Notice of Privacy Rules/HIPAA

NOTICE OF PRIVACY PRACTICES FOR THE OFFICES OF:

Ear Nose and Throat Associates of Texas, PA

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 of our office at:

Frisco – Administrative Office

4401 Coit Rd, Suite 411 6717 W. Eldorado Parkway, Suite 140
Frisco, TX 75035
(972) 731-7654
(972) 731-6226
info@enttex.net

WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, staff and other office personnel. The practices described in this notice will also be followed by health care providers you consult with by telephone (when your regular health care provider from our office is not available) who provide "call coverage" for your health care provider.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the health care and services you receive at this office. We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment

We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health. For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you. Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have.

For Payment

We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

For Health Care Operations

We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care. for example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

Appointment Reminders

We may contact you as a reminder that you have an appointment for treatment or medical care at the office.

Treatment Alternatives

We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Products and Services

We may tell you about health-related products or services that may be of interest to you. Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products and services. If you advise us in writing (at the address listed at the top of this Notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

SPECIAL SITUATIONS

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

To Avert a Serious Threat to Health or Safety

We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Required By Law

We will disclose health information about you when required to do so by federal, state or local law.

Research

We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

Organ and Tissue Donation

If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

Military, Veterans, National Security and Intelligence

If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation

We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks

We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Health Oversight Activities

We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes

If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

Law Enforcement

We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

Coroners, Medical Examiners and Funeral Directors

We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

Information Not Personally Identifiable

We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Family and Friends

We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written Authorization. If you give us Authorization to use or disclose health information about you, you may revoke that authorization, in writing, at any time. If you revoke that Authorization, in writing, at any time. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission. If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization from you that complies with the law governing HIV or substance abuse records.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy

You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to:

Ear Nose and Throat Associates of Texas, PA
4401 Coit Rd, Suite 411 6717 W. Eldorado Parkway, Suite 140
Frisco, TX 75035

in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Amend

If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

a) We did not create, unless the person or entity that created the information is no longer available to make the amendment.
b) Is not part of the health information that we keep.
c) You would not be permitted to inspect and copy.
d) Is accurate and complete.

Right to an Accounting of Disclosures

You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and health care operations. To obtain this list, you must submit your request in writing to:

Ear Nose and Throat Associates of Texas, PA
4401 Coit Rd, Suite 411 6717 W. Eldorado Parkway, Suite 140
Frisco, TX 75035

It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions

You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are Not Required to Agree to Your Request

If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you may complete and submit a Request For Restricting Uses and Disclosures and Confidential Communications Form Information to our office.

Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.
To request confidential communications, you may complete and submit the Requests For Restricting Uses and Disclosures and Confidential Communications to:
We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact our office.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact:

Ear Nose and Throat Associates of Texas, PA
4401 Coit Rd, Suite 411 6717 W. Eldorado Parkway, Suite 140
Frisco, TX 75035

You will not be penalized for filing a complaint.

Signature:

FRISCO OFFICE
4401 Coit Rd., Ste 411
Frisco, TX. 7503

McKINNEY OFFICE
6717 West Eldorado Pkwy, Ste 140
McKinney, TX. 75070

PLANO OFFICE
4716 Alliance Blvd. Ste 260
Plano, TX. 75093

Phone (972) 731-7654 **Fax (972) 731-6226**

Neelesh Mehendale, M.D. Chad McDuffie, M.D. Dale Ehmer, Jr., M.D. Nicholas Peiffer, M.D. Lav Kapadia, M.D.
A. Kathryn Smith, PA-C Angela M. Jorrey, PA-C

PATIENT REGISTRATION

Thank you for choosing Ear, Nose and Throat Associates of Texas (ENTTEX).
It is mandatory that this be completed for optimal medical care, communication with providers, and data collection.

Please print legibly

Patient Name: (Last) ____________________________ (First)_____________________________(Initial)_______

Birth date:_____/______/______ Social Security #:_________-_______-__________ Sex (✓): M___ F___

Mailing Address:________________________________Apt:_____City________________ State______ Zip________

Email:___________________________________ Marital Status (✓) Single_____ Married____

Day Phone:( )_____-______ (Home ☐ Work ☐ Cell ☐) Evening Phone:( )_____-______(Home ☐ Work ☐ Cell ☐)

☐ I authorize messages and reminders may be left at the contact methods listed above.

