EAR, NOSE, AND THROAT CENTER OF NORTHWEST HOUSTON
PATIENT REGISTRATION FORM

(Please Print)

Today's date:	Primary Care Physician:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

If this is not, what is your legal name?	(Former/Maiden name):	Social Security no.:	Birth date: / /	Age:	Sex: ❑ M ❑ F

Home phone no.: ( )	Cell phone no.: ( )	Other phone no.: ( )	Preferred contact method: ❑ Home ph. ❑ Cell ph. ❑ Other ph. ❑ Work ph.

E-Mail Address:

Street address:	City:	State:	ZIP Code:

Occupation (if student please specify):	Employer:	Employer/Work phone no.: ( )

Referred to clinic by (please check one box): ❑ Dr.					❑ Insurance Company/Plan
❑ Our Website	❑ Other Webpage	❑ Friend / Family	❑ Yellow Pages	❑ Newspaper	❑ Other
Preferred language:	❑ English ❑ Spanish ❑ Vietnamese ❑ Other (please specify):				

FINANCIAL INFORMATION

(Please give your insurance card(s) and identification card/driver's license to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

INSURANCE INFORMATION

Is patient covered by insurance? ❑ Yes ❑ No Primary Insurance Company:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative to contact in an emergency:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize the EAR, NOSE, AND THROAT CENTER OF NORTHWEST HOUSTON or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Ninh Nguyen, D.O.
Otolaryngology/Facial Plastic Surgery
11307 FM 1960 RD W., Suite 260
Houston, TX 77065
Office: 832-604-3636
Fax: 281-469-8932

Patient Medical History Form

(The Following information is very important to your health. Please take the time to fully and completely fill out both sides. This is important information and we are counting on you.)

Name:_____ DOB: AGE:_____

_ Height: Weight: Gender:_____

Reason for visit: _____

Any recent diagnostic tests for this problem? _____

Who is your PCP?_____ Who referred you to this office?_____

ALLERGIES:

Are you allergic to any medicines (including any tape, iodine, or latex)

0 Yes 0 No (If yes, please complete the allergy information below)

Medications:	Type of reaction you experience:

PAST SURGICAL HISTORY:

TYPe of operation:	Date or age at time of operation:

CURRENT MEDICATIONS:

Medication	Dose	Frequency	Medication	Dose	Frequency

Are you required to take antibiotics before procedures? O Yes D No

Are you on Oxygen or CPAP? O Yes 0 No

Is there a chance you may be pregnant? 0 Yes D No

SOCIAL HISTORY:

	yes	no	
Do you smoke?	O	0	If yes, how much per day and how many years_____
Have you ever smoked?	0	0	If yes, start date/quit date? _____
Do you drink alcohol?	0	0	If yes, how much, how often? _____

Are you exposed to second hand smoke? 0 Yes D No

What is your occupation?_____ Who currently lives in your home? _____

FAMILY MEDICAL HISTORY:

	Yes	No	(relationship to you)		Yes	No	(relationship to you)
Cancer	O	0		Bleeding problem	D	0	
High Blood pressure	0	0		Diabetes	D	D	
Heart problems	0	0		Seizures/epilepsy	D	D	
Hepatitis	D	D		Asthma	D	D	

Unusual reaction to anesthesia? _____

Patient/Guardian Signature:_____ Today's Date: _____

Name: _____ DOB _____ Date: _____

MEDICAL HISTORY (continued)

Have you been diagnosed with or are currently having problems with any of the following:

