

Southern E.N.T. & Sinus Center, P.C.
John A. Jebeles, M.D. - D. Trent Lowery, M.D.

Patient Name: _____ **Social Security #:** _____

Address: _____ **Zip** _____

Home Telephone #: _____ **Cell Phone #:** _____ **Work Phone #:** _____

Patient's Birth Date: _____ **Sex:** M/F **Marital Status:** _____

Patient's Employer: _____

Responsible Party: _____ **Social Security #:** _____

Address: _____ **Daytime Telephone:** _____

Responsible Party's Employer: _____

Person to contact in case of emergency: _____ **Phone #:** _____

Primary Insurance: _____

Contract Holder: _____ **Policy/Contract #** _____

Contract Holder Birthdate: _____

Secondary Insurance: _____

Contract Holder: _____ **Policy/Contract#** _____

Contract Holder Birthdate: _____

Referring or Primary Care Doctor: _____

The patient/responsible party agree(s) to pay in full all charges submitted by Southern ENT & Sinus Center, P.C. during patients treatment, including treatment rendered during hospitalization, unless PC is legally obligated to accept payment for those charges solely from a third party. The patient/responsible party agrees to be fully financially responsible to the PC, even though there may be insurance or other third party coverage, HMO, or other third parties requiring specific referral authorization prior to making payment. Party acknowledges and agrees that for any service rendered without prior authorization, the patient/responsible party will be solely responsible for payment. Patient/responsible party acknowledges that payment is due at the date of service. **AGGREEMENT TO PAY:** I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all costs of collection, (33.33%), attorney fees and court costs, if such be necessary. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other State. **EXPRESS PRIOR CONSENT TO CONTACT CONSUMER BY CELL PHONE:** I, the undersigned, give Southern ENT & Sinus Center, P.C., its employees and/or agents "express prior consent" to contact me any any/all phone numbers, including cell phone numbers (by phone call or text message), for the purpose of treatment, insurance or payment.

Date

Signature of Patient/Responsible Party

Date

Signature of Witness

Medical Information Form

NAME: _____ **AGE:** _____ **DATE:** _____

REASON FOR VISIT: _____

Many ear, nose and throat problems or treatments are affected by other health problems or medications. Please circle "yes" or "no" for the following:

Heart Problems	yes	no	Stomach Ulcers	yes	no
High Blood Pressure	yes	no	Hepatitis	yes	no
Stroke	yes	no	Kidney Failure	yes	no
Seizures	yes	no	Thyroid Problems	yes	no
Meningitis	yes	no	Diabetes	yes	no
Asthma	yes	no	Arthritis	yes	no
Emphysema	yes	no	Weight Loss	yes	no
Severe Heartburn	yes	no	Enlarged Lymph Nodes	yes	no
Hiatal Hernia	yes	no	Free Bleeding	yes	no
Anesthesia Problems	yes	no	History of Tuberculosis	yes	no
Cancer*	yes	no			

***If yes, type of treatment:**

Please list any operations you have ever had:

Please list any medications you are now taking:

Are you allergic to any of the following: (Please circle yes or no)

Penicillin	yes	no	Codeine	yes	no
Sulfa	yes	no	Tetanus	yes	no
"Mycins"	yes	no	Demerol	yes	no
Aspirin	yes	no	Tetracycline	yes	no

Other medications: _____

Has any blood relative ever had the following: (Please circle)

Allergies	Tuberculosis	Hearing Loss
Heart Disease	Cancer	Bleeding Problems
Stroke	High Blood Pressure	
Diabetes	Anesthesia Problems	

Occupation: _____

Do you drink alcohol? yes no _____

Do you use tobacco products? yes no **Amount** _____ **Number of Years** _____

SOUTHERN ENT & SINUS CENTER, P.C.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I, _____, acknowledge I have
Received a copy of the Notice of Privacy Practices.

Signature of Patient/Parent/Guardian

Date

Relationship to patient

**** AUTHORIZATION TO RELEASE MEDICAL RECORDS AND RELATED TEST RESULTS ****

**I, hereby authorize the physicians and/or staff of SOUTHERN ENT AND SINUS CENTER, P.C.,
to discuss my medical condition and to release my lab/pathology reports to:**

- _____ **Only to myself**
- _____ **Leave lab/pathology results on answering machine**
- _____ **Any member of my family**
- _____ **Only to the following family members:**

Signature of (Patient/Parent/Guardian)

Date

SOUTHERN ENT & SINUS CENTER, P.C.

Notice of Privacy Practices Summary

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. If you have any questions about this Notice please contact our Privacy Officer at (205) 838-3755.

This is a summary of our Notice of Privacy Practices which describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information.

We are required by law to maintain the privacy of your protected health information and to provide you with a notice of our legal duties and privacy practices with respect to protected health information.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time, and reserve the right to do so. The new notice will be effective for all protected health information that we maintain at that time.

We will use your protected health information as part of rendering patient care, including treatment, payment and healthcare operations.

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. 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.

We may use or disclose your protected health information in certain situations without your authorization or opportunity to agree or object.

You have the right to request a restriction of your protected health information.

You have the right to request to receive confidential communications of your protected health information.

You have the right to inspect and copy your protected health information.

You have the right to amend your protected health information.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

You have the right to obtain a paper copy of this notice from us.

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.

This summary was published along with the Notice of Privacy Practices.