Referring Physician:______________________________or ☐ I do not have one City_______________________

Primary Care Physician:___________________________or ☐ I do not have one City_______________________

Emergency Contact Name:____________________ Relationship:_______________Phone: ( )______-_______

☐ I authorize release of information contained the medical record of this patient to the emergency contact above.

Please check (✓) one from each column. This is solely for data collection and will not affect your care.

Race:
____ American Indian or Alaska Native
____ Asian
____ Black or African American
____ Native Hawaiian or Other Pacific Islander
____ White
____ Other ___________________
____ Patient declined to answer

Ethnicity:
____Hispanic
____Non-Hispanic
____Patient declined to answer

Language:
____English
____Spanish
____Other________________

INSURANCE INFORMATION

Please present insurance card (and secondary cards) with current Driver's license or other photo ID.
This is mandatory or your appointment may be rescheduled.

Primary Insurance Carrier Name____

Policy Holder: ____________________________________ Relationship to Patient__________________________

Policy Holder's Social Security Number: _____ - _____ - _____ Policy Holder's Date of Birth: _____/_____/_____

Employer:____City____________________________

If you have presented your insurance card to receptionist, DO NOT complete this box.

Plan Name: ______________________________________ I.D. Number: ____________________________

Address: ____ Group Number: ___________________________

Effective Date: ___________________________________ Phone Number:___________________________

PLEASE READ THE FOLLOWING AND INITIAL

_______Initial I authorize medical treatment by the physician and other providers at ENTTEX.

_______Initial I authorize the release of medical records necessary to process insurance claims, and for coordination and communication with other providers.

_______Initial I authorize information relating to my care represented in this medical record may be released to the following individuals_____________________________________Relationship__________________

_______Initial I authorize payment of medical benefits to be made directly to ENTTEX for services filed to insurance on my behalf.

_______Initial I acknowledge that payment is due at the time of service, unless other arrangements have been made. I assume financial responsibility for any and all healthcare services provided to me.

_______Initial ENTTEX files claims for any of the Managed Care Plans with which we participate. Any applicable co-payment, co-insurance or deductible is expected to be paid at the time of service. Our office is willing to assist in claim filing for insurance carriers with which we are not contracted. We require that these arrangements be made with our office staff prior to your visit.

_______Initial If my insurance plan requires a referral or prior authorization from my primary care physician, it is my responsibility to ensure that one is issued. Arriving at our office without the required referral may result in cancellation and rescheduling of your appointment to ensure that one is issued.

_______Initial I understand that ENTTEX adheres to state and federal guidelines for privacy and to HIPAA laws. I understand that I will be provided a copy at my request.

Signature ____Date____________________

By signing above, I have read and understand all of the above and certify that all information provided to ENTTEX is correct.

FOR PATIENTS UNDER 18

This is for the parent or guardian accompanying the patient on the day of the appointment.

Parent/Guardian Name:_________________________________ Relationship to patient:__________________

Birth date:_____/______/______ Social Security #:_________-_______-__________ Sex (✓): M___ F___

Address:________________________________ Apt #:______City:________________ State:______ Zip:_______

Day Phone:( )_____-______ (Home ☐ Work ☐ Cell ☐) Evening Phone:( )_____-______(Home ☐ Work ☐ Cell ☐)

_______Initial Consent for Treatment-Accompanied by Other than Parent or Legal Guardian.
Authorized Individual______________________________Relationship to Patient_________________

_______Initial I authorize information relating to the care of the child represented in this medical record may be released to the following _____________________________Relationship_____________________

_______Initial I warrant that I am the party responsible for making medical decisions for the child represented in this medical record.

_______Initial I assume financial responsibility for all healthcare services provided to this patient.

_______Initial I understand that ENTTEX will not get involved in matters involving third party personal billing whether result of custody, court order or personal circumstances.

Signature of parent/guardian ________________________________ Date____________________

By signing above, I have read and understood all of the above and certify that all information provided to ENTTEX is correct.

Ear, Nose and Throat Associates of Texas, PA

Welcome!! Please read the following office policies and let us know if you have questions.

