WYO ENT

EAR, NOSE & THROAT
FACIAL PLASTICS
Dr. Ian Swift

PATIENT INFORMATION

Preferred Pharmacy: ❑ Walgreens ❑ Albertsons ❑ Medicap ❑ Walmart ❑ Kmart ❑ Other _____

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____ Preferred: _____
Date of Birth: __/__/____ Sex: ❑ M ❑ F SSN: _____ Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed
Race: _____ Ethnicity: _____ Primary Language: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Physical Address: _____ City: _____ State: _____ Zip: _____
Home#: _____ Work#: _____ Cell#: _____
Preference for Reminder Calls: ❑ Text ❑ Automated Call ❑ Email _____
Employer: _____ Work#: _____
Address: _____ City: _____ State: _____ Zip: _____
Emergency Contact: _____ Date of Birth: _____ Relationship: _____ Phone#: _____

SPOUSE INFORMATION

Last Name: _____ First Name: _____ MI: _____ Date of Birth: _____/_____/_____
SSN: _____ Home#: _____ Work#: _____ Cell#: _____
Employer: _____ Work#: _____
Address: _____ City: _____ State: _____ Zip: _____

GUARANTOR (IF UNDER 18 YEARS OLD)

Name: _____
Address: _____
Home# _____ Cell#_____
Date of Birth: __/__/____ SSN: _____
Employer: _____
Relationship to Patient: _____

Name: _____
Address: _____
Home# _____ Cell#_____
Date of Birth: __/__/____ SSN: _____
Employer: _____
Relationship to Patient: _____

INSURANCE INFORMATION

Primary Insurance: _____
Policy: _____Group#_____
Policy Holder: _____
Address: _____
City: _____ State: _____ Zip: _____
Home# _____ Cell# _____
Date of Birth: __/__/____ SSN: _____
Employer: _____
Relationship to Patient: _____

Secondary Insurance: _____
Policy: _____Group#_____
Policy Holder: _____
Address: _____
City: _____ State: _____ Zip: _____
Home# _____ Cell# _____
Date of Birth: __/__/____ SSN: _____
Employer: _____
Relationship to Patient: _____

WORKER'S COMPENSATION

Insurance Company_____ Address: _____ Zip: _____
Contact Person: _____ Phone#_____ Claim#_____
Date of Accident: __/__/____ Employer: _____ Employer Phone# _____
What Happened? _____

FINANCIAL AGREEMENT

I understand and agree that I am assuming responsibility to pay ALL fees and charges for the treatment of the person named above (regardless of insurance), unless I inform you otherwise in writing. I agree to pay all charges for me and members of my family when services are rendered. In the event legal action becomes necessary to collect any unpaid charges, I agree to pay costs of collection, including attorney's fees. It is agreed that payments will not be delayed or withheld because of my insurance coverage or the pendency of claims for the collection therof, and all proceeds of insurance are assigned to this office. Unless otherwise paid, but without the office assuming any responsibility for the collection therof. A copy of this assignment is as valid as the original. I understand that all charges are payable at the time of service, regardless of insurance and any charges allowed. Pending insurance is at the sole discretion of Swift WY ENT.

Patient Signature: _____ Date: ___/___/_____

407 Medical Arts Court Suite F · Gillette, WY 82716 · Phone: (307)670-8290 · Fax: (307)670-8291 · www.wyoentpc.com

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ALLERGIES / MEDICATION

PATIENT INFORMATION

Name: _____ Date of Birth: __/__/____ Age: _____
Main Reason for Today's Visit: _____
Family Physician: _____
Referred By: _____

Please list all allergies and reactions to medications, foods etc. (If Known) and description of reactions.

