

DATE \_\_\_\_\_

PT ID# \_\_\_\_\_

**FOOTHILLS EAR NOSE and THROAT, ALLERGY and HEARING CENTER  
PATIENT INFORMATION**

Last name \_\_\_\_\_ Occupation \_\_\_\_\_

Legal First & Middle Name \_\_\_\_\_ Employer \_\_\_\_\_

Home Address \_\_\_\_\_ Work Address \_\_\_\_\_

City, State \_\_\_\_\_ Zip \_\_\_\_\_ City, State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone# \_\_\_\_\_ Work Phone# \_\_\_\_\_

Cell Phone# \_\_\_\_\_ May we contact you on your cell? Yes \_\_\_ No \_\_\_

Social Security# \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Marital Status of Patient: \_\_\_ Married \_\_\_ Single \_\_\_ Separated \_\_\_ Divorced \_\_\_ Widowed

Have we ever seen any other member of your family? Yes \_\_\_ No \_\_\_ If so, who? \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_

Who is the patient's Primary Care physician? \_\_\_\_\_

(Must be Physician, not Dentist, P.A. or Nurse Practitioner)

Pharmacy Name: \_\_\_\_\_ City: \_\_\_\_\_

**RESPONSIBLE PARTY (if different from patient)**

Last name \_\_\_\_\_ Occupation \_\_\_\_\_

Legal First & Middle Name \_\_\_\_\_ Employer \_\_\_\_\_

Home Address \_\_\_\_\_ Work Address \_\_\_\_\_

City, State \_\_\_\_\_ Zip \_\_\_\_\_ City, State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone# \_\_\_\_\_ Work Phone# \_\_\_\_\_

Cell Phone# \_\_\_\_\_ May we contact you at work? Yes \_\_\_ No \_\_\_

Social Security# \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Relationship to patient \_\_\_\_\_

**SPOUSE, OTHER PARENT OR EMERGENCY CONTACT**

Last name \_\_\_\_\_ Occupation \_\_\_\_\_

Legal First & Middle Name \_\_\_\_\_ Employer \_\_\_\_\_

Home Address \_\_\_\_\_ Work Address \_\_\_\_\_

City, State \_\_\_\_\_ Zip \_\_\_\_\_ City, State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone# \_\_\_\_\_ Work Phone# \_\_\_\_\_

Cell Phone# \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Social Security# \_\_\_\_\_ May we contact you at work? Yes \_\_\_ No \_\_\_

Relationship to patient \_\_\_\_\_

Is this person also financially responsible for patient? Yes \_\_\_ No \_\_\_

Is this visit work, auto or accident related? Yes \_\_\_ No \_\_\_

**\*\*\*\*\*ANY CO-PAYS, CO-INS, DEDUCTIBLE OR OUTSTANDING BALANCES ARE DUE UPON CHECK IN.  
WE ACCEPT CHECKS, CASH, VISA & MC AND CARECREDIT.**

**PLEASE CONTINUE ON OTHER SIDE OF FORM ⇨ ⇨ ⇨ ⇨ ⇨ ⇨ ⇨ ⇨ ⇨ ⇨ ⇨ ⇨**

**Thank you for choosing us as your health care provider. The following is a statement of our Financial and Office policies, which we require you to read and sign prior to any treatment. Please read each statement and sign below.**

**OUR OFFICE POLICY**

◆◆ **Release of Medical Information:** Your signature below allows us to release to insurance company(s), hospitals, referring physicians, other healthcare providers, and attorneys your health information for treatment, billing and healthcare operations. It also allows us to obtain necessary information from your other healthcare providers if needed for care provided by our office.

◆◆ **Appointments:** We require at least 48 hours' notice to reschedule or cancel an appointment. **Our office may elect to reschedule an appointment if the patient is late.** We reserve the right to charge for missed appointments or for insufficient notice when canceling or rescheduling appointments. Excessive missed appointments may result in discharge from this practice. It is imperative to your health and well-being that follow-up appointments are kept.