1. Please sign in at the front desk at each visit. Please complete any paperwork in its entirety.
2. Please pay your co-payment when you check out.
3. Please have your driver's license and insurance card ready. We must have a copy of your current insurance card. Please bring your insurance card with you to all visits, as we must periodically verify your insurance coverage.
4. Please inform our office 24 hours prior to your appointment if your insurance has changed. If your insurance plan changes and you fail to notify us at the time of service, you may be held responsible for the entire balance due.
5. We ask that you please contact our office with any address, telephone or insurance changes.
6. Please turn off cell phones when you are in the exam room.
7. If surgery becomes necessary, there may be a surgery deposit required depending upon your insurance plan.
8. Your insurance company may require additional information from you in order to process your claim, such as: accident or injury details, other insurance coverage information or student status. If your insurance company pends your claim or does not pay your claim for your failure to respond to their inquiries, you may be held responsible for the entire balance of the claim.
9. After your insurance carrier has paid their portion, there may be an amount not covered and a balance due. If so, we will send you a statement.
10. If your insurance mistakenly sends you our payment, please forward the check to us immediately.
11. If your insurance plan requires you to have a referral, you must verify that a valid referral is on file with our office prior to your appointment.
12. If you need a prescription refilled, please contact your pharmacist.
13. WE DO NOT BILL AUTO INSURANCE OR THIRD PARTY LIABILITY INSURANCE OR WORKER'S COMP. Payment will be expected at the time of service.
14. Many insurance plans classify procedures such as, but not limited to: hearing tests, sinus debridement, cerumen (ear wax) removal, CT scans and allergy tests/injections in the same category as minor surgery. Therefore, these claims may be processed using surgical benefits, and may require additional payment from you for deductible and/or co-insurance.
15. There is a $25.00 returned check fee. In the event of a returned check, please contact the billing office immediately.

I, __________________________, do hereby affirm that I have read and understand the
Patient or guardian
above office and financial policies. I understand that I am ultimately responsible financially for all medical fees incurred during my treatment with ENTTEX, regardless of insurance coverage benefits.

______________________________	______________________________	____________
Patient name, please print	Signature of Patient/Guarantor	Date

Follow My Health Patient Portal Authorization Form

ENT*tex* provides patients with online access to their personal health records through Follow My Health. Once enrolled for access, you will receive an email invitation from noreply@followmyhealth.com to activate your account. If you do not see the invitation within 72 hours, please check your Junk or Spam folder; if you need assistance, call 972-731-7654 during business hours for support.

Adult Patient ☐ And/or Parent/Guardian Minor Proxy ☐	Full Name:		
	Address:		
	City:	State:	Zip:
	Date of Birth:	Phone #:	
	Email Address:		

Please complete the below section for each child under the age of 18. ☐ Non applicable.

Child 1	Child's Name:	Date of Birth:
	Child's address: City, State and Zip ☐ Same as above	Relationship to Child:
Child 2	Child's Name:	Date of Birth:
	Child's address: City, State and Zip ☐ Same as above	Relationship to Child:
Child 3	Child's Name:	Date of Birth:
	Child's address: City, State and Zip ☐ Same as above	Relationship to Child:

Signature of Patient and/or Guardian	Date

By signing above, I authorize Ent*tex* to invite me and the above named child(ren) to enroll in Follow My Health, for online access to personal health records.

To help Ent*tex* protect your health information, please present this completed form and your picture ID to our Ent*tex* personnel.

FOR OFFICE USE: Completed form needed in all instances.

☐Identification of Patient/Proxy Verified	☐Activation Code Communicated to Patient/Proxy	☐Patient/Proxy Invitation Sent from FMH Dashboard

Frisco Office
4401 Coit Rd., Ste 411
Frisco, TX. 75035

McKinney office
6717 West Eldorado Pkwy, Ste 140
McKinney, TX. 75070

Plano office
4716 Alliance Blvd. Ste 260
Plano, TX. 75093

Phone (972) 731-7654 **Fax (972) 731-6226**

Neelesh Mehendale, M.D. Chad McDuffie, M.D. Dale Ehmer, Jr., M.D. Nicholas Peiffer, M.D. Lav Kapadia, M.D.

