Rex Ear, Nose & Throat Specialists
790 SE Cary Parkway
Suite 110
Cary, NC 27511

PATIENT NAME: _____ **Today's date:** _____
Nickname: _____ **Gender:** M / F **Date of Birth:** _____

REFERRING PHYSICIAN: _____

WHAT IS THE REASON FOR TODAY'S VISIT? _____
When did this problem start? _____
What makes this problem worse / better? _____
Where is the problem located? _____
What other symptoms are associated with this problem? _____

PAST HISTORY
List current medications (including over-the-counter/vitamins): _____
_____
List medical problems (such as high blood pressure, diabetes, asthma, etc): _____
_____
List past surgeries / hospitalizations: _____
_____
List drug / latex / food allergies: _____
_____

Review of systems: Are you CURRENTLY having any of the following?

Fever	Y	N	Weight changes	Y	N
Skin rash	Y	N	Headache	Y	N
Chest pain	Y	N	Ear drainage	Y	N
Nausea / vomiting	Y	N	Shortness of breath	Y	N
Easy bleeding	Y	N	Cough	Y	N
Eating / swallowing problems	Y	N	Urinary Problems	Y	N

Social History:
Occupation: _____ Marital Status: _____ Children: ___
Past military service? _____
Do you smoke currently? Y N Did you smoke in the past? Y N
Do you drink alcohol? If so, how often / amount? _____

Family History: Has anyone in your family been diagnosed or treated for:

Diabetes	Y	N	Hearing Loss	Y	N
Heart problems	Y	N	Cancer	Y	N
High blood pressure	Y	N	Kidney disease	Y	N
Seizures	Y	N	Tuberculosis (TB)	Y	N
Stroke	Y	N	Asthma	Y	N
Thyroid Problems	Y	N	Allergies (environmental)	Y	N

Prior patient of NCEENT? Y N

Physician signature: _____ Date: _____

REX EAR NOSE AND THROAT SPECIALISTS

PATIENT IDENTIFICATION SECTION

Rex Healthcare will compare your Legal Name to your name as it appears on your insurance card.

Patient's Legal Name (Last, First, Middle) _____

Sex _____ Social Security # _____ Birth Date _____

PATIENT INFORMATION

Race _____Ethnicity _____ Marital Status _____

Mailing Address _____

Physical Address (if different from mailing address) _____

City _____ State _____ Zip Code _____

County _____ Country _____

Home Phone # _____ Cell Phone _____

Primary Spoken Language _____

Church/ Place of Worship _____ Religious Denomination _____

Email Address _____

Mother's Maiden Name (Last and First) _____

Referring Physician _____ Phone _____

Primary Care Physician _____ Phone _____

PATIENT'S EMPLOYMENT INFORMATION

Employment Status _____ Retirement Date (if applicable) _____

Employer's Name _____

Employer's Address _____

City _____ State _____ Zip Code _____

Phone # _____ Extension _____

GUARANTOR INFORMATION (Person Financially Responsible)