ALLERGIES	REACTION

MEDICATION NAME	DOSE	TIMES A DAY	MEDICATION NAME	DOSE	TIMES A DAY

SOCIAL HISTORY / LIFESTYLE

Employed: ❑ Yes ❑ No Occupation: _____ ❑ Single ❑ Married
Do you currently use tobacco? ❑ Yes ❑ No If not currently, did you ever use tobacco? ❑ Yes ❑ No
_____ pack(s) a day chew _____ a day. Quit at what age? _____ How long ago did you quit? _____
Do you drink alcohol? ❑ Yes ❑ No How many drinks per day/week? _____

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MEDICAL HISTORY

PAST MEDICAL HISTORY

Abnormal Birth/Delivery:	❑ Yes ❑ No	Frequent Throat Infections:	❑ Yes ❑ No
Allergies:	❑ Yes ❑ No	Hearing Loss:	❑ Yes ❑ No
Asthma:	❑ Yes ❑ No	Heart Disease:	❑ Yes ❑ No
Bleeding/Bruising:	❑ Yes ❑ No	High Blood Pressure:	❑ Yes ❑ No
Cancer:	❑ Yes ❑ No	HIV/Aids:	❑ Yes ❑ No
Developmental Delay:	❑ Yes ❑ No	Kidney/Bladder Disease:	❑ Yes ❑ No
Seizure:	❑ Yes ❑ No	Liver or Intestinal Problems:	❑ Yes ❑ No
Anxiety/Depression:	❑ Yes ❑ No	Sinusitis:	❑ Yes ❑ No
Mental Illness:	❑ Yes ❑ No	Stomach Acid Reflux:	❑ Yes ❑ No
Stroke:	❑ Yes ❑ No	Thyroid Disease:	❑ Yes ❑ No
Other:	❑ Yes ❑ No	Missed Any Immunizations?	❑ Yes ❑ No

PAST SURGICAL HISTORY

❑ Ear Surgery	Date: _____	❑ Throat/Neck	Date: _____
❑ PE Tubes	Date: _____	❑ Thyroid	Date: _____
❑ Sinus Surgery	Date: _____	❑ Tonsils/Adenoids	Date: _____

❑ Other: _____

FAMILY MEDICAL HISTORY

High Blood Pressure:	❑ Yes ❑ No	Cancer:	❑ Yes ❑ No
Thyroid Problems:	❑ Yes ❑ No	Asthma:	❑ Yes ❑ No
Mental Illness:	❑ Yes ❑ No	Diabetes:	❑ Yes ❑ No
Hearing Loss/Ringing:	❑ Yes ❑ No	Allergies:	❑ Yes ❑ No
Reaction to Anesthesia:	❑ Yes ❑ No	Heart Disease:	❑ Yes ❑ No
Bleeding/Bruising:	❑ Yes ❑ No	Stroke:	❑ Yes ❑ No
Sinusitis:	❑ Yes ❑ No	Other: _____	

REVIEW OF SYSTEMS

Fatigue:	❑ Yes ❑ No	Wheezing:	❑ Yes ❑ No
Night Sweats:	❑ Yes ❑ No	Cough:	❑ Yes ❑ No
Joint Pain:	❑ Yes ❑ No	Hearing Loss:	❑ Yes ❑ No
Headaches:	❑ Yes ❑ No	New Skin Lesions:	❑ Yes ❑ No
Impaired Vision:	❑ Yes ❑ No	Heartburn:	❑ Yes ❑ No
Anxiety/Depression:	❑ Yes ❑ No	Shortness of Breath:	❑ Yes ❑ No
Ringing in Ears:	❑ Yes ❑ No	Loss of Balance:	❑ Yes ❑ No
Sore Throat:	❑ Yes ❑ No	Changes to Moles:	❑ Yes ❑ No
Sinus/Allergy:	❑ Yes ❑ No	Nausea:	❑ Yes ❑ No
Chest Pain:	❑ Yes ❑ No	Pigmentation change:	❑ Yes ❑ No
Snoring:	❑ Yes ❑ No	Muscular Weakness:	❑ Yes ❑ No
Weight Loss:	❑ Yes ❑ No	Loss of Hair:	❑ Yes ❑ No

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NOTICE OF PRIVACY PRACTICES

This Notice outlines how your Protected Health Information (PHI) may be used and disclosed. It also explains how you can personally obtain access to this information.

Patient Rights
As a patient, you have a number of rights with respect to your PHI.