Patient name: (Last)__________________________ (First)____________________ Birth Date: _____/_____/_____

Reason for today's visit? ____

When did symptoms first begin? _____________________________ Referring Physician______________________

Drug Allergies: ____ **No known drug allergies** _____

□ List current medications below OR □ I have provided a separate list of my medications
OR □ I am not currently taking any Medications

Medication	Dose	Medication	Dose
1.		**7.**	
2.		**8.**	
3.		**9.**	
4.		**10.**	
5.		**11.**	
6.		**12.**	

Preferred Pharmacy_____________________________ Location (cross streets) _____________________________
(Prescriptions are sent electronically) City____

Infections in the last Six Months

Number of Nasal/Sinus Infections ______
Number of Ear Infections ______
Number of Tonsil/Strep Infections ______

Antibiotics taken in the last Six Months

_____Amoxicillin _____Ciprofloxacin ____Omnicef
_____Zithromax _____Ceftin ____Augmentin
_____Biaxin _____Cefzil ____Suprax
_____Ceclor _____Rocephin ____Other

Past Surgical History

	Year	Other surgeries	Year	Other surgeries	Year
____Adenoidectomy	______	________________________	______	______________________	______
____Tonsillectomy	______	________________________	______	______________________	______
____Ear Tubes	______	________________________	______		
____Nasal/Sinus Surgery	______	________________________	______		

Social History

Marital Status: ____Single ____Married Live alone? Yes No

Do you have children? Yes No How many? ________

Do you use tobacco? Yes No If yes, choose one: □ Smoke everyday □ Smoke some days
□ Former smoker □ Unknown

Do you drink alcohol? Yes No Beer Wine Liquor Drinks per week________

Do you use drugs? Yes No Marijuana Heroin Cocaine Other ______________________

IF THE PATIENT IS UNDER 18 YEARS OF AGE:

Does your child attend school or day care? Yes No How many children are in the class? ________

Who lives at home with your child? ____________________ Is your child exposed to cigarette smoke? Yes No

Patient History
(Current or past)

Medical Conditions	Yourself YES	Family YES	Explanation Specify family member if you marked Yes
Acid Reflux			
Alcoholism			
Anemia			
Arthritis			
Asthma/Emphysema			
Bleeding Disorder			
Cancer			
Diabetes			
Epilepsy/Seizures			
Glaucoma			
Headaches			
Heart disease/failure			
HIV/AIDS			
High Blood Pressure			
High Cholesterol			
Kidney Disease			
Liver dysfunction			
Mental/Psychiatric Illness			
Stroke			
Thyroid Problem			
Tuberculosis			
Ulcers of Stomach			
Other (Hospitalizations, etc)			
Other			

ROS
Please check (✓) all current symptoms that apply

General
____Fever
____Weight loss
____Night Sweats

Eyes, Ears, Nose and Throat
____Cataracts
____Hearing loss
____Wear hearing aids
____Dizziness
____Ear pain
____Ear infections
____Ringing in the ears
____Inability to smell
____Nosebleeds
____Nasal congestion
____Nasal drainage
____Sinus problems
____Sinus headaches
____Sore throats
____Snoring

Neck
____Neck swelling
____Neck pain
____Neck stiffness
____Swollen glands

Respiratory
____Chronic cough
____Shortness of breath
____Pneumonia
____Lung cancer
____Bloody sputum

Neurological
____Fainting spells or 'blackouts'
____Seizures
____Memory problems
____Disorientation
____Difficulty with your speech
____Double or blurred vision
____Face weakness
____Loss of coordination
____Speech delay

Cardiovascular
____Irregular Pulse
____Heart murmur
____Swelling of feet

Endocrine
____Increased appetite
____Excessive thirst or urination

Gastrointestinal
____Indigestion
____Nausea
____Vomiting
____Jaundice
____Heartburn

Genitourinary
____Urinary tract infections
____Painful urination
____Blood in urine
____Kidney stones
____Incontinence

Psychiatric
____Anxiety
____Depression
____Other psychiatric
(Please list under patient history)

Musculoskeletal
____Arm or leg weakness
____Joint pain or swelling
____Arthritis

Hematologic/Lymphatic
Allergic/Immunologic
____Anemia
____Hemophilia
____Bleeding tendencies
____Blood transfusions
____Food allergies
____Inhalant (nasal) allergies

The above information is accurate to the best of my knowledge.

______________________________ Patient or Parent / Guardian signature

__________ Date

______________________________ Physician signature

__________ Date