Name of Guarantor _____ Relationship to Patient _____

Social Security # _____ Sex _____ Birth Date _____

Mailing Address _____

Physical Address (if different from mailing address) _____

City _____ State _____ Zip Code _____

Home Phone # _____ Employment Status _____

Employer's Name _____ Work Phone # _____

Full Time Student? Y / N

EMERGENCY CONTACT

Name of Emergency Contact _____ Relation to Patient _____

Mailing Address _____

Physical Address (if different from mailing address) _____

City _____ State _____ Zip Code _____

Home Phone # _____ Work Phone # _____

Cell Phone # _____

Patient Signature: _____ Date: _____

REX EAR NOSE AND THROAT SPECIALISTS

Patient's Name _____ Birth Date _____

PRIMARY INSURANCE

Insurance Plan Name as it Appears on Insurance Card _____

Patient's Relation to Policyholder _____

Policyholder's Birth Date _____ Policyholder's Sex _____

Policyholder's Policy Number _____ Patient's Policy Number _____

Group Name (Employer Name) _____ Group Number _____

Customer Service Phone # _____

Claims Address _____

City _____ State _____ Zip Code _____

SECONDARY INSURANCE

Insurance Plan Name as it Appears on Insurance Card _____

Patient's Relation to Policyholder _____

Policyholder's Birth Date _____ Policyholder's Sex _____

Policyholder's Policy Number _____ Patient's Policy Number _____

Group Name (Employer Name) _____ Group Number _____

Customer Service Phone # _____

Claims Address _____

City _____ State _____ Zip Code _____

MEDICAL INFORMATION

Are you enrolled in a Hospice Program? _____

If yes, is this service related to your hospice diagnosis? _____

If yes, which Hospice agency are you enrolled with? _____

ACCIDENT INFORMATION (Complete this section ONLY if your condition is accident related)

Type of Accident (Auto, Work, Other) _____

Accident Date and Time _____ State of Accident _____

Place of Accident and County _____

Description of Accident _____

_____

Patient/Authorized Representative Signature _____

Date Signed _____

Health Insurance Portability and Accountability Act

Confidentiality Policy

POLICY

Rex Ear, Nose & Throat Specialists are entrusted by patients and required by law to ensure the security of individually identifiable health information. This protected health information is preserved by law and regulatory requirements and these laws and regulatory requirements are to be upheld by each individual involved with this organization.

- We are subject to the compliance of the law as we are a health care provider and we maintain and transmit health information in electronic form in connection with transactions referred to as claims, encounters, eligibility, referrals, payments, electronic remittance, coordination of benefits, claim status, first report of injury, health claim attachments and any other transactions as the Secretary may prescribe by regulation.

- We are permitted to use and disclose protected health information for the purpose of treatment, payment and health care operations.

- We shall make all reasonable efforts not to use or disclose more than the minimum amount of protected health information necessary to accomplish the intended purpose of the use or disclosure.

- When making disclosures to public officials, we will reasonably rely on the representations of such officials that the information requested is the minimum necessary for the stated purpose(s).

- We may use or disclose any de-identified protected health care information provided that the key or other devices designed to enable coded or otherwise de-identified information is not used or provided.

- We recognize all individually identifiable health information identifiers as created, received and used within our electronic computer systems and will make every reasonable effort to ensure they are secure in our environment. These identifiers are listed as:

  Name, address (street, city, county, zip code, geocode), names of relatives, names of employers, birth date, telephone numbers, fax numbers, social security number, medical record number, account number, health plan beneficiary number, certificate or license number, E-mail address, IP address, vehicle or other device serial number, Web URL, finger or voice prints, photographic images, and any others added by the Secretary in future regulations

- The death of a patient does not terminate his rights to protection of health information. We shall apply all reasonable efforts to protect the individually identifiable health information of a deceased individual in the same manner we protect the living. This policy shall be in effect for <u>two</u> years following the death of the individual.

- I give my physician permission to communicate health information via my answering machine or voicemail.

Signature: _____ Date: _____

By signing above, I acknowledge receipt of the privacy policy as outlined by the Health Insurance Portability and Accountability Act. A general notice of privacy practices is available on request.

Patient Label Here

GENERAL CONSENT FOR TREATMENT (Page 1 of 4)
HIM #129s

I understand that the University of North Carolina Health Care System (UNC Health Care) is an integrated health system made up of various entities, including (but not necessarily limited to) UNC Hospitals; Rex Hospital, Inc.; High Point Regional Health; Regional Physicians, LLC; Premier Surgery Center, LLC; Caldwell Memorial Hospital, Incorporated; Chatham Hospital, Inc.; Henderson County Hospital Corporation d/b/a Margaret R. Pardee Memorial Hospital; the University of North Carolina at Chapel Hill, School of Medicine; Johnston Health Services Corporation; Nash Hospitals, Inc.; Nash MSO, Inc.; NHCS Physicians, Inc.; UNC Physicians Network, LLC; and UNC Physicians Network Group Practices, LLC (each referred to in this form as a "UNC Health Care affiliate" or collectively as "UNC Health Care affiliates"). **This consent will be effective for 1 year after the date it is signed at any UNC Health Care affiliate of which I am a patient; however, this consent will not expire for services, claims processing or collection activities for admissions or visits occurring while this consent was in effect.**

