ASHFORD CLINIC
EAR · NOSE · THROAT

First Name: _____ Middle Initial: _____ Last Name: _____

Date: _____/_____/_____ DOB: _____/_____/_____ Age:_____ Sex: Male / Female SSN: _____–____–_____

Email: _____ Responsible Party (if other than patient): _____

Physical Address: _____ City: _____ State: ____ Zip: _____

Mailing Address: _____ City: _____ State: ____ Zip: _____

Home Phone #: _____ Mobile #: _____ Work #: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Employer: _____ How did you hear about Ashford Clinic? _____

Pharmacy Name: _____ Pharmacy Location: _____

Primary Care Physician: _____ Referring Physician: _____

Authorizations, Medical Records Release, Assignment of Benefits

1. **Treatment Authorization:** I authorize you to give me reasonable and proper medical care by today's standards.
2. **Release of Information:** I authorize release of my records to Ashford Clinic (AC) including HIV, psychiatric, drug/abuse records, venereal disease and any other statutory protected disease, as necessary for continued medical care, to obtain insurance reimbursement, or to comply with utilization review. I authorize this office to obtain previous medical records from other physicians and/or medical facilities.
3. **Medical Lifetime Signature on File:** (if applicable) I request that payment of authorized Medicare Benefits be made to AC for any services furnished by a member of this group. I authorize the holder of medical information about me to release the Health Care Finance Administration and its agents any information needed to determine these benefits or benefits payable for related services.
4. **Assignment of Benefits:** I request that payment of authorize insurance benefits be made on my behalf to AC.
5. **Financial Responsibility:** I understand that AC will file my insurance as a courtesy to me and that I remain responsible for payment of co-pays, coinsurance, deductibles, non-covered services, and any other charges not paid by insurance within 45 days.
6. **Patient Rights:** I have received a letter of patient rights.
7. **Communication:** I authorize the use of email to contact me.
8. **Multimedia use:**

☐ Yes, I consent to allowing AC to use any photographs of videos for multimedia use, knowing all identifiers of my identity will be removed prior to publication

☐ No, I do NOT consent to allowing AC to use any photographs or video for multimedia use despite the removal of all of my identifiers

Signature: _____ Date: _____

ASHFORD CLINIC
EAR · NOSE · THROAT

Patient's name: _____ Date of Birth:_____

I understand that my health information is private and confidential. I understand that Ashford Clinic (AC) works very hard to protect my privacy and preserve the confidentiality of the personal health information.

I understand that AC may use and disclose my personal health information (PHI) to help provide health care to me, to handle billing and payment, and to take care of the other health care operations. In general, there will be no other uses and disclosures of this information unless I authorized it in writing. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual.

AC has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting our patient's privacy. I understand that I have the right to read the "Notice" before signing this agreement. AC may update this "Notice of Privacy Practices" at any time. If I ask, AC will provide me with the most current "Notice of Privacy Practices". Under the terms of this consent, I can ask AC to limit how my personal health information is used or disclosed to carry our treatment, payment or health care options. I understand that AC does not have to agree to my request. If AC does agree to my request, I understand that they would follow the agreed limits.

Our Notice of Privacy Practices states that we may disclose your PHI to others who may assist in your care, such as your spouse, children, parents, or caregiver. **Please list any family members and caregivers with whom we are authorized to discuss your medical care or to whom we may release medical records.**

_____

_____

☐ No, I do not authorize release of information to family/caregivers. If you wish to RESTRICT use/disclosure in other ways, please request a form.

I may cancel this consent in writing at any time by writing, signing, and dating a letter to AC. The letter must say that I want to revoke my consent to authorize the use and disclosure of my personal health information for treatment, payment and health care operations. If I revoke this consent, AC does not have to provide any further health care services to me.

My signature below indicates that I have been given the chance to review a current copy of AC's "Notice of Privacy Practices". My signature means that I agree to allow AC to use and disclose my patient's personal health information to carry out treatment, payment and health care operations.

_____ _____

Patient or legally authorized individual signature Date

_____

Relationship to patient if signed by anyone other than the patient

ASHFORD CLINIC
EAR · NOSE · THROAT

Financial Policy

Thank you for choosing us as your provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate with most insurance plans, including Medicare. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service and will be collected at check-in. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit. There is a form called an ABN form that you will be asked to sign before services are performed. This form states that you understand that some services may not be covered by your insurance carrier.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. Missed appointments. We request that you give 24 hours notice if unable to keep your appointment. If this is not possible please give the maximum notice possible. This will allow us to keep our schedule open for patients to be seen if possible. Please help us to serve you better by keeping your regularly scheduled appointment. Failure to show for your appointment will result in a $50 no-show fee on your account that must be paid before you can be seen again.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I understand and agree to the terms of this payment policy:

Signature: _____ Date: _____

ASHFORD CLINIC
EAR · NOSE · THROAT

What is your primary problem bringing you here today? (please describe your symptoms) _____

_____

_____

How long have you had these issues? _____

Do you use tobacco products? ☐ Never ☐ Quit (quit date:_____) ☐ Yes (if yes, please describe the type, how much, and how often)

_____

How often do you drink alcohol? ☐ Never ☐ Daily ☐ Weekly ☐ Occasionally

Personal use of recreational drugs? ☐ No ☐ Yes

Do you have any allergies? ☐ No ☐ Yes (if yes, please list any allergies to medications, IV contrast or pollens)

_____

Have you ever had a CT scan? If so, when and where? _____

_____

Please list any medical problems: _____

_____

_____

Please list previous surgeries/procedures:

Procedure/Surgery	Date	Procedure/Surgery	Date
1._____		2._____	
3._____		4._____	
5._____		6._____	

List medications you are currently taking: (including prescriptions, over the counter, and herbal)

Medication	Dose	Frequency	Medication	Dose	Frequency
1._____			2._____		
3._____			4._____		
5._____			6._____		
7._____			8._____		
9._____			10._____		

Do you have problems with any of the following? Please circle yes or no.

