SIERRA NEVADA
EAR • NOSE • THROAT

www.sierranevadaent.com

Patient Information

Patient Name _____
Last First Middle

Date of Birth _____ **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 #** _____

Race _____ **Ethnicity** _____ **Preferred Language** _____

Email Address _____

Referring Doctor _____ **Primary Doctor** _____

Pharmacy _____ **Location** _____

May we receive your Rx history from your pharmacy? _____ Yes or No

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 **Please Print Clearly**

INSURANCE INFORMATION

Responsible Party

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

Home Phone _____ **Cell Phone** _____

Primary Insurance

Please list the information for the Policy Holder

Name _____
Last First Middle

Date of Birth _____ **SSN#** _____

Home Phone _____ **Cell Phone** _____

Employer _____ **Work #** _____

Secondary Insurance

Please list the information for the Policy Holder

Name _____
Last First Middle

Date of Birth _____ **SSN#** _____

Home Phone _____ **Cell Phone** _____

Employer _____ **Work #** _____

Is this a workers comp claim? If Yes, please fill out below: YES NO

Date of Injury _____ Case# _____

Employer _____ Work # _____

Work Comp Carrier _____ Case Manager Name _____

Address _____ Phone _____

_____

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):_____

Current Medications/Dose:_____

_____

_____

Past Or Current Medical Problem(s): Please circle Yes or No

Heart disease	**Yes / No**	Diabetes	**Yes / No**	High blood pressure	**Yes / No**
Stroke	**Yes / No**	Thyroid disease	**Yes / No**	Asthma	**Yes / No**
Sleep Apnea	**Yes / No**	COPD	**Yes / No**	Acid Reflux	**Yes / No**
Anemia	**Yes / No**	Blood Clots	**Yes / No**	Migraines	**Yes / No**
Depression	**Yes / No**	Anxiety	**Yes / No**	High Cholesterol	**Yes / No**
Cancer	**Yes / No If yes, location:**				

Other medical history (please list)_____

Prior Surgeries:_____

_____

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)

Do you have a FAMILY HISTORY of:

FAMILY HISTORY	ALIVE (YES / NO)	AGE AT DEATH	DIABETES	HIGH BLOOD PRESSURE	HEART DISEASE	STROKE	THYROID	CANCER (TYPE)
Father:								
Mother:								
Siblings:								

Other significant family history (please list)_____

Do you experience the following?

Do you hear words but not understand 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:_____

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
___ ringing in ears
___ decreased hearing

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

Endocrine:
___excessive thirst
___frequent urination
___hot intolerance
___cold intolerance

Hematologic:
___bleeding tendencies
___immune dysfunction

Neurologic:
___numbness
___muscle weakness
___frequent headache
___dizziness
___balance difficulty

Musculoskeletal:
___ joint pain

Skin:
___new skin lesions (e.g., moles)
___non-healing sore
___painful lesions
___rashes

Psychiatric:
___ panic attacks
___depression
___anxiety

Other: (Please List)
_____
_____
_____
_____

Patient Signature: _____ **Date:** _____

Sierra Nevada Ear, Nose and Throat Associates

FINANCIAL POLICY

Our practice accepts most insurance and bills your insurance as a courtesy. All deductibles, co-pays and percentages of the bill that are the responsibility of the patient are expected to be paid at the time of service. 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 the following fees:

- $35 for cancelled appointments, or missed appointments without 24 hour advance notice
- $75 for cancelled VNG's without 48 hours advance notice
- $75 for cancelled allergy testing without 48 hours advance notice
- $250 for cancelled surgeries without a 7 day advance notice
- $10 for secondary paperwork including but not limited to disability and FMLA paperwork

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

_____ _____

Patient / Parent / Legal Guardian (Signature) Date

_____

Patient Name (if patient is a minor)

HIPAA Exceptions

Is it OK to leave message with your 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 discuss your care with a friend or family member please list their name below:

_____

_____

RECEIPT OF PRIVACY NOTICE

I have received or been offered a copy of the Notice of Privacy Practices from Sierra Nevada Ear Nose and Throat Associates concerning the use and disclosure of how Protected Health Information is handled by the practice.

_____ _____

Patient / Parent / Legal Guardian (Signature) Date

_____

Patient Name (if patient is a minor)

Sierra Nevada Ear Nose and Throat Associates

www.sierranevadaent.com

Sierra Nevada Ear Nose and Throat
PO Box 4270, Carson City, NV 89702

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Sierra Nevada Ear Nose and Throat Associates does not:
- create or manage a hospital directory
- create or maintain psychotherapy notes
- perform fundraising services
- sell your information for any reason

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective 3/11/16

This Notice of Privacy Practices applies to the following organizations.

Sierra Nevada Ear Nose and Throat Associates
2874 N. Carson St, Ste 220, Carson City NV 89706
1520 Virginia Ranch Rd, Ste 103, Gardnerville, NV 89410
801 E. Williams Ave, Ste 3310, Fallon NV 89406

Sierra Nevada Hearing Aid Center
2874 N. Carson St, Ste 225, Carson City NV 89706
1520 Virginia Ranch Rd, Ste 103, Gardnerville, NV 89410
801 E. Williams Ave, Ste 3310, Fallon NV 89406

ENT Billing Services
PO Box 2384, Carson City, NV 89702

Privacy & Security Officer: Yvonne Meares
Phone: (775) 883-7666