Southern E.N.T. & Sinus Center, P.C.
D. Trent Lowery, M.D.-David Walters, M.D.- Matthew Fort, 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 Collection Agency Fee, (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. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

_____ _____

Date **Signature of Patient/Responsible Party**

_____ _____

Date **Signature of Witness**

SOUTHERN ENT & SINUS CENTER, P.C.
OTOLARYNGOLOGY, HEAD AND NECK SURGERY
ADULT AND PEDIATRIC

D. Trent Lowery, M.D.
David Walters, M.D.
Matthew Fort, M.D.

Certain in office surgical procedures (Video Stroboscopy, nasal endoscopy, etc), imaging studies (CT) and audiology services may be subject to an individual's deductible, based on their insurance policy.
It is the responsibility of the patient to know their insurance policy.

By signing this document, I acknowledge I am responsible for the cost if not covered by insurance.

_____ _____

Patient Signature **Date**

Southern ENT and Sinus Center
Medical Information Form

Name: _____ DOB: _____ Today's 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	HIV/AIDS	yes	no
Cardiac stents	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	Unexplained weight loss	yes	no
Severe heartburn	yes	no	Enlarged lymph nodes	yes	no
Hiatal/Umbilical hernia	yes	no	Free bleeding	yes	no
Anesthesia problems	yes	no	History of tuberculosis	yes	no
Sleep apnea	yes	no	Pregnant	yes	no
Use CPap or BiPap	yes	no	If so, how many weeks?	_____	
Cancer**	yes	no			

**If so, type of treatment: _____

Any other serious medical condition: _____

Please list any operations you have ever had: _____
_____

Please list any medications you're currently taking: _____
_____

Circle **"yes or no"** if you are allergic to any of the following:

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

Other: _____

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

Allergies	Tuberculosis	Hearing loss
Heart disease	Cancer	Bleeding problems
Stroke	High blood pressure	Anesthesia problems
Diabetes		

Occupation: _____

Do you drink alcohol?	Yes	No	Amount _____ Number of years _____
Do you use tobacco products?	Yes	No	Amount _____ Number of years _____

Preferred pharmacy: _____ Address: _____

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.

1809 GADSDEN HWY
BIRMINGHAM, AL 35235

AUTHORIZATION FOR TEXT MESSAGING/EMAIL

I consent to receive appointment reminders and other healthcare communications/information via text message/email from Southern ENT & Sinus Center. This is to remind you of an appointment and to provide general health reminders/information.

The **CELL PHONE** number I authorize to receive text messages:
(_____) _____-_____
Carrier: _____
(Example: Verizon, AT&T, Sprint, T-Mobile)

EMAIL: _____

I understand Southern ENT & Sinus Center is not responsible for any overages or text messaging charges. Your standard text messaging rates will apply.

This request to receive text messages will apply to all future appointment reminders/health information unless I request a change in writing.

PRINT NAME: _____

PATIENTS SIGNATURE: _____

DATE: _____

OFFICE USE ONLY, MR#_____

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.