

Receipt of Notice of Privacy Practices

I, _____ have received a copy of the Notice of Privacy Practices from **SIERRA NEVADA ENT. ASSOCIATES** concerning how the use or disclosure of Protected Health Information will be handled by the practice.

Copy available upon request.

Patient Signature

Date

ropt01

SIERRA NEVADA
EAR, NOSE & THROAT ASSOCIATES

OTOLARYNGOLOGY • HEAD & NECK SURGERY
OTOLOGY • FACIAL PLASTIC & LASER SURGERY
ALLERGY • AUDIOLOGY & HEARING AIDS

PAUL D. MANOUKIAN, M.D., M.P.H.
K. BRIAN ROMANESCHI, M.D.
JOHN A. FOREST III, M.D.

NOTICE OF PRIVACY PRACTICES

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

Our goal is to take appropriate steps to attempt to safeguard any medical or other personal information that is provided to us. We are required to: (i) maintain the privacy of medical information provided to us; (ii) provide notice of our legal duties and privacy practices; and (iii) abide by the terms of our Notice of Privacy Practices currently in effect.

WHO WILL FOLLOW THIS NOTICE

This notice describes the practices of our employees and staff as well as.

- **All of these individuals, entities, sites, and locations will follow the terms of this notice. In addition, these individuals, entities, sites, and locations may share medical information with each other for the treatment, payment, or health care operations purposes described in this notice.**

INFORMATION COLLECTED ABOUT YOU

In the ordinary course of receiving treatment and health care services from us, you will be providing us with personal information such as:

- Your name, address, and phone number
- Information relating to your medical history
- Your insurance information and coverage
- Information concerning your doctor, nurse, or other medical providers.

In addition, we will gather certain medical information about you and will create a record of the care provided to you. Some information also may be provided to us by other individuals or organizations that are part of your "circle of care" - such as the referring physician, your other doctors, your health plan, and close friends or family members.

INDIVIDUAL RIGHTS

You have the right to ask for restrictions on the ways in which we use and disclose your medical information beyond those imposed by law. We will consider your request, but we are not required to accept it.

You have the right to request that you receive communications containing your protected health information from us by alternative means or at alternative locations. For example, you may ask that we only contact you at home or by mail.

Except under certain circumstances, you have the right to inspect and copy medical and billing records about you. If you ask for copies of this information, we may charge you a fee for copying and mailing.

If you believe that information in your records is incorrect or incomplete, you have the right to ask us to correct the existing information or correct this missing information. Under certain circumstances, we may deny your request.

You have a right to ask for a list of instances when we have used or disclosed your medical information for reasons other than your treatment, payment for services furnished to you, our health care operations, or disclosures you give us authorization to make. If you ask for this information from us more than once every twelve months, we may charge you a fee.

You have the right to a copy of this Notice in paper form. You may ask us for a copy at any time.

To exercise any of your rights, please contact us in writing: Privacy Officer, Sierra Nevada ENT Associates, P.O. Box 4270, Carson City, Nevada 89702.

HOW WE MAY USE AND DISCLOSE INFORMATION ABOUT YOU

We may use and disclose personal and identifiable health information about you in different ways. All of the ways in which we may use and disclose information will fall within one of the following categories, but not every use or disclosure in a category will be listed.

We may disclose information in response to a warrant, subpoena, or other order of a court or administrative hearing body, and in connection with certain government investigations and HIPPA law enforcement activities, as the law requires.

We may release personal health information to a coroner or medical examiner to identify a deceased person or determine the cause of death. We also may release personal health information to organ procurement organizations, transplant centers, and eye or tissue banks.

We may release your personal information to workers' compensation or similar programs.

Information about you also will be disclosed when necessary to prevent a serious threat to your health and safety or the health and safety of others.

We may use or disclose certain personal health information about your condition and treatment for research purposes where an Institutional Review Board or a similar body referred to as a Privacy Board determines that your privacy interests will be adequately protected in the study. We may also use and disclose your protected health information to prepare or analyze a research protocol and for other research purposes.

If you are a member of the Armed Forces, we may release personal health information about you as required by military command authorities. We also may release personal health information about foreign military personnel to the appropriate foreign military authority.