◆◆ **Physicians:** Drs. Adham, Almand and Tigner are Otolaryngologists/Head and Neck Surgeons (Ear, Nose and Throat Physicians). They are primarily trained as surgeons, but can also help with difficult ear, nose and throat problems. **As specialists, they are unable to provide routine medical treatment that could and should be provided by your primary care physician.**

◆◆ **HIPAA:** You have been given a copy of our privacy practices that describes how your health information is used and shared. The Otolaryngology Center of East Tennessee, P.C. has the right to change this notice at any time and a current copy can be obtained by contacting our office.

◆◆ **List person(s) to whom our office is allowed to release information regarding your medical care:**  
(Name & relationship):

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◆◆ **List any additional people that have your permission to seek medical treatment/services for your child:**  
(Names):

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◆◆ **Emergencies:** If you have a true emergency after hours, Dr. Adham, Almand and Tigner can be reached by calling the office and following the recorded telephone instructions. Please do not call after office hours for problems that are not considered emergencies. Non-emergencies must be handled during regular office hours.

◆◆ **Contact:** I hereby give my permission for doctors or staff to leave a message at the home and cell telephone numbers listed on the patient information sheet.

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**I have read and understand the policies listed above and agree to the terms. I agree to take full responsibility for this account. I also authorize the doctors to provide me with reasonable and proper medical care by today's standards. I have received a copy of the full Financial Policy.**

DATE \_\_\_\_\_ PATIENT / PARENT SIGNATURE \_\_\_\_\_

# PATIENT MEDICAL HISTORY

Today's Date: \_\_\_\_\_

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

## CHIEF COMPLAINT

What is the main reason for today's visit? \_\_\_\_\_

When did the symptoms begin? \_\_\_\_\_

What Medications have you taken or are you taking for this problem? \_\_\_\_\_

## PAST MEDICAL HISTORY

Please list any medical problems, illnesses, hospitalizations or surgeries that you have had in the past or that you currently have:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\* Do you have a history of any abnormal bruising or bleeding? \_\_\_\_ Yes \_\_\_\_ No

Do you take any medications/supplements on a routine basis? \_\_\_\_ Yes \_\_\_\_ No ; **If yes, please complete reverse side of this form.**

Are you allergic to any medications? \_\_\_\_ Yes \_\_\_\_ No If Yes, please list \_\_\_\_\_

Are you allergic to Latex? \_\_\_\_ Yes \_\_\_\_ No

## FAMILY HISTORY

\* Is there any family history of abnormal bruising or bleeding? \_\_\_\_ Yes \_\_\_\_ No

\* Is there any family history of problems with general anesthesia? \_\_\_\_ Yes \_\_\_\_ No

Medical Problems of Mother or Father? \_\_\_\_\_

Medical Problems of Immediate Blood Relatives: \_\_\_\_\_

## SOCIAL HISTORY

Have you ever smoked or chewed tobacco? \_\_\_\_ Yes \_\_\_\_ No If Yes, how many packs per day \_\_\_\_\_ For how many years? \_\_\_\_\_

Are you still smoking? \_\_\_\_\_ If not, how many years since you quit? \_\_\_\_\_

Are you now or have you ever been a heavy drinker? \_\_\_\_ Yes \_\_\_\_ No; Are you still drinking? \_\_\_\_ Yes \_\_\_\_ No

## REVIEW OF SYSTEMS

Please check the following symptoms that you currently have or had:

### ALLERGY

- Hay Fever
- Itchy Eyes or Throat
- Post Nasal Drip
- Asthma
- Blocked Nose

### EARS

- Hearing Loss
- Ringing in Ears
- Dizziness
- Earache
- Ear Infections

### MEDICAL

- Thyroid Disease
  - Chest Pain
  - Heart Murmur
  - Tuberculosis
  - Gastrointestinal Problems
  - Diabetes
  - Liver Disease
  - Genitourinary Problems
  - Neurologic Problems
  - Seizures
  - High Blood Pressure
  - Heart Disease (Describe Below)
  - Lung Disease (Describe Below)
- Fever / Chills
  - Weight Gain
  - Weight Loss
  - Depression
  - Cancer

