



PATIENT NAME: _____

Patient's Address _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth Date: _____ Age: _____ Social Security Number: _____

Sex: Male / Female (circle one) Marital Status: Married / Single / Widowed / Divorced (circle one)

Preferred Language: _____ Race: _____ Ethnicity: _____

INDICATE PERSON RESPONSIBLE FOR THIS ACCOUNT _____

Patient's Employer: _____

Referring Physician: _____ Family Physician: _____

Spouse's Name: _____ Spouse's Employer: _____

Spouse's Employer Phone: _____ Spouse's Cell Phone: _____

Emergency Contact Name: _____ Phone: _____ HM WK CELL

How is the patient related to this contact person? _____

INSURANCE INFORMATION

Primary Ins. Co. _____

Secondary Ins. Co. _____

Name of Cardholder _____

Name of Cardholder _____

ID / Policy #: _____

ID / Policy #: _____

Cardholder's DOB: _____

Cardholder's DOB: _____

Co-pay: _____

Co-pay: _____

Third Ins. Co.: _____

Name of Cardholder: _____

ID / Policy #: _____

Cardholder DOB: _____

COMPLETE THIS SECTION IF THE PATIENT IS A MINOR OR FULL TIME STUDENT

Father/Guardian: _____ SSN# _____ Birth Date: _____

** Address if not the same as patient's listed above** _____

Employer: _____ Work #: _____ Hm #: _____ Cell #: _____

Mother/Guardian: _____ SSN# _____ Birth Date: _____

** Address if not the same as patient's listed above** _____

Employer: _____ Work #: _____ Hm #: _____ Cell# _____

Step-parent Name: _____ SSN# _____ Birth Date: _____

** Address if not the same as patient's listed above _____

Employer: _____ Work #: _____ Hm #: _____ Cell# _____

I authorize ENT Clinic of Iowa, P.C. to furnish information to insurance carriers concerning my illness and treatments and hereby assign the clinic all payments for services rendered to dependents or myself. **I understand that I am responsible for amounts not covered by my insurance.**

SIGNATURE: _____ DATE: _____



Name _____
 Date of Birth _____

Family Physician _____
 Today's Date _____

Current Medications _____

Drug Allergies _____
 Non Drug Allergies _____

As Needed Medications _____
 (OTC and vitamins included) _____

Birth Hospital _____
 Born Full Term Yes/No
 NICU stay Yes/No

Preferred Pharmacy: _____

Height: _____ Weight: _____

Ear History

Newborn Hearing Screening Pass/Fail
 School/AEA/Pediatrician Hearing Screening Pass/Fail
 Ear Infections Yes/No
 age of onset _____
 how often _____
 medications used _____
 Previous Ear Surgery Yes/No
 Concern for Hearing Loss Yes/No
 Concern for Speech Delay Yes/No
 Family History of Early Onset Hearing Loss Yes/No
 if yes, please explain _____

Nasal/Sinus History

Congestion Yes/No
 Nasal Drainage Yes/No
 Chronic Cough Yes/No
 if yes, more often during Day/Night
 Headaches Yes/No
 Seasonal Allergies Yes/No
 allergy testing Yes/No
 family history of seasonal allergies Yes/No
 Eczema Yes/No
 Nosebleeds Yes/No
 if yes, how frequent _____

Oral/Throat History

Recurrent infections/sore throats Yes/No
 strep swab positive Yes/No
 Snoring Yes/No
 Episodes of paused breathing during sleep Yes/No
 if yes, what is the duration _____
 Restless sleeper Yes/No
 Difficulty swallowing food Yes/No
 picky eater Yes/No
 Bad Breath Yes/No

Airway History

Reactive airway disease/asthma Yes/No
 Describe symptoms _____
 is it improving with time? Yes/No
 is it worse with feeding? Yes/No
 is child gaining weight? Yes/No
 Previous Chest Xray Yes/No
 Previous Swallow Study Yes/No
 Hospitalizations Yes/No
 ER Visits Yes/No