Cardiac (heart/circulation)	yes	no		yes	no		yes	no
Chest Pain	0	O	heart munnur	O	O	Rheumatic fever	O	O
Congestive heart fail	0	O	Heart attack	O	O	Irregular heart beat	O	O
High blood pressure	0	O	Pacemaker	O	O			
Heart valve problem!	0	O	Palpitations	O	O			
Pulmonan: (lung}	**yes**	**no**		**yes**	**no**		**yes**	**no**
Shortness of breath	0	O	Asthma	O	O	Recurrent cough	D	O
Wheezing	0	O	Chest tightness	O	O	Bloody cough	O	O
Emphysema/COPD	0	O	Lung cancer	O	O	Productive cough	O	O
Pulmonary embolism	0	O	Recurrent bronchitis	O	O			
Digestive(stomach/intestines }		**no**		**yes**	**no**		**yes**	**no**
Heart burn	O	O	Acid reflux disease	O	O	Cirrhosis	O	O
Ulcers	O	O	Pancreatitis	O	O	Crohn's/Colitis	O	O
Abdominal pain	O	O	Diverticulitis	O	O	Irritable bowel syndr	D	O
Kidney	**yes**	**no**		**yes**	**no**		**yes**	**no**
Kidney failure	O	O	Recurrent Kidney inl	O	O	Urinary retention	O	O
Endocrine (hormon	**yes**	**no**		**yes**	**no**		**yes**	**no**
Thyroid problems	O	O	High blood sugar	O	O	Diabetes	O	O
Chronic fatigue	O	O	Excessive thirst	O	O	Lupus	O	O
Hematologic (blooc	**yes**	**no**		**yes**	**no**		**yes**	**no**
Anemia	O	O	leukemia	O	O	clotting problems	O	O
Immune deficiency	O	O						
Infectious Disease	**yes**	**no**		**yes**	**no**		**yes**	**no**
Hepatitis (A, B, or C	O	O	AIDS/HIV	O	D	Tuberculosis	O	O
Chronic fatigue synd	D	D	Chronic Epstein-Ban	D	D			
Musculoskeletal				**yes**	**no**		**yes**	**no**
Chronic back proble1	D	O	Chronic neck proble1	D	D	Fibromyalgia	D	O
TMJ Syndrome	O	D	Arthritis	D	O	MS or MD	O	O
Skin	**yes**	**no**		**yes**	**no**		**yes**	**no**
Psoriasis	O	O	Eczema	D	D	Jaundice	D	D
Neurologic	**yes**	**no**		**yes**	**no**		**yes**	**no**
Seizure	D	D	Stroke/TLA	O	O	Migraine headaches	O	O
Multiple Sclerosis	O	O	Parkinson's	O	D	Numbness	O	O
Loss of strength	O	O						
Psychologic	**yes**	**no**		**yes**	**no**		**yes**	**no**
Depression	O	O	Anxiety/nervousness	O	O	Paranoia	O	O
Bipolar Disorder	O	O	Schizophrenia	O	O			
Immune System	**yes**	**no**		**yes**	**no**		**yes**	**no**
Lupus	O	O	Autoimmune disease	O	O	Immune deficiency	O	O
Cancer	O	O						

Type: First diagnosed: _____

_____

Other:

Do you have any reactions with anesthesia? ___

_____ Do you have any other

health conditions that are not listed? _____

Reviewed by: _____ Date: _____

Ear, Nose and Throat Center of Northwest Houston

Patient Name:
DOB:

ePRESCRIBING / PHARMACY SELECTION

ENT Center of Northwest Houston participates with local pharmacies in e-prescribing. This allows your pharmacy of choice to receive your prescriptions electronically. Your prescriptions can be filled faster, easier, and more efficiently!

Please select your pharmacy of choice from the list provided below, or if not listed, provide it in the space indicated.

CVS/pharmacy	Walgreens	Walmart Pharmacy
❒ 12550 Louetta Rd. (281) 257-7797 Corner of Louetta & Eldridge	❒ 12407 Grant Rd. (281) 655-0478 Corner of Grant & Eldridge	❒ 13742 Eldridge Parkway (281) 655-8758 Corner of Eldridge & Grant
❒ 13757 Cypress N. Houston Rd. (281) 890-2479 Corner of CNH & Huffmeister	❒ 12300 Jones Rd. (281) 955-5619 Corner of Jones & Cypress N.H.	❒ 26270 Northwest Freeway (281) 304-9664 Corner of 290 & Cypress Rose Hill
❒ 12234 Jones Rd. (281) 517-5691 Corner of Jones & Cypress N. H.	❒ 12445 FM 1960 West (281) 477-3792 Corner of 1960 & Eldridge	❒ 12353 FM 1960 West (832) 912-7331 Corner of 1960 & Eldridge
❒ 11600 FM 1960 West (281) 517-7258 Corner of 1960 & Fallbrook	❒ 10965 FM 1960 West (281) 890-3346 Corner of 1960 & Jones	❒ 7075 FM 1960 West (281) 893-1701 Corner of 1960 & Cutten