### NOSE AND SINUS

- Sinus Headaches
- Sinus Infections
- Stuffy Nose
- Snoring
- Nose Bleeds
- Recurrent Head Colds
- Facial Pain

### THROAT / MOUTH

- Recurrent Sore Throats
- Enlarged Neck Glands
- Difficulty Swallowing
- Hoarseness
- Bad Breath
- Cough
- Oral Sores

Other medical problems, surgeries or illnesses not listed above (use back if needed):

\_\_\_\_\_  
\_\_\_\_\_

Are you HIV positive? \_\_\_\_ Yes \_\_\_\_ No IV drug user/recreational drug user? \_\_\_\_ Yes \_\_\_\_ No

Have you taken aspirin, aspirin - containing, blood thinning or anti-inflammatory medications in the last two weeks? \_\_\_\_ Yes \_\_\_\_ No

**If you are scheduled to have ANY surgery, you MUST be off all aspirin - containing products for two weeks prior to having surgery.**



## Patient Financial Policy

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Thank you for choosing **Foothills Ear Nose and Throat** for your ENT, allergy and audiology care!

We are committed to the success of your medical treatment and care. Please understand that a mutual financial understanding is part of our relationship.

We sincerely hope that by sharing our financial expectations we will strengthen the physician-patient relationship and keep the lines of communication open. This financial policy helps us provide quality care to our valued patients. If you have any questions or need clarification of any of the below policies, please feel free to ask a receptionist or contact us at **865-983-4090**.

### Payment is Due At the Time of Service

- We accept cash, checks, debit, credit cards and Care Credit.
- All Insurance co-payments, deductibles, co-insurance and fees for non-covered services are due at the time of service.
- Patient-responsible balances are due when you check in for your appointment.
- There is a \$29.00 charge for checks returned to us for NSF.
- Outstanding balances not paid within 60 days of receiving your statement may be forwarded to an external collection agency and additional fees of **25%** will be added to your account. We also reserve the right to discontinue care.
- If you make an overpayment on your account, we will issue a refund only if there are no other outstanding debts on your account to the same guarantor or financial responsible party that paid.

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**PLEASE REMEMBER- Your insurance is a contract between you and your insurance carrier. We, as healthcare providers, just execute that agreement for you. We are bound by the terms in your contract. As a result, it is your responsibility to understand your coverage and benefits. If your insurance requires a referral for "specialist" office visits, you need to contact your primary care physician to get that referral. We cannot see you without it, if it is required.**

### Filing Claims

■ We will gladly submit claims for your services to your insurance company on your behalf. If your insurance company has not paid the claims within 60 days, the balance becomes patient responsibility. We try to resolve most claim issues, but it may become necessary for you to contact your insurance company to get the claim paid. **Be sure to keep your insurance information up-to-date with us with any changes.**

### Referrals

■ If you have a plan we are contracted with that requires a referral authorization for office visits (ie. AARP Medicare Complete, UHC Compass plan), you will need to obtain one from your primary care physician. If we have not received an authorization prior to your arrival at the office you will be asked to reschedule your appointment. Without an insurance required referral, the insurance company will deny payment for services.

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### No Show Policy

■ We request that at least a **two-business day** advance notice be given to the office if you will be unable to keep your scheduled appointment. This allows us to release your appointment time to another patient. We charge an administration fee of **\$50 for no-shows or late cancellations**. Patients who repeatedly "no show", cancel or reschedule appointments may be discharged from the practice.

### Arriving late for Appointment

■ We understand that sometimes you may be running late. Unfortunately, we have patients scheduled throughout the day and may not be able to see you if you arrive late. We will try to accommodate you if possible. Otherwise, you will need to reschedule your appointment.

