Keller Ear, Nose, & Throat

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

NAME _____ **SS NUMBER**_____

DATE OF BIRTH _____ **MARITAL STATUS** _____ **PRIMARY CARE PROVIDER** _____

ADDRESS_____

CITY_____ **STATE**_____ **ZIP CODE**_____ **COUNTY**_____

HOME #_____ **CELL#** _____ **Preferred:** □ **Home** □ **Cell**

EMAIL_____

PATIENT PORTAL INFORMATION WILL BE RELEASED TO THIS EMAIL

DO YOU WANT TO BE INVITED TO THE PATIENT PORTAL? ○ **YES** ○ **NO**

******IF YES, THE ANSWER TO THE SECURITY QUESTION SENT TO YOUR EMAIL IS YOUR ZIP CODE******

I **AUTHORIZE** THE **USE**, **RELEASE** AND **DISCLOSURE** OF THE ABOVE NAMED INDIVIDUALS HEALTH INFORMATION AS DESCRIBED - FACESHEET, OPERATIVE NOTES, PROGRESS NOTES, OUT PATIENT RECORDS, LAB REPORTS, IMAGING RESULTS, AND **COMPLETE MEDICAL RECORDS** TO THE **FOLLOWING INDIVIDUALS**. I AUTHORIZE THE RELEASE OF MY PROTECTED HEALTH INFORMATION, INCLUDING DIAGNOSIS, RECORDS, AND EXAMINATIONS RENDERED TO ME.

**********I UNDERSTAND** THAT THE INFORMATION IN MY HEALTH RECORD **MAY INCLUDE INFORMATION** RELATING TO SEXUALLY TRANSMITTED DISEASES, ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) OR HUMAN IMMUNODEFICIENCY VIRUS (HIV). IT MAY ALSO INCLUDE INFORMATION ABOUT BEHAVORIAL OR MENTAL HEALTH SERVICES, AND TREATMENT FOR ALCOHOL AND DRUG ABUSE.

NAME	DOB	RELATIONSHIP	PHONE NUMBER

I UNDERSTAND THAT I HAVE A RIGHT TO **REVOKE THIS AUTHORIZATION** AT ANY TIME. I UNDERSTAND IF I REVOKE THIS AUTHORIZATION, I MUST DO SO **IN WRITING** TO THE MEDICAL RECORD DEPARTMENT. THIS AUTHORIZATION **WILL REMAIN IN EFFECT** UNTIL TERMINATED OR CHANGED BY ME IN WRITING.

SIGNATURE:_____ DATE: _____

AUTHORIZATION TO CALL

I authorize HH System Clinics to leave the following messages on my answering machine/voicemail:

[ ] Reminder appointment calls [ ] Do not leave a message
[ ] Lab and/or Test results [ ] Only leave a message asking me to return your call

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HH System Clinics Registration Update Sheet

Patient: _____ Date of Birth: _____

HH SYSTEM CLINICS ADVANCE DIRECTIVE POLICY

In our practices we have decided that we will initiate resuscitative measures anytime they are needed.

FINANCIAL FEES AND ASSISTANCE

FINANCIAL ASSISTANCE: I understand that financial assistance may be available for individual patients who are uninsured or who otherwise meet financial aid criteria. The hospital's overall ability to remain financially stable and provide essential health care services to all members of our community is dependent upon financial resources available to cover services provided to patients. My assistance in providing such information is necessary to determine possible financial aid available to me. If I am uninsured and need financial assistance, I may contact a Financial Counselor and make a request to see if I qualify at 256-265-9438.

AUTHORIZATION OF TREATMENT

I hereby consent and authorize my physician and/or Allied Health professional to render usual and customary medical/emergency treatment that they deem advisable and necessary. I also authorize HH System Clinics to electronically request my medication history if my pharmacy participates in electronic prescribing in order to assist the provider in prescribing necessary medication therapy.