General History

Previous Surgeries

Previous Hospitalizations

Gastrointestinal Problems

Yes/No

Immune/Endocrine Problems

Fevers/Chills/Weight Loss

Yes/No

abnormal immune studies

Yes/No

Kidney Problems

Yes/No

sweat chloride test

Yes/No

Neurological Problems

HIV/HEP/TB

Yes/No

balance issues

Yes/No

family history of immune disorders

Yes/No

head injury

Yes/No

BLEEDING

seizures

Yes/No

history of bleeding disorder

Yes/No

Social History

Father's Age

Father's Health

Good

Fair

Poor

Mother's Age

Mother's Health

Good

Fair

Poor

Brother's Age(s)

Brother's Health

Good

Fair

Poor

Sister's Age(s)

Sister's Health

Good

Fair

Poor

Breast fed or Bottle fed as infant

Attends Daycare

Yes/No

how long?

in home or center?

Grade Level in School

Second Hand Smoke Exposure

Yes/No

Family History

Life threatening problems with Anesthesia

Yes/No

Bleeding Disorders

Yes/No

Hearing Loss

Yes/No

Malignant Hyperthermia

Yes/No

Other

Other Speciality Physicians Your Child May See

please list physician name and their speciality

Thank you for taking the time to complete this information for your child.



Patient#: _____

Patient Consent Form (HIPAA)

I understand under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have been informed by you and your *Notice of Privacy Practices* containing a more complete description the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

Kay Spear
ENT Clinic of Iowa, PC
1455 29th Street
West Des Moines, IA 50266
(515) 267-1800

(See back for extended HIPAA)

Extended HIPAA

(Not needed for referring or family doctors or your insurance company)

Please complete this form in its entirety. Items not checked or blanks unfilled are assumed to be non-applicable or specifically not authorized for release. This release is not valid if it does not contain the patient's original signature and date signed or if it has expired as described below. A copy of this signed form will be provided to the patient upon request.

I hereby authorize ENT Clinic of Iowa, PC, to disclose the following information from the health records of:

Patient Name: _____

Birth date: _____/_____/_____ Last First MI Previous Name
Social Security No. xxx-xx-_____

Telephone: (H) () _____ (W) () _____ (C) () _____

Address: _____
Street City State Zip

This information is to be disclosed to:

Covering the periods of healthcare (Date(s) of service) from (date): _____ to (date) _____

For the purpose of: _____
(Not required if the disclosure is requested by the patient)

The following information may be released:

_____ Appointment Dates _____ Medical Information / Medical Care _____ Test Results
_____ No Limits _____ Other (explain) _____

I understand that this will include information relating to (check and initial, if applicable):

_____ Acquired immunodeficiency syndrome (AIDS) human immunodeficiency virus (HIV) infection

_____ Behavioral health service/psychiatric care

_____ Treatment for alcohol and/or drug abuse

Affirmation of Release:

I give ENT Clinic of Iowa, PC or the named agency permission to release only the information I have selected on this form to the individuals(s) or agency(s) I have named and only for the purposes I have checked. I understand that this release is valid up to one year from the date I sign it and I may refuse to sign this authorization or revoke this authorization at any time. Any revocation or refusal to sign this authorization will not affect my ability to obtain treatment or payment or my eligibility for benefits. The revocation will take effect on the day it is received in writing. As a patient I have the right to access my treatment records during hospitalization and after discharge. Copies of the records may be obtained with reasonable notice and payment of copying cost. I further understand that if the person or entity that receives the above specified information is not a health care provider, health plan or health care clearinghouse covered by the federal privacy regulations or a business associate of these entities, the information described above may be redisclosed and no longer protected by the regulations.

Signature of Patient/Guardian/Legal Representative Date Signed

Signature of Witness/Relationship to Patient Date Signed

Expiration Date: _____ (One year from date signed)

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.

