, realizing that I am responsible to pay non-covered services. I further authorize the release of pertinent medical information to my insurance carriers.

Patient's or Guardian's signature: _____

Date: _____

A photocopy of this assignment shall be considered as effective and valid as the original.

Peoria Ear, Nose & Throat Group, S.C.
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This practice creates a medical record of your health information in order to treat you, receive payment for services delivered, and to comply with certain policies and laws. We are also required by law to provide you with this Notice of our legal duties and privacy practices. In addition, the law requires us to ask you to sign an Acknowledgment that you received this Notice.

We are required by federal and state law to maintain the privacy of your medical information. Medical information is also called "protected health information" or "PHI." We are also required by law to notify you if you are affected by a breach of your unsecured PHI.

This is a list of some of the types of uses and disclosures of PHI that may occur:

Treatment: We obtain health information, or PHI, about you to treat you. Your PHI is used by us and others to treat you. We may also send your PHI to another physician, facility, or counselor to which we refer you for treatment, care, procedures, or testing. We may also use your PHI to contact you to tell you about alternative treatments, or other health-related benefits we offer. If you have a friend or family member involved in your care, we may give them PHI about you.

Payment: We use your PHI to obtain payment for the services that we render. For example, we send PHI to Medicaid, Medicare, or your insurance plan to obtain payment for our services.

Health Care Operations: We use your PHI for our operations. For example, we may use your PHI in determining whether we are giving adequate treatment to our patients. From time-to-time, we may use your PHI to contact you to remind you of an appointment.

Legal Requirements: We may use and disclose your PHI as required or authorized by law. For example, we may use or disclose your PHI for the following reasons:

Public Health: We may disclose your health information to prevent or control disease, injury or disability, to report births and deaths, to report reactions to medicines or medical devices or to report suspected cases of abuse or neglect.

Health Oversight Activities: We may use and disclose your PHI to state agencies and federal government authorities when required to do so. We may use and disclose your health information in order to assist others in determining your eligibility for public benefit programs and to coordinate delivery of those programs. For example, we must give PHI to the Secretary of Health and Human Services in an investigation into our compliance with the federal privacy rule.

Judicial and Administrative Proceedings: We may use and disclose your PHI in judicial and administrative proceedings. Efforts may be made to contact you prior to a disclosure of your PHI to the party seeking the information.

Law Enforcement: We may use and disclose your PHI in order to comply with requests pursuant to a court order, warrant, subpoena, summons, or similar process. We may use and disclose PHI to locate someone who is missing, to identify a crime victim, to report a death, to report criminal activity at our offices, or in an emergency.

Avert a Serious Threat to Health or Safety: We may use or disclose your PHI to stop you or someone else from getting hurt.

Work-Related Injuries: We may use or disclose PHI to an employer if the employer is conducting medical workplace surveillance or to evaluate work-related injuries.

Coroners, Medical Examiners, and Funeral Directors: We may use or disclose PHI to a coroner or medical examiner in some situations. For example, PHI may be needed to identify a deceased person or determine a cause of death. Funeral directors may need PHI to carry out their duties.

Armed Forces: We may use or disclose the PHI of Armed Forces personnel to the military for proper execution of a military mission. We may also use and disclose PHI to the Department of Veterans Affairs to determine eligibility for benefits.

National Security and Intelligence: We may use or disclose PHI to maintain the safety of the President or other protected officials. We may use or disclose PHI for the conduct of national intelligence activities.

Correctional Institutions and Custodial Situations: We may use or disclose PHI to correctional institutions or law enforcement custodians for the safety of individuals at the correctional institution, those that are responsible for transporting inmates, and others.

Research: You will need to sign an Authorization form before we use or disclosure PHI for research purposes except in limited situations. For example, if you want to participate in research or a clinical study, an Authorization form must be signed.

Fundraising: We do not engage in fundraising activities. We do not engage in marketing activities, and need your authorization to do so.

Immunizations: If we obtain and document your verbal or written agreement to do so, we may release proof of immunization to a school where you are a student or prospective student.

Illinois law: Illinois law also has certain requirements that govern the use or disclosure of your PHI. In order for us to release information about mental health treatment, genetic information, your AIDS/HIV status, and alcohol or drug abuse treatment, you will be required to sign an Authorization form unless state law allows us to make the specific type of use or disclosure without your authorization.

Your Rights: You have certain rights under federal and state laws relating to your PHI. Some of these rights are described below:

Restrictions: You have a right to request restrictions on how your PHI is used for purposes of treatment, payment and health care operations. We are not required to accommodate to your request, except as required by law. The practice is required to comply with your request for restrictions on the use or disclosure of your PHI to health plans for payment or health care operations purposes when the practice has been paid out of pocket in full and the practice has been notified of the request for restriction in writing, and the disclosure is not required by law.

Communications: You have a right to receive confidential communications about your PHI. For example, you may request that we only call you at home. If your request is reasonable, it may be accepted.

Inspect and Access: You have a right to inspect your health information. This information includes billing and medical record information. You may not inspect your record in some cases. If your request to inspect your record is denied, we will send you a letter letting you know why and explaining your options.

You may have a paper or electronic copy of your PHI in most situations. If you request a copy of your PHI, we may charge you a fee for making the copies and mailing them to you, if you ask us to mail them.