We may disclose your protected health information for legal or administrative proceedings that involve you. We may release such information upon order of a court or administrative tribunal. We may also release protected health information in the absence of such an order and in response to a discovery or other lawful request, if efforts have been made to notify you or secure a protective order.

If you are an inmate, we may release protected health information about you to a correctional institution where you are incarcerated or to law enforcement officials.

Finally, we may disclose protected health information for national security and intelligence activities and for the provision of protective services to the President of the United States and other officials or foreign heads of state.

OUR PROFESSIONAL BUSINESS ASSOCIATES

We sometimes work with outside individuals and businesses who help us operate our business successfully. We may disclose your health information to these business associates so that they can perform the tasks that we hire them to do. Our professional business associates must guarantee to us, in writing, that they will respect the confidentiality of your personal and identifiable health information (Business Associate Agreement on file).

INDIVIDUALS INVOLVED IN YOUR CARE OR PAYMENT FOR YOUR CARE

We may disclose information to individuals involved in your care or in the payment for your care, but we will obtain your agreement before doing so. This includes people and organizations that are part of your "circle of care" - such as your spouse, your other doctors, or an aide who may be providing services to you. Although we must be able to speak with your other physicians or health care providers, you can let us know if we should not speak with other individuals, such as your spouse or family.

Appointment Reminders: We may use and disclose medical information to contact you as a reminder that you have an appointment or that you should schedule an appointment.

Treatment Alternatives: We may use and disclose your personal health information in order to tell you about or recommend possible treatment options, alternatives or health-related services that may be of interest to you.

OTHER USES AND DISCLOSURES OF PERSONAL INFORMATION

We are required to obtain written authorization from you for any other uses and disclosures of medical information other than those described above. If you provide us with such permission, you may revoke that permission, in writing, at any time. If you revoke your permission, we will not longer use or disclose personal information about you for the reasons covered by your written authorization. We will be unable to take back any disclosures already made based upon your original permission.

CHANGES TO THIS NOTICE

We reserve the right to make changes to this notice at any time. We reserve the right to make the revised notice effective for personal health information we have about you as well as any information we receive in the future. In the event there is a material change to this Notice, the revised Notice will be posted. In addition, you may request a copy of the revised Notice at any time.

COMPLAINTS / COMMENTS

If you have any complaints concerning our Privacy Policy, you may contact the Secretary of the Department of Health and Human Services at: 200 Independence Avenue SW, Room 509F, HHH Building, Washington, D.C. 20201 (e-mail: ocrmail@hhs.gov). You also may contact us at: Privacy Officer, Sierra Nevada ENT Associates, P.O. Box 4270, Carson City, Nevada 89702.

To obtain more information concerning this Notice of Privacy Practices, you may contact our Privacy Officer at: Privacy Officer, Sierra Nevada ENT Associates, P.O. Box 4270, Carson City, Nevada 89702.

This Privacy Policy is effective April 14, 2003.

Sierra Nevada Ear, Nose and Throat Associates

Please Print Clearly

Patient Information

Patient Name _____
Last First Middle

Date of Birth _____ **Age** _____ **Gender:** M F **SSN#** _____

Home Phone _____ **Cell Phone** _____

Mailing Address _____

City _____ **State** _____ **Zip** _____

Employer _____ **Work #** _____

Emergency Contact _____ **Phone #** _____

Spouse, Parent, or Guardian Information

Name _____ **Date of Birth** _____ **SSN#** _____

Mailing Address _____

City _____ **State** _____ **Zip** _____

Home Phone _____ **Cell Phone** _____

Employer _____ **Work #** _____

Referring Doctor _____ **Location/Phone #** _____

Primary Doctor _____ **Phone #** _____

Pharmacy _____ **Location** _____

The undersigned hereby consents to and authorizes treatment by the physicians of Sierra Nevada Ear, Nose and Throat Associates. This authorization expires one year from the signature date and may be revoked, in writing, at anytime. The undersigned acknowledges and agrees that he/she has read the above and is ultimately liable for any unpaid medical bills for services rendered.