### Proof of Insurance

- Please bring your insurance card(s) and a valid photo ID with you to each appointment.

**\*\*It is your responsibility to notify the practice of changes in your health insurance.**

### Self-Pay Accounts

- We designate accounts, **Self-Pay**, under the following circumstances: (1) patient does not have health insurance coverage (2) patient is covered by an insurance plan that our providers do not participate in, (3) patient does not have a current, valid insurance card on file, (4) patient does not have a valid insurance referral on file.

Self-Pay patients, please be prepared to pay in full at time of service. This includes the cost for the patient office visit and possible diagnostic endoscopy (scope). There may additional fees for in office procedures, including cerumen (earwax) removal, postoperative sinus debridement, allergy testing, hearing tests or hearing aids. If you are unable to pay, you will be asked to reschedule your appointment.

### In Office Procedures

- In order to properly evaluate/diagnose your problem, we may need to do a **diagnostic procedure** or use an instrument to perform a “**scope**”. This allows the physician to see into your sinus and/or throat. Most insurance companies classify this as a “**surgical procedure**” and in most cases, gets applied to your deductible or co-insurance and is **NOT** covered under your office co-pay. This amount is determined by your insurance carrier.

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### Surgical Procedures

- If you/your child requires a surgical procedure at the hospital, please note you will receive separate billing statements from the hospital, pathologists (if applicable) and anesthesiologist. Your responsibility to us is for our physician only.
- **We will call you with the amount you will be responsible for on your surgery.** This amount will need to be paid 2 business days prior to your surgery day.
- **Post-Surgery-** Office visits after surgery that are related to the surgery and are within the “**global period**” as determined by the Center for Medicare & Medicaid Services, are included in the surgical charge and will not require an additional co-pay. However, endoscopic procedures (*scopes*) and a few other procedures do not have a global period and surgical aftercare is not included in the surgical fee. Many sinus surgeries require 1 or 2 “**debridements**” post-surgery which co-insurance and deductibles are applied, resulting in possible additional payments being due.

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### Audiology Services

- Hearing tests are an integral part of diagnosing hearing, tinnitus (ringing or noise in ear), pressure or pain in your ear. Without these tests your physician cannot make a proper diagnosis to help you. Hearing tests are **NOT** included in your office visit co-pay therefore, co-insurance and deductibles apply for these charges.

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**As a courtesy, you will receive an automated call to remind you of your appointment two business days prior.**

**I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility.**

**I authorize my insurance benefits be paid directly to Ear, Nose and Throat Consultants of East Tennessee.**

Patient/Guarantor Signature \_\_\_\_\_ Date \_\_\_\_\_

# FOOTHILLS ENT, ALLERGY & HEARING CENTER

## SUMMARY OF (HIPAA) PRIVACY PRACTICES

This summary of our privacy practices contains a condensed version of our Notice of Privacy Practices. Our full-length Notice is available upon request.

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.

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As your patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your protected health information is kept private.

### **How we will use and disclose your patient health information:**

- For medical treatment
- To obtain payment for our services (insurance companies)
- Public Health Authorities
- Law Enforcement purposes
- Law Suits and Legal Proceedings
- Abuse or Neglect Reporting
- For appointment and patient recall reminders
- For workers' compensation programs
- Other Health Providers as deemed necessary

### **Individual Rights:**

You have certain rights regarding the information we maintain about you.

These rights include:

- The right to inspect and copy records
- The right to request restrictions of the use of your health information as permitted by law
- The right to ask for an amendment to your records if you feel they are incorrect
- The right to a paper copy of this notice
- The right to an accounting of disclosures
- The right to request confidential communications

### **Complaints:**

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our office manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

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Per Title Transparency Law T.C.A. § 63-1-109:

**Bond Almand, III, Medical Doctor and Surgeon**

**Bryan J. Tigner, Medical Doctor and Surgeon**

Ear, Nose and Throat Consultants of East Tennessee, PC

**Foothills Ear Nose and Throat, Allergy and Hearing Center**