Effective Date: April 14, 2003

If you have any questions about this notice, please contact:

Kay Spear
ENT Clinic of Iowa, PC
1455 29th Street
West Des Moines, IA 50266

Purpose of This Privacy Notice

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, initiate payment, or conduct health care operations and for other purposes that are permitted or required by law. **The medical practice reserves the right to make changes in the Notice of Privacy Practices.** The Notice describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Who Will Follow This Notice:

This notice describes the privacy policies of our practice and that of:

- Any health care professional authorized to enter information into your medical record
- All employees of the practice
- Written acknowledgement of your receipt of this notice

Our Pledge Regarding Medical Information

We understand that medical information about you and your health is personal, and we are committed to protecting it. A record of the care and services you receive at this practice is created and maintained at this location. This notice applies to all of those records of your care.

We are required by law to:

- Make sure that medical information that identifies you is kept private
- Provide you this notice of our legal duties and privacy practices regarding your medical information
- Follow the terms of the notice that is currently in effect. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may obtain a copy by calling our office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

How We May Use And Disclose Medical Information About You:

The following categories describe ways that we use and disclose medical information. Examples of each category are included. Not every use or disclosure in each category is listed; however, all of the ways we are permitted to use and disclose information falls into one of these categories:

- For Treatment: We may use medical information about you to provide, coordinate, or manage your medical treatment or services. We may disclose medical information about you to other physicians or health care providers who are or will be involved in taking care of you. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. Another example is that your protected health information may

be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

- **For Payment:** We may use and disclose medical information about you so that the treatment and services you receive at our practice may be billed to and payment may be collected from you, an insurance company, or a third party. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, to determine whether your plan will cover the treatment, and for undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.
- **For Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of our practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. We may call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may share your protected health information with third party “business associates” that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. You may contact our Privacy Officer to request that these materials not be sent to you.

Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician’s practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person’s involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician shall try to obtain your acknowledgement of receipt of the Notice of Privacy Practices as soon as reasonably practicable after the delivery of treatment.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that law requires the use or disclosure. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or

medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Workers' Compensation: we may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Sale or Closure of the Practice: In the event that ENT Clinic of Iowa, PC is sold or acquired by another facility or physician group, your protected health information will be disclosed to that group or entity.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice use for making decisions about you.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewed. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by contacting and discussing the issue with the Privacy Officer.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an

amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer to determine if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You will receive a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer, Kay Spear at 515-267-1800 for further information about the complaint process.

This notice was published and becomes effective on April 14, 2003.

ENT Clinic of Iowa, P.C.

Children's Sleep Questionnaire

Please take the time to fill out this information for your child, so we may better understand his or her condition.

While sleeping, does your child...	Snore more than half the time?	Yes/No
	Always snore?	Yes/No
	Snore loudly?	Yes/No
	Have "heavy" or loud breathing?	Yes/No
	Have trouble breathing or struggle to breathe?	Yes/No

Have you ever seen your child stop breathing during the night? Yes/No

Does your child...	Tend to breathe through the mouth during the day?	Yes/No
	Have a dry mouth on waking up in the morning?	Yes/No
	Occasionally wet the bed?	Yes/No
	Wake up feeling unrefreshed in the morning?	Yes/No
	Have a problem with sleepiness during the day?	Yes/No

Has a teacher or other supervisor commented that your child appears sleepy during the day? Yes/No

Is it hard to wake your child up in the morning? Yes/No

Does your child wake up with headaches in the morning? Yes/No

Did your child stop growing at a normal rate at any time since birth? Yes/No

Is your child overweight? Yes/No

Please mark the following statements if they apply to your child.

_____ My child does not seem to listen when spoken to directly.

_____ My child has difficulty organizing tasks and activities.

_____ My child is easily distracted by extraneous stimuli.

_____ My child fidgets with hands or feet or squirms in seat.

_____ My child is 'on the go' or often acts as if 'driven by a motor'.

_____ My child interrupts or intrudes on others (i.e., conversations or games).