Patient Name: _____
Last First MI

Address: _____
Street City State Zip

Phone: _____
Home Work Cell

Preferred Contact Method: Text or Call **Preferred #** _____

Race: African American Asian Caucasian Other: _____ **Ethnicity:** Hispanic Non-Hispanic

Email: _____

Primary Care Physician: _____ **Pharmacy:** _____

Date of Birth: _____ **Gender:** **M** **F** **Marital Status:** Single Married Divorced Widowed

Social Security _____ **Employer Name** _____

Complete if under 18 years of age or a student

Parent(s)/ Legal Guardian(s) _____ **Phone:** _____

EMERGENCY CONTACT (a person not living within the patient's home)

Name: _____ **Relationship:** _____

Address: _____ **Phone:** _____

INSURANCE INFORMATION

Primary Insurance Company: _____

Subscriber's Name: _____ **Subscriber's DOB:** _____

Secondary Insurance Company: _____

Subscriber's Name: _____ **Subscriber's DOB:** _____

AUTHORIZATION

I do hereby request and authorize my insurance company &/or companies to pay directly to *Conway Ear, Nose & Throat Clinic, Dr. James Douglas Stroud, M.D.* any proceeds payable under the terms of my policy &/or policies. I understand and agree any unpaid balance not covered by my policy &/or policies is my obligation and will be paid by me. I do hereby authorize this health care provider or its agent(s) to discuss the patient's account with the patient's insurance provider(s) or any other party in order to affect payment of any unpaid balance(s). Further, it is agreed that should the health care provider determine that it is necessary to employ an attorney &/or collection agent to recover any unpaid balance owed, I will pay any and all cost expended to affect collections, including attorney's fees &/or collection agent fees.

Signature (or Guardian's Signature) Date

PATIENT NAME: _____ DATE: _____

REASON FOR VISIT: _____

_____

PRIMARY CARE PHYSICIAN: _____ TELEPHONE: _____

PHARMACY & LOCATION: _____ TELEPHONE: _____

CURRENT MEDICATIONS: DRUG ALLERGIES:

_____ _____ _____

_____ _____ _____

_____ _____ _____

PATIENTS: HEIGHT:_____ WEIGHT:_____

TOBACCO USE OR EXPOSURE:
(circle those that apply)

CURRENT EVERYDAY SMOKER
CURRENT SOME DAY SMOKER
FORMER SMOKER
NEVER A SMOKER
EXPOSURE TO SMOKE

Family History (Please fill in circle)

	Mother	Father	Sibling	Children
Diabetes	o	o	o	o
Coronary Artery Disease	o	o	o	o
Stroke (CVA)	o	o	o	o
Hearing Loss	o	o	o	o
Hypertension	o	o	o	o

ALCOHOL USE: YES/NO
If yes; How Often:

_____

PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING:

SURGERY
ADENOIDECTOMY_____
APPENDECTOMY_____
BREAST SURGERY_____
CORONARY BYPASS_____
EAR TUBES_____
HERNIA REPAIR_____
HEMORRHOIDECTOMY_____
NASAL SURGERY_____
SINUS SURGERY_____
TONSILLECTOMY_____
GALLBLADDER_____
Other _____
_____

MEDICAL ILLNESSES
ANEMIA_____
ASTHMA_____
CANCER_____
COPD_____
DIABETES_____
EAR INFECTIONS_____
ELEVATED CHOLESTEROL_____
HEPATITIS_____
HIGH BLOOD PRESSURE_____
KIDNEY DISEASE_____
SINUSITIS_____
STOMACH ULCERS_____
STROKE_____
TONSILLITIS_____

TRAUMA HISTORY: _____

HIPPA AUTHORIZATION

I hereby give my authorization for *Dr. James Douglas Stroud*, Health Care Provider of *Conway Ear, Nose & Throat*. To use or disclose my Protected Health Information to carry out treatment, payment, or any other health care operations.

I understand that my Protected Heath Information is as follows:

Information that is oral or recorded in any form that relates to my past, present or future, physical or mental health condition. My past, present or future health care treatment, or the payment of my past, present or future health care treatment, that is or could reasonably identify me and is transmitted in an electronic form or maintained in any form. This Protected Health Information could include information that *Dr. James Douglas Stroud* created, received from me, received from another Health Care Provider, received from a Health Plan, Health Care Clearing House, Insurance Company, Employer, or any other source, and could include demographic information about me.

I give *Dr. James Douglas Stroud* authorization to use or disclose my Protected Health Information to other health care providers, group health plans, and business associates to provide for my medical care, treatment and evaluation; the payment of my medical care, treatment and evaluation; and to provide information for utilization and quality care purposes.

< > I specifically give *Dr. James Douglas Stroud* authorization to use or disclose my Protected Health Information to the following persons for the following purposes:

I requested this specific authorization expire on the following date: _____

I understand that I have the right to revoke my authorization, however, it shall not be considered revoked to the extent *Dr. James Douglas Stroud* has relied on it. I understand that once this information has been disclosed to third parties, there may not be any safeguards to prevent the third party from further disclosing the Protected Health Information.

This authorization shall remain in effect until I revoke it in writing by contacting *Conway Ear, Nose and Throat's* Privacy Officer at 515 Locust Street, Conway, AR 72034, (501) 327-5250. I understand *Dr. James Douglas Stroud* can condition my treatment or evaluation on my signing this authorization.

I understand that I have the right to request in writing to inspect and copy my Protected Health Information. There are a few exceptions to this rule. *Dr. James Douglas Stroud* must approve or deny my request within 30 days and, in the case of a denial, provide me an explanation of the reason. *Dr. James Douglas Stroud* may charge, in certain situations, a fee of $25 for copying, preparation, and postage, which must be prepaid.