You have the right to access, copy or inspect most of the health information about you that we maintain. We will normally allow access to this information within 30 days of request. A reasonable fee may be charged for copies of any health information that you may have a right to access. We have forms available to request access to your PHI. If you are denied access, a written response will be provided outlining our rights of appeal. You also have the right to receive confidential communications of your PHI. If you wish to inspect and/or request copies of your PHI, contact our office.

The right to amend your PHI
You have the right to ask us to amend written medical information that we may have about you. If an amendment is warranted, it will be done within 60 days of your request and you will be notified upon completion. We are permitted by law to deny your request to amend your health information only in certain circumstances, like when we believe the information you have asked us to amend is correct. If you wish to request that we amend the health information that we have about you, you should contact our office.

The right to request a summary
You may request a summary from us of certain disclosures of your health information that we have made in the last six years prior to the date of your request. We are not required to give you a summary of information we have used or disclosed for purposes of: treatment, payment, health care operations, or when we share your health information with our business associates, like our billing company or medical facility.

The right to request that we restrict the use and disclosures of your PHI
You have the right to request that we restrict how we use and disclose your health information. WYO ENT is not required to agree to any restrictions, but any restrictions agreed to by WYO ENT in writing are binding. Internet, electronic mail, and the right to obtain a paper notice on request If we maintain a website, we will prominently post a copy of this notice on our website. If you allow us, we will forward you this notice by electronic mail instead of on paper. You may also request a paper copy of this notice.

Revisions to the Notice
WYO ENT reserves the right to change the terms of this Notice at any time. Changes will be effective immediately and will apply to all PHI that we maintain. Any material changes to the notice will be promptly posted in our facility and posted to our website, if we maintain one. You can obtain a copy of the latest version of this notice by contacting our office.

Your legal rights and complaints
If you believe your privacy rights have been violated, you have the right to complain to us, or to the Secretary of the United States Department of Health and Human Services. You will not be retaliated against in any way for filling a complaint with us or to the government. All questions, comments, or complaints should be directed to our office.

Privacy Notice
WYO ENT is required by law to maintain the privacy of certain Private Health Information, or PHI, and to provide you with a notice of our legal duties and privacy practices with respect to your PHI. WYO ENT is also required to abide by the terms of the version of this notice currently in effect.

Uses and disclosures of PHI
WYO ENT may use PHI for the purposes of treatment, payment, and health care operations in most cases without your written permission.

Examples include:

For Treatment
This includes obtaining verbal and written information from yourself or others regarding your medical condition and treatment. We may give your PHI to any health care provider involved in your treatment. We may transmit your PHI via radio, telephone, fax and/or electronic or postal mail as necessary.

For Payment
This includes any activities we must undertake in order to obtain reimbursement for services we provide to you. This includes but is not limited to: submitting bills to insurance companies, medical necessity determinations, and collection of outstanding accounts.

For Health Care Operations
This includes quality assurance activities, licensing, and training programs to ensure that our personnel meets our standards of care and procedures, as well as certain management functions.

Reminders and Information
We may contact you to provide a reminder of any scheduled appointments, or to communicate information about other services we provide.

Permissible uses and disclosures of PHI without your authorization
WYO ENT is permitted to use PHI without your written authorization, nor the opportunity to object, in certain situations. Unless prohibited by a more stringent state law, these situations include:

- For treatment, payment, or health care operation activities of another health care provider involved in your treatment;
- For health care and compliance activities;
- To a relative or individual involved in your care if we obtain your verbal consent to do so or if we give you an opportunity to object to such as disclosure and you do not raise an objection. In certain circumstances where we are unable to obtain your agreement and believe the disclosure is in your best interest.;
- To a public health authority in certain situations as required by law. Examples include but are not limited to: abuse, neglect, or domestic violence;
- For health oversight activities including audits, government investigations, inspections, disciplinary proceedings and other administrative , or judicial actions undertaken by the government (or their contractors) by law to oversee the health care system;
- For judicial and administrative proceedings as required by court or administrative order or in response to a subpoena or legal process;
- For law enforcement activities in limited situations, such as responding to a warrant;
- For military, national defense and security, and any other special government functions;
- To avert a serious threat to the health and safety of a person or the public at large;
- For workers' compensation purposes and in compliance with workers' compensation laws;
- To coroners, medical examiners, and funeral directors for identifying a deceased person, determining cause of death or carrying on their duties authorized by law;
- To organizations that handle organ procurement or eye/tissue transplantation or to an organ donation bank, as necessary to facilitate organ donation and transplantation.
- For research projects, however, this will be subject to strict oversight and approval;
- We may also use or disclose health information about you in a way that does not personally identify you or reveal who you are;