Amendments of Your Records: If you believe there is an error in your PHI, you have a right to request that we amend your PHI. We are not required to agree with your request to amend.

Accounting of Disclosures: You have a right to receive an accounting of disclosures that we have made of your PHI for purposes other than treatment, payment, and health care operations, or release made pursuant to your authorization.

Copy of Notice: You have a right to obtain a paper copy of this Notice, even if you originally received the Notice electronically. We have also posted this Notice at our offices.

Complaints: If you feel that your privacy rights have been violated, you may file a complaint with us by calling our Privacy Officer at (309) 589-5900. We will not retaliate against you for filing a complaint. You may also file a complaint with the Secretary of Health and Human Services in Washington, DC if you feel your privacy rights have been violated.

Authorizations: We are required to obtain your written Authorization when we use or disclose your PHI in ways not described in this Notice or when we use or disclose your PHI as follows: for marketing purposes, for the sale of your PHI, or for uses and disclosures of psychotherapy notes (except certain uses and disclosures for treatment, payment, or health care operations). You may revoke your Authorization at any time in writing, except to the extent that we have already acted on your Authorization.

We are required to abide with terms of the Notice currently in effect, however, we may change this Notice. If we materially change this Notice, you can get a revised Notice by stopping by our office to pick up a copy. Changes to the Notice are applicable to the health information we already have.

By signing below, I hereby acknowledge that I have had an opportunity to review and have received or have been offered a copy of Peoria Ear, Nose and Throat Group's Notice of Privacy Practices, effective as of the date of my signature.

_____ _____ _____

Print Patient Name **Date of signature** **Patient Date of Birth**

_____

Signature of Patient/Representative/Guardian

I hereby authorize this office to use or disclose my Patient Health Information to the following person(s):

_____

_____

_____

Do you give Peoria Ear, Nose and Throat Group authorization to leave test results on your answering machine or voicemail?

Yes **No**

PEORIA
EAR, NOSE,
& THROAT
GROUP

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Dear Parent(s) or Guardian(s):

Under Illinois law, except in narrowly defined circumstances a minor is a person who has not attained the age of 18 years. Only a parent or guardian may consent for non-emergency medical treatment or evaluation of a minor child.

However, there may be times when, for various reasons a parent or guardian will not be available to accompany a minor on a visit to our clinic. A grandparent, aunt, uncle, nanny or even a family friend may be available and willing to serve as the responsible adult in a parent or guardian's absence. In order for our providers to legally treat a minor and share HIPAA protected medical information with the accompanying adult we will need your specific written consent.

In order to help facilitate treatment of a minor we have prepared the following authorization form that you may use:

CONSENT BY PROXY FOR NON-URGENT TREATMENT OF MINORS

This form grants authority to the providers of Peoria Ear, Nose & Throat Group, S.C. to deliver medical care to minors if a parent or legal guardian cannot be present prior to or during treatment and allows someone specifically authorized by you to accompany your child and serve as the "Medical Decision Maker" for the minor on his or her visit to our clinic.

In order for us to properly treat a minor when accompanied by someone other than that child's parent or guardian we would need to have this form or a similar form signed and witnessed listing parent or guardian's name, minor's name and date of birth, period of time the authorization covers and the name or names of the individual(s) you are entrusting to make medical decisions on your behalf.

We are happy to assist with any questions or concerns you may have on this or any other of our Practice's policies or procedures.

Sincerely,

Robert J Tudor II
Administrator

PEORIA EAR, NOSE & THROAT GROUP, S.C.
7301 N KNOXVILLE AVE
PEORIA, IL. 61614

CONSENT BY PROXY FOR NON-URGENT TREATMENT OF A MINOR

Please print or type

I, _____, custodial parent or guardian of

_____, a minor, do hereby authorize the following named individual(s); (example: name of friend, grandparent, aunt, uncle, care-giver, etc.)

a. _____

b. _____

c. _____

as my Proxy Decision Maker(s) for consenting to non-urgent medical care including but not limited to any x-ray examination, ct-scan, anesthesia, medical evaluation and/or treatment, surgical evaluation, and/or treatment, diagnosis or care which is deemed advisable by and is to be rendered under the general or special supervision of a licensed physician. It is understood that this authorization is given to provide authority and power on the part of the aforesaid proxy holder(s) to give specific consent to any and all such evaluation, diagnosis, office treatment, anesthetic administration or surgical treatment(s) which a physician, in the exercise of his/her best judgment, may deem advisable.

This authorization also grants to my proxy holder(s) the power to sign for release of information to any third party payers who may be responsible for part or all of the cost of the services provided. This authorization shall remain effective from ____/____/____ to ____/____/____, unless sooner revoked in writing and delivered to proxy holder and this Practice.

_____	_____	_____
Date	Signature of custodial parent or guardian	Witness

PATIENT INFORMATION FOR MINOR LISTED ABOVE

Patient's Name: _____ Date of Birth: ____/____/____

Home Address: _____

_____

Current Medication(s): _____

Allergies: _____

Parent or Guardian Name(s): (1) _____

Relationship _____

(2) _____

Relationship _____

Primary Insurance Company: _____

Person who carries this Insurance: _____

Address (if different from patient): _____

Insurance ID Number: _____ Group Number: _____