❒	My Pharmacy is not listed above
	Pharmacy Name:
	Phone Number:
	Fax Number:
	Zip Code:
	Location Type: ❒ Retail Store Pharmacy ❒ Mail Order Pharmacy

ePrescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These include:

- Formulary and benefit transactions - Gives the prescriber information about which drugs are covered by the drug benefit plan.
- Medication history transactions - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- Fill status notification - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that ENT Center of Northwest Houston can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to ENT Center of Northwest Houston to enroll me in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Patient/Legal Representative Signature	Representative Relationship	Date

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION (Please Print):

Name: _____

Date of Birth: ____

Social Security Number: _____

Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

RELEASE OF MEDICAL RECORDS FROM:

Name: _____

Telephone: _____

Fax Number: _____

PLEASE SEND RECORDS TO:

Ear, Nose, and Throat Center of Northwest Houston

Attn: _____

❒ **Please Mail to: 11307 FM 1960 RD W, Suite 260, Houston, TX 77065**

❒ **Please Fax to: (281) 469-8932**

PLEASE SEND A COPY OF THE FOLLOWING MEDICAL RECORDS ONLY:

❒ **Entire Patient Record**
❒ **Last Clinic Visit Note**
❒ **Lab Results**
❒ **Consultation Reports**
❒ **Imaging/Imaging Reports (including MRI/CT/X-Ray/Ultrasound)**
❒ **Other: _____**

BY MY SIGNATURE I AUTHORIZE RELEASE OF MEDICAL RECORDS

Patient's Printed Name Date of Birth

Patient/Legal Representative Signature Representative Relationship Date

If there are any problems processing this request, please contact the office at (832) 604-3636.

EAR, NOSE AND THROAT CENTER OF NORTHWEST HOUSTON
FINANCIAL POLICY

Thank you for choosing The Ear, Nose, and Throat Center of Northwest Houston as your health care provider. We are committed to providing excellent health care services to you, our patient. As a part of our professional relationship, it is important that you have an understanding of our financial policy.

All patients must read and sign this form prior to receiving services.
It is your responsibility to provide us with your most current insurance information.

- If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim. If the claim is denied, you will be financially responsible for services rendered.
- We must emphasize that, as medical providers, our relationship is with you, the patient, and not your insurance company. Your insurance is a contract between you, your insurance company and possibly your employer. It is your responsibility to know and understand the level of services covered by your insurance company.
- If you have Medicaid coverage of any kind, you must notify us prior to your visit. This is part of your agreement with Medicaid, and failure to notify us of Medicaid coverage will result in full financial responsibility for services rendered.
- We may accept assignment of insurance after verification of your coverage. Please be aware that some or perhaps all of the services provided may not be covered in full by your insurance company. **You are financially responsible for services not covered by your insurance company.**
- Before receiving services, you must verify that we are participating providers for your insurance company. It is also necessary that our primary care physician is listed as your primary care provider with your insurance company, if required by your contract with your insurance company. In the event we are not participating providers or our physician is not listed as your primary care provider with your insurance company, we will file the initial claim as a courtesy. Payment, however, is due in full at the time of service.
- We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- Copayments, coinsurance and/or deductibles are due at the time of service. We will estimate the amount you owe based on information we receive from your insurance company. However, you are responsible for paying the full amount determined by your insurance company once they have paid your claim – regardless of our estimation.
- **It is your responsibility to provide us with your most current billing information.**
- You must provide your most current billing address, all available telephone numbers and any other important contact information. If your address or contact information changes, it is your responsibility to contact us with the updated information.
- We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance, it is your responsibility to contact our business office within 30-days after receipt of the initial statement. You can call **(817) 514-5200** or (**800) 555-1429**.
- **Payment in full is due upon receipt of the statement.** Patient balances not paid in full within 30 days of the statement issue date are deemed past due. **Past due accounts may be subject to a $5.00 monthly late fee and may be referred to a professional collection agency and/or attorney for further collection activity.** You will be responsible to pay all collection costs incurred, including attorney's fees and court costs if applicable.
- If you are not able to pay the balance due in full, you must contact our billing office to discuss a payment schedule. Any late fees already incurred on past due balances will be included in any mutually agreed upon arrangements. If you fail to make payments as agreed upon, your account may be referred to a professional collection agency and/or attorney. You will be responsible for all collection costs incurred, including attorney's fees and court costs if applicable.
- If your account is assigned to a professional collection agency, you will be notified by certified mail that you will no longer be able to receive services from any of the physicians at Ear, Nose, and Throat Center of Northwest Houston. Failure to accept this certified letter (and/or to pick it up at the post office) serves as notice of termination of services.
- In the event you submit payment by check and the bank returns the check unpaid for any reason, we will add $25.00 to your original balance. In addition, we may seek all additional legal remedies provided to us under Texas law.
- We may charge you a "No Show" fee if you fail to cancel or reschedule your appointment at least 24 hours prior to your appointment date.
- **Failure to keep your account balance current may require us to cancel or reschedule your appointment.**