Signature of patient, parent, or legal guardian

Date

Sierra Nevada Ear, Nose, and Throat Associates

Patient Health History

Name _____ Occupation _____

Chief Complaint/Main Problem(s): _____

Past Or Current Medical Problem(s): _____

Prior Surgeries: _____

Current Medications / Dose: _____

Allergies To Medications: _____

Social History:

Marital Status: _____ Single / Married / Divorced / Widowed

Exercise frequency: _____

Tobacco Use: Yes / No _____ Current _____ Past (quit when? _____) Quantity _____ packs/day _____ years of use

Alcohol Use: Yes / No _____ Quantity: _____ (frequency and amount)

Drug Use: Yes / No _____ Explain: _____

Caffeine: Yes / No _____ Quantity: _____ (frequency and amount)

FAMILY HISTORY

Alive (yes/no)

Cause of death

Age at death

Father: _____

Mother: _____

Sibling(s): _____

Do you have a family history of :

Heart disease **Yes/No** Diabetes **Yes/No** High blood pressure **Yes/No**

Stroke **Yes/No** Thyroid disease **Yes/No**

Cancer (include location) **Yes/No** _____

Other (please list) _____

Do you experience the following?

Understand words but not the meaning of the conversation? **Yes/No**

Have trouble hearing in background noise? **Yes/No**

Friends/Family tell you that you have hearing loss? **Yes/No**

Hear a ringing, buzzing or other noise in ears? **Yes/No**

Feel room spinning, vertigo or imbalance? **Yes/No**

Patient Signature: _____ Date: _____

Reviewed By:	Date:
<input type="checkbox"/> K. Brian Romaneschi, MD _____	
<input type="checkbox"/> Paul D. Manoukian, MD, MPH _____	
<input type="checkbox"/> John A. Forest, MD _____	

Symptoms Review

(Please indicate any that you **CURRENTLY HAVE** or have had **IN THE PAST YEAR**)

General:

- fever
- weight loss
- fatigue
- night sweats
- head trauma

Respiratory:

- frequent cough
- painful breathing
- shortness of breath
- sputum production
- noisy breathing
- recurrent infection
- wheezing

Cardiovascular:

- chest pain
- irregular heart beats
- murmurs
- valve disease
- severe leg pain with exercise

Mouth/Throat:

- difficulty swallowing
- hoarseness
- non-healing sores
- neck mass

Ears:

- ear pain
- ear discharge
- deformity of ear
- prominent ear

Nose:

- nasal deformity
- nasal breathing difficulty
- sinus pain or headache
- allergy symptoms
- nasal discharge
- bloody noses

Eyes:

- double vision
- scratchy eyes
- loss of vision
- eye pain

Gastrointestinal:

- abdominal pain
- bloody vomit
- black bowel movement
- diarrhea/constipation
- jaundice (yellow skin)

Genitourinary:

- blood in urine
- painful urination
- penile/vaginal discharge
- pregnant at present

Endocrine:

- excessive thirst
- frequent urination
- hot/cold intolerance

Hematologic:

- bleeding tendencies
- immune dysfunction

Neurologic:

- numbness
- muscle weakness
- frequent headache

Musculoskeletal:

- joint pain

Skin:

- new skin lesions (e.g., moles)
- non-healing sore
- painful lesions
- rashes

Psychiatric:

- panic attacks/depression

Other: (Please List)

Patient Signature: _____ **Date:** _____

Physician's Signature:	Date:
<input type="checkbox"/> K. Brian Romaneschi, MD _____	
<input type="checkbox"/> Paul D. Manoukian, MD, MPH _____	
<input type="checkbox"/> John A. Forest, MD _____	

Sierra Nevada Ear, Nose, and Throat

PLEASE PRINT CLEARLY

PLEASE COMPLETE ALL SECTIONS

INSURANCE INFORMATION

Primary Insurance Policy Holder

Policy Holder

Last

First

Middle

Date of Birth

SSN #

Mailing Address

City

State

Zip

Home Phone

Cell Phone

Employer

Work#

ext.

What is policy holder relationship to patient? _____

Secondary Insurance Policy Holder

Policy Holder

Last

First

Middle

Date of Birth

SSN #

Mailing Address

City

State

Zip

Home Phone

Cell Phone

Employer

Work#

ext.