Any other use or disclosure of PHI, other than those listed above will only be made with your written authorization. You may revoke your authorization at any time, in writing, except to the extent that we have already used or disclosed PHI in accordance to that authorization.

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ACKNOWLEDGMENT OF RECEIPT

I hereby acknowledge that I have reviewed WYO ENT's Notice of Privacy Practices Summary.

_____ Date: __/__/____
Signature of patient or patient's representative.

Printed name of patient: _____ DOB: ___/___/_____

Printed name of patient's representative: _____

Relationship to patient: _____

USE / RESTRICTION OF PATIENT INFORMATION *In general, the Hippa privacy rules give the individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.*

MEDICAL RECORDS RELEASE AUTHORIZATION *I Authorize and direct any holder of medical information regarding my medical history, symptoms, treatment, examination results or diagnosis to release ALL information to WYO ENT, PC. I also give my permission for records FROM any physician, hospital or any other medical provider be released BY WYO ENT, PC as pertains to their care of me. This authorization shall remain in full force and effect until revoked in writing by myself. A photocopy of this authorization shall be considered as valid as the original*

INSURANCE AUTHORIZATION & ASSIGNMENT *I authorize WYO ENT, PC to release any information needed to my insurance carriers to determine benefits payable for related services. I hereby assign to WYO ENT, PC all payments for medical/surgical services rendered to me and/or my dependents. In consideration of professional services rendered to the above patient, I/we agree to pay your customary charge for these services in full at the time of service, unless other arrangements are made with the doctor or office manager. I/we authorize the Doctor to receive assignment of Insurance payments. If the customary charges are more than the benefits allowed under any Insurance plan that I/we have, I/we agree to pay the difference.*

BASIC POLICY: *Pay for service is due in full at the time service is provided in our office.*

FOR PATIENTS WITH INSURANCE: *We bill most insurance carriers for you if proper paperwork is provided to us. We will also bill most secondary insurance carriers for you. Copayments and deductibles are due at the time of service.*

MEDICARE PATIENTS: *We will bill Medicare for you. We will also bill secondary insurance carriers for you. All copayments or deductibles are due and payable at the time service is provided.*

SURGERY FEES: *All co-pays, deductibles, and payments for non-covered surgical procedures are due prior to your surgery. Prior authorization may be required by your carrier.*

NON-COVERED SERVICES: *Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.*

WORKER'S COMPENSATION: *If your injury is work related, we will need the case number and carrier name prior to your visits in order to bill the Worker's Compensation insurance company.*

I wish to be contacted in the following manner (check all that apply):

Home Telephone: (____)_____
- ❑ OK to leave message with detailed information
- ❑ Leave message with callback number only

Work Telephone: (____)_____
- ❑ OK to leave message with detailed information
- ❑ Leave message with callback number only

Cell Phone: (____)_____
- ❑ OK to leave message with detailed information
- ❑ Leave message with callback number only

Verbal Communication:
- ❑ OK to release information verbally & physically to:

_____ DOB: ___/___/_____
_____ DOB: ___/___/_____

Written Communication:
- ❑ OK to mail to my home address
- ❑ OK to mail to work/office address

It is the patient's responsibility to provide updates or changes to this information.

_____ Date: __/__/____
Signature of patient or patient's representative.

The privacy rule generally requires health providers to take reasonable steps to limit the use or disclosure of and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Note: uses and disclosures for treatment, payment and healthcare operation (TPO) may be permitted without prior consent in an emergency.