Full payment is due at the time of service. We accept cash, checks and credit cards. I have read and understand this Financial Policy.

Patient's Printed Name Date of Birth

Patient/Legal Representative Signature Representative Relationship Date

EAR, NOSE, AND THROAT CENTER OF NORTHWEST HOUSTON
CONSENT FOR TREATMENT

By signing this consent, I am authorizing my physician and/or other individuals he or she deems appropriate to perform and/or order exams, tests, procedures, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to Ear, Nose, and Throat Center of Northwest Houston unless revoked by me orally or in writing.

Please be informed Texas law allows a patient to be tested for possible exposure to the Human Immunodeficiency Virus (HIV), the virus associated with AIDS, in the following situations: 1) to screen blood, blood products, organs or tissues to determine suitability for donation; 2) if another individual is accidentally exposed to a patient's blood or body fluids, such as through a needlestick (any such test shall be conducted pursuant to Ear, Nose, and Throat Center of Northwest Houston' infectious disease protocol); or 3) if a medical or surgical procedure is to be performed which could expose health care workers to the patient's blood or body fluids. This disclosure is to inform you that you may be tested, at the expense of Ear, Nose, and Throat Center of Northwest Houston. If any of these situations occur during your treatment period.

Patient's Printed Name	Date of Birth
Patient/Legal Representative Signature	Date
Relationship to Patient	
Witness	Date

Procedure Acknowledgement

In order to diagnose your condition appropriately, the doctor will often perform and endoscopy or laryngoscopy. These procedures, as well as any earwax (cerumen) removal, foreign object removal, or any other procedures are not included in the cost of your regular examination and you will likely incur additional charges. If you have insurance, these charges are usually in addition to your co-pay and subject to your deductible. These procedures are considered surgical procedures.

Endoscopy and Laryngoscopy are procedures where a scope ("camera") is inserted into your throat or nose, to aid the doctor in diagnosing your condition.

If you do not want or consent to having these procedures performed, you must notify the doctor immediately.

Patient's Printed Name		Date of Birth
Patient/Legal Representative Signature	Representative Relationship	Date

Patient Portal Informed Consent & User Agreement

Patient Portal

The Ear, Nose and Throat Center of Northwest Houston offers its patients the use of a secure web-based Portal which provides you with secure electronic access to your medical record and communications between our office and you. To use the Portal you must agree to the Portal policies and procedures by signing the Informed Consent and User Agreement, and by activating your Portal account. Our Practice staff will enroll you and provide you with a confidential "token" and instructions on how to complete your enrollment. Your "token" is your access code to the Portal and will no longer be needed after activation. If unused, it will expire within in 30 days.