General:
Weight loss yes no
Weight gain yes no
Fatigue yes no
Night sweats yes no
Fevers/chills yes no
Easy bleeding/bruising yes no
Heat/cold intolerance yes no
Heavy menses yes no
Excessive sweating yes no

Face:
Pain yes no
Numbness yes no
Twitching yes no
Weakness yes no
Lop-sided yes no
Previous Bell's palsy yes no

Eyes:
Recent changes in vision yes no
Blurry/double vision yes no
Wear glasses/contacts yes no
Floaters yes no
Glaucoma yes no
Cataracts yes no
Watery or itchy eyes yes no
Dry eyes yes no
Previous eye surgery yes no
Blindness yes no

Ears:
Ear pain yes no
Ear drainage yes no
Ear pressure yes no
Ear fullness yes no
Ringing/roaring noises yes no
Pulsing noises yes no
Dizzy yes no
Vertigo yes no
Previous ear surgery yes no
Ear infections yes no
Use Q-tips yes no
Too much wax yes no
Ear tubes yes no

Hearing:
Hearing Loss yes no
Recent changes in hearing yes no
Hearing going up and down yes no
Use of hearing aids yes no
Deafness yes no

Nose:
Obstruction yes no
Post-nasal drainage yes no
Nasal congestion/stuffiness yes no
Purulent/foul nasal drainage yes no
Itchy, watery nose yes no
Frequent sneezing yes no
Nasal allergies yes no
Nosebleeds yes no
Difficulty breathing through nose yes no
Nose surgery yes no

Sinuses:
Sinus headaches yes no
Sinus pressure: cheeks yes no
Sinus pressure: forehead yes no
Sinus pressure: eyes yes no
Colds last longer than average yes no
Frequent sinus infections yes no
Chronic sinus infections yes no
Sinus surgery yes no
Tooth pain yes no
Altered smell/taste yes no

Throat:
Sore throat yes no
Dry mouth/throat yes no
Difficulty swallowing yes no
Painful swallowing yes no
Frequent throat/tonsil infections yes no
Something stuck in throat yes no
Hoarseness yes no
Voice wears out quickly yes no
Weak voice yes no
Voice tremor or stutter yes no
Frequent throat clearing yes no
Increased phlegm yes no
Food sticking or going down wrong yes no
Lesion in mouth/throat yes no
Previous tonsil/adenoid surgery yes no

Neck:
Pain yes no
Mass/lump yes no
Goiter yes no
Previous spine surgery yes no
Decreased neck mobility yes no
Thyroid problem yes no
Thyroid nodule yes no

Skin:
Skin cancer yes no
Skin lesion yes no
Dry skin yes no
Rashes yes no
Changes to skin/hair/nails yes no
Eczema yes no

Immunologic:
Abnormal/large lymph nodes yes no
Rheumatoid arthritis yes no
Lupus yes no
Sjogren's yes no
Wegener's yes no
Sarcoidosis yes no
Psoriasis yes no
Previous transplant yes no
HIV/AIDS yes no
Hepatitis B/C yes no

Gastrointestinal:
Stomach pain/cramping yes no
Diarrhea yes no
Constipation yes no
Nausea yes no
Vomiting yes no
Appetite changes yes no
Blood in stool yes no
Heartburn yes no

Neurologic:
Stroke yes no
Headaches yes no
Migraines yes no
Numbness/tingling yes no
Weakness yes no
Walking problems yes no
Frequent falls yes no
Difficulty thinking/memory loss yes no
Passing out yes no
Dizzy or giddy feeling yes no
Light-headed yes no

Heart:
Heart attack yes no
Heart failure yes no
Chest pain yes no
Abnormal rhythm yes no
Palpitations/funny heart beat yes no
Blood thinner use yes no
Pacemaker yes no
Previous heart surgery/CABG yes no
Shortness of breath lying flat yes no
Pain in calves when walking yes no
Fast or slow heart rate yes no
High blood pressure yes no
Swelling in legs yes no

Lungs:
Breathing problems yes no
Asthma yes no
COPD/emphysema yes no
Smoking yes no
Dry cough yes no
Cough with phlegm/sputum yes no
Cough up blood yes no
Wheezing yes no
Shortness of breath at rest yes no
Shortness of breath walking yes no
Noisy breathing yes no
Use of oxygen yes no

Sleep:
Difficulty falling/staying asleep yes no
Problems sleeping yes no
Sleep apnea yes no
Use of CPAP/BiPap yes no
Snoring yes no
Wake up frequently yes no
Stop breathing at night yes no
Choking/gagging during sleep yes no
Sleepy during day/not well rested yes no

Other:
Osteoarthritis yes no
Diabetes yes no
Depression yes no
Anxiety yes no
Bipolar disorder yes no
Fibromyalgia yes no

_____
_____
_____
_____
_____
_____
_____