_____ _____

Patient Signature/Guardian's Signature Patient Date of Birth

_____ _____

Printed name of Patient Date

Please fill in circle completely

General/Constitutional

Fever	O Yes O No
Fatigue	O Yes O No
Weight loss	O Yes O No
Weight gain	O Yes O No

ENT

Chronic Allergies	O Yes O No
Chronic Sinusitis	O Yes O No
Nasal Congestion	O Yes O No
Nasal Drainage	O Yes O No
Dizziness	O Yes O No
Ringing in the ears	O Yes O No
Hearing Problems	O Yes O No
Ear pain	O Yes O No
Ear Drainage	O Yes O No
Sore throat/pain	O Yes O No

Respiratory

Hoarseness	O Yes O No
Chronic Cough	O Yes O No
Shortness of breath	O Yes O No
Snoring	O Yes O No
Apnea	O Yes O No

Cardiovascular

Chest pain	O Yes O No
Chest Pressure	O Yes O No
Chest Tightness	O Yes O No
Swelling of Legs	O Yes O No

Gastrointestinal

Heartburn	O Yes O No
Reflux	O Yes O No
Nausea	O Yes O No
Vomiting	O Yes O No
Difficulty swallowing	O Yes O No

Genitourinary

Kidney problems	O Yes O No

Neurologic

Headache	O Yes O No
Convulsions	O Yes O No
Seizures	O Yes O No

Psychiatric

Hx of Drug/Alcohol Abuse	O Yes O No
Difficulty sleeping	O Yes O No

Please fill in circle completely

Name:_____

DOB:_____

AUTHORIZATION AND ACKNOWLEDGEMENT

I hereby authorize the physician of Conway Ear Nose, & Throat Clinic, Dr. James Douglas Stroud and affiliated or other providers to release m information acquired in the course of my treatment to my insurance company employer based health plan, or third-party payer as required of claims filed, quality assurance, health plan administration, complaints/grievances.

I authorize direct payment to be made to Conway ENT Clinic or other providers at the facility for any and all medical and surgical services rendered. I understand that I am responsible for all charges if any services are not covered by insurance or if Conway ENT is unable to verify eligibility. I grant Conway ENT the rights to coordinate benefits with other insurance coverage and to collect against another party for reimbursement of expense, if my illness is reimbursable by that party. I authorize that Conway ENT to leave appointment and payment reminders on telephone answering devices.

Financial Policy

The Clinic participates with many health plans. As a courtesy to our patients, we will file claims with these companies. It is ultimately your responsibility for the full and timely payment on your account.

Please be prepared to submit your current insurance card at each visit. A scanned copy of this card may be kept as a part of your permanent record. You may also be asked for photo identification. Please also provide the clinic with up to date contact information including your home address, telephone number, and emergency contact information.

The clinic will attempt to verify coverage and benefits prior to your visit with the physician. If we are unable to obtain a verification of coverage you may be asked to pay in full or reschedule your visit at a time the verification can be obtained. This verification will be used to estimate your financial responsibility; however, this verification is not a guarantee by your health plan of coverage or payment.

Payment of your estimated patient liability is expected at the time services are render. This payment will include know deductibles, copays, and coinsurance due for this visit. While we may estimate your financial responsibility, it is your insurance company that makes that makes the final determination regarding your eligibility and benefits.

Please be aware that certain office procedures or services may not be covered, or may be considered “not medically necessary”, “experimental”, or “cosmetic” by your health plan. You are responsible for payment of these services. In the even your care exceeds a plan limitation; you will be responsible for the balance. *It is your responsibility to know the benefits and limitations of your current health care coverage.* Conway ENT Clinic will provide medically necessary care based on patients’ medical needs, not a patient’s insurance coverage. Your Physician is not responsible for knowing your plan’s specific benefit and coverage limitations.

Please be aware that additional charges may be incurred if during the course of a physical exam the physician addresses diagnoses or treats a problem-focused health concern.

Appointment Policy

All consultations are provided by appointment only. This time is reserved for your exclusive use.

As a courtesy to me, my office staff and other patients, please call our office 24 hours prior to your appointment time if you need to cancel or reschedule. We have a waiting list of patient who are willing and eager to use your appointment time if you are unable to keep your appointment.

In order to provide you with the very best of service and accommodate all appointment requests, we have a Cancellation Policy.

Cancellation Policy

We will confirm all appointment a day in advanced by calling your contact number given to us. This is done as a courtesy to you. Canceling and reschedule of appointment is your responsibility. If you fail to notify our

office of your intent to cancel within 24 hours of your appointment, you will be charged $50. This fee is not covered by insurance, Medicare or Medicaid. It is an out of pocket expense billed directly to you as the patient.

Future consultation time will be given only if the accrued fees are paid in advance. Emergency situations will be considered with Dr. Stroud's discretion.

Past Due Accounts

If your account becomes past due we will take necessary steps to collect this debt. Referral to a collection agency may adversely impact your credit record. Accounts turned over to collection agencies may also result in you being dismissed for non-payment as a patient from Conway ENT Clinic.

Please contact our billing department at 1-888-298-3132 or 501-327-5250.

Self Pay Discounts

As a courtesy, the clinic offers a discount to uninsured patient's for certain medically necessary services. This discount only applies to balances paid in full at the time of service.

Again thank you for choosing Conway ENT Clinic. We appreciate the opportunity to serve you.

I acknowledge receipt of Conway ENT Clinic Acknowledgement and Financial Policy. I acknowledge that I have received a copy of the Conway Ear, Nose & Throat Notice of Privacy Practices and Cancellation Policy.

_____ _____

Patient Printed Name Patient Date of Birth

_____

Printed name of Parent/Guardian
(if patient is under 18 years of age or disabled)

_____ _____

Signature Date