Portal Risks and Precautions

Secure messaging can be a valuable communications tool, but certain precautions should be used to minimize risks. Your signature on this form will document that you have been informed of and accept these risks and agree to the conditions of participation.

Privacy Protection of your Health Information

All messages sent to you will be encrypted to keep unauthorized persons from accessing your information. Keeping information secure depends on two factors: the secure message must reach the correct email address and only the correct individual (or someone authorized by the individual) must have access to it. While the likelihood of risks associated with the use of Portal is substantially reduced, there are risks which are important for you to understand. By signing this consent agreement you agree you will follow prudent security measures when you access the Portal and will communicate in a manner that reduces the likelihood of these risks occurring including but not limited to:

- Never use a public computer to access the Portal
- Do not store, send or access messages on your employer-provided computer or hand-held device as information is normally accessible by your employer
- Use a screen saver or close your messages so that others nearby cannot read them
- Keep your username and password safe and private
- If you are accessing the Portal via your mobile handheld device, you should password protect your device in the event your device is lost and/or stolen
- If you think someone has learned your password, you should promptly change it using Portal
- You are responsible for updating your contact information with the Practice any time it changes including the email address you designate for Portal or outside Portal messenging
- If you receive access to health care information which is not yours, immediately stop viewing such information and notify the Practice via a secure message on the Portal or by phone call

Access, Use of Online Communications and Conditions of Participation

- ***Use of Portal is limited to non-emergency communications and requests***
- In an emergency, call 911 or go to the nearest Emergency Room
- The Portal does not provide online medical advice, or replace the services of your provider
- A diagnosis can be made and treatment rendered **only after** your provider sees you
- You may view educational resources on various topics listed in the Portal library
- You may view a clinical summary of your most recent office visit as well as lab and test results
- You may send messages to your provider or staff, and you may view and respond to messages they send to you. All communications will be included in the clinical record maintained by the Practice
- Communications regarding sensitive subject matters such as mental health, HIV, clinical research, employer-related services, etc., are not permitted through the Portal
- When using the Portal please be concise. Confirm that your name and other personal information in a message is correct, and review before sending to make sure it is clear and all relevant information is included
- Your provider or staff, in their judgment, may decline to respond to a communication, and may ask you to call or to schedule an appointment at the office concerning the matter
- Access to the secure web Portal is a service, and we may suspend or discontinue at any time and for any reason
- Messages will be reviewed during normal hours of operation and every attempt will be made to respond to your messages within 48 business hours

Please see our Notice of Privacy Practices for additional information on privacy of your health information.

I have read the portal policies and procedures and consent to the terms and conditions of portal use.

Patient Information:

Name:	Date of Birth:
Address:	
E-Mail Address:	
Signature:	Date:

***Minors or users requiring caregivers - Acknowledgement of portal access to my health information to the following individual:**

Name:	Date of Birth:
Relationship to Patient:	
Address:	
E-Mail Address:	
Signature:	Date:

_ Parent/Guardian agreement to waive my right to the above minor's Portal and allow (initials) him/her to be treated as an adult for Portal enrollment and access.

NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGEMENT

A **Notice of Privacy Practices (NPP)** is provided to all patients. This Notice of Privacy Practices identifies: 1) how medical information about you may be used or disclosed; 2) your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information; 3) your rights to complain if you believe your privacy rights have been violated; and 4) our responsibilities for maintaining the privacy of your medical information.

The undersigned certifies that he/she has read the foregoing, received a copy of the Notice of Privacy Practices and is the patient, or the patient's personal representative.

Name of Patient	Signature of Patient	Date Signed
Patient's Legal Representative	Signature of Legal Representative	Date Signed

FOR INTERNAL USE ONLY

Name of Employee	Signature of Employee

If applicable, reason patient's written acknowledgement could not be obtained:

- ☐ Patient was unable to sign.
- ☐ Patient refused to sign.
- ☐ Other _____

Version 3 August 2013 (Notice Dated: As noted on NPP) 09/23/2013 (Date: As noted on NPP)