What is policy holder relationship to patient? _____

Is this a workers comp claim? If yes, please fill out below

Yes No

Date of Injury on the job

Case #

Employers Name

Work #

Workers Comp Carrier

Carrier Address

City

State

Zip

Signature of patient, parent, or legal guardian

Date

FOR OFFICE USE ONLY: VERIFICATION IN: _____ VERIFICATION OUT: _____

SIERRA NEVADA
EAR. NOSE & THROAT

FINANCIAL POLICY

Our practice accepts most insurance. We expect all deductibles, co-pays and percentages of the bill that are the responsibility of the patient to be paid at the time of service.

If we are not contracted with your carrier, we will expect payment in full for today's visit. We will bill your insurance, as a courtesy, for your reimbursement. We accept VISA, Mastercard, and Discover for your convenience. As a courtesy we will bill your secondary insurance. Extenuating financial circumstances will be handled in a confidential manner between the patient, the physician, and the patient service representative.

If your insurance is an HMO (Health Maintenance Organization) or EPO (Exclusive Provider Organization), it is your responsibility to first obtain the required authorization from your Primary Care Provider (PCP) prior to the appointment, and present the authorization at the reception desk before being seen by the doctor.

We reserve the right to charge \$35 for cancelled appointments, or missed appointments without 24 hour advance notice. We reserve the right to charge \$75 for cancelled VNG's without 48 hours advance notice and \$250 for cancelled surgeries without a 7 day advance notice.

DISCLOSURE OF PHYSICIAN OWNERSHIP

Please carefully review the information contained in this notice.

1. Certain physicians in this office have interests in Sierra Surgery and Imaging, LLC and New River Ambulatory Surgery Center.
2. You have the right to choose the provider of your health care services. Therefore, you have the option to use a health care facility other than the facilities listed above.
3. You will not be treated differently by your physician if you choose to obtain health care services at a facility other than those listed above.

If you have any questions concerning this notice, please feel free to ask your physician or any representative of one of these facilities. We welcome you as a patient and value our relationship with you.

***** Effective 1/1/2009: We will be charging a \$10.00 fee for secondary disability forms. *****

I have read this Financial Policy and consent to being responsible for any unpaid medical bills for services received.

Patient / Parent / Legal Guardian (Print)

Date

Patient / Parent / Legal Guardian (Signature)

Relationship

Patient Name (Print)

Sierra Nevada Ear, Nose and Throat Associates

Patient Name: _____ **Guardian:** _____

Date of Birth: ____ / ____ / ____ **SSN:** _____

Please Read Information Below and Sign

Your Insurance Policy

Please help us help you. There are hundreds of insurance companies and it is impossible for our staff to know the specific requirements of each!

It is YOUR responsibility to know your insurance. You should know your policies:

- CONTRACTED PROVIDERS
- Need for PRIOR AUTHORIZATION for procedures
- SPECIFIC FACILITY for lab work and x-ray
- CO-PAYMENT amount
- Your YEARLY DEDUCTIBLE.

Protocol for Prescription Refills

In order to be efficient, these are the set policies that are in effect regarding all prescriptions:

In Office Refills

- Contact our Dispensing Technician @ (775) 283-3336.
- Please allow **48-72 hours on refill request.**

Pharmacy Refills

- Contact your Pharmacy directly on request for refill.
- Please allow **48-72 hours on refill requests.**

HIPAA Exceptions

(Patient privacy-regarding: leaving phone messages)

Please circle ALL that apply:

- Is it OK to leave message regarding appointments ONLY? YES / NO
Is it OK to leave message with my spouse? YES / NO
Is it OK to have message left on my answering machine with personal information? YES / NO

If you would like us to leave messages with a friend or family member just add their name below. Thank you.

Name:	Phone Number:

I have read and understood the above information regarding MY INSURANCE POLICY, PRESCRIPTION REFILLS and the HIPAA EXCEPTIONS AUTHORIZATION for LEAVING PHONE MESSAGES for the patient.

Patient/Guardian Name: _____

Patient/Guardian Signature: _____

Date: _____