ASSIGNMENT OF BENEFITS, AGREEMENT AND GUARANTY

I authorize HH System Clinics to release any information regarding services rendered to me to third party payers in consideration of payment for my care or to other healthcare providers involved in my care. I understand payment of all insurance benefits, basic and major medical for this period of service must be made directly to HH System Clinics. If the check must be made out to me, I understand the check must be sent to this address: PN Billing P.O. Box 2705 Huntsville, AL 35804. I understand the HH System Clinics must collect for all charges not covered by insurance payments. Payment for all collection costs, securing, or attempting to collect and secure including reasonable attorney fees or Collection Agency fees, whether suit be necessary or otherwise is the financial responsibility of the patient and guardian. Patients who are considered a legal adult are financially responsible for all services rendered.

HH HEALTH SYSTEM NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I acknowledge that a copy of the Notice of Privacy Practices for HH Health System has been made available to me. In connection with the Notice, I also acknowledge that I have been provided with an opportunity to ask questions regarding the Notice and its contents. I understand that the most current version of the Notice will be posted with the Health System and on www.huntsvillehospital.org.

EXPRESS PERMISSION TO CONTACT PATIENT BY CELL PHONE

I agree in order for HH System Clinic to service my account or to collect monies I owe, HH System Clinics and/or our agents may contact me by any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. HH System Clinics may also contact me by sending text messages or emails, using any email address I provided. Methods of contact may include pre-recorded/artificial voice messages and/or use of automatic dialing devices, as applicable. I have read this disclosure and agree that HH System Clinics, its employees, and/or agents may contact me as described.

PHOTOGRAPHY CONSENT

I authorize photography for purposes of clinical treatment and staff education. I understand that any images or photographs will be used solely for these purposes and that I have the right to revoke this authorization or to refuse to be photographed at any time. I understand that only hospital authorized or issued equipment will be used to take photographs, and that privacy and confidentiality will be maintained in the use of these images. _____ Consent to Photography for Medical Treatment/Staff Education

_____ Decline Consent to Photography for Medical Treatment & Staff Education

Patient: _____ Date of Birth: _____

Printed Name of Person Authorized to sign for patient: _____

Basis of Authority to sign for Patient: _____

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Medical History

Circle any of the following that you have experienced:

Emphysema Tuberculosis Acid Reflux Stomach Ulcers Heart Attack Mitral Valve Prolapse

Anemia Bleeding Disorder Blood Transfusions Diabetes Mellitus Migraine Headaches

Hypertension Stroke Epilepsy/Seizures Thyroid Disease HIV+ Hepatitis

Pneumonia Asthma

Past Medical History (PMH):

Have you ever had cancer? □ YES □ NO If yes, please list type:_____

Any other medical problems:_____

When was your last: Colonoscopy:_____ Mammogram: _____
PSA: _____ Flu Vaccination:_____
Pap Smear:_____ Pneumonia Vaccination:_____

Current Medications:

What Pharmacy do you use? _____ Location:_____

Are You Allergic to Any Medications/Latex? □ YES □ NO

List the Name and Your Reaction: _____

_____

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Social History (SH):

Occupation:_____

Have you ever smoked? □ YES □ NO
How old were you when you started smoking? _____
At most, how many packs a day did you smoke? _____/day

Are you a current smoker? □ YES □ NO

When did you last smoke? _____

Alcohol Intake (amount per week): _____

Any Recreational Drug Use? □ YES □ NO

Past Surgical History (PSH)

List any previous surgeries, date of surgery, and name of surgeon: □ Never Had Surgery

Procedure Name:	Date of Procedure:	Surgeon Name:

Family History (FH):

Circle all that apply.

Mother: Alive/Deceased Age:_____
Bleeding Disorder Hypertension Lung Disease
Cancer:_____ Stroke Heart Disease
Other:_____

Father: Alive/Deceased Age:_____
Bleeding Disorder Hypertension Lung Disease
Cancer:_____ Stroke Heart Disease
Other:_____

Siblings: Alive/Deceased # of Sisters:_____
# of Brothers:_____
Bleeding Disorder Hypertension Lung Disease
Cancer:_____ Stroke Heart Disease
Other:_____