Consent for Treatment/Care
I consent to treatment and care by UNC Health Care affiliates and by their physicians and health care providers, including those who are located at sites other than the one at which I am present and who provide treatment and care through electronic communications/telemedicine. I also consent to treatment and care by physicians and health care providers who are not employees or agents of UNC Health Care affiliates but are authorized by UNC Health Care affiliates to provide treatment and care to me as a patient of the UNC Health Care affiliate. I am aware that the providers listed on Exhibit A to this consent are independent contractors of UNC Health Care affiliates, as listed, and they provide services to the UNC Health Care affiliate's patients in accordance with their professional judgment. The providers listed on Exhibit A are not employees or agents of the UNC Health Care affiliate. I understand that my treatment and care may include routine care, such as immunizations, and a variety of other medical services depending on my condition, such as laboratory testing. I can receive a list of services and care from my health care provider. I understand that my care team at UNC Health Care affiliates may include resident physicians and students or other trainees. I am aware that the practice of medicine (including surgery) is not an exact science, and no one has made any guarantees about the results of my treatments, examinations, or procedures.

Consent for Use and Release of Information
I give permission to UNC Health Care affiliates – including their treating and referring providers and other staff members – to release any information about me, my health, the health services provided to me, or payment for my health services, that may be necessary: (1) for my treatment (to health care providers or facilities that need the information for my continued care); (2) for any purposes related to payment by me or a third party for services (to determine eligibility, to process an insurance claim, for utilization and quality review, or for billing or collection purposes, as necessary to obtain payment); (3) for the health care operations of the UNC Health Care affiliate or another health care provider that has had a relationship with me (quality assessment, training programs, planning, and fundraising); or (4) as otherwise described in the Notice of Privacy Practices and as permitted by law.

For more detailed information about the way my information may be used or released, I can read the UNC Health Care's *Notice of Privacy Practices.*
I give permission to UNC Health Care affiliates and their employees, agents, and contractors to take photographs or make videos or drawings of me for permissible treatment, payment, or health care operations purposes (which may include quality assessment, education, and training), as long as consistent with policies and laws that protect my rights.

Consent for Use Within UNC Health Care

I further give permission to UNC Health Care affiliates and their treating providers and other staff members to disclose to each other any of my sensitive information necessary for my treatment, including information related to behavioral and/or mental health (including records of my treatment by a facility whose primary purpose is to provide services for the care, treatment, habilitation, or rehabilitation of the mentally ill, developmentally disabled, or substance abusers, as defined by N.C.G.S. Chapter 122C, Articles 1 and 3), drugs and alcohol (including records of a provider that provides alcohol or drug abuse diagnosis, treatment, or referral, as defined by federal law at 42 C.F.R. Part 2), HIV/AIDS and other communicable diseases, and genetic testing.

I further authorize release of financial information and activity related to payment for services to:
Name of Individual: _____
Relationship to Patient: _____

Financial Responsibility

I understand and agree that physician charges for medical and related professional services performed or supervised by a physician will be billed separately from hospital charges. I understand that my actual charges may be different from charge estimates given to me. I also understand that an insurance company may not pay the full amount of my charges, and I may be responsible (as a patient, spouse, or the parent of a minor child) for the amount not paid. If I do not have health insurance or have not provided current or accurate insurance information, I am responsible for payment of all charges. If I have overpaid any of my accounts with a particular UNC Health Care affiliate, I agree that the overpayment may be applied to pay any outstanding charges on any of my accounts with other UNC Health Care affiliates.

Medicare/Medicaid/Insurance Certification, Assignment & Payment Request

I have been informed that Medicare will only pay for services that it determines to be reasonable and necessary under section 1862(a)(1) of the Medicare Law. I certify that the information given by me or by my authorized representative in applying for payment for my health care under the Medicare or Medicaid programs is correct. I request that payment of authorized benefits be made to the appropriate UNC Health Care affiliate on my behalf. I authorize UNC Health Care affiliates to bill directly and assign the right to all health and liability insurance benefits otherwise payable to me, and I authorize direct payment to the appropriate UNC Health Care affiliate.

Social Security Number

I have given my social security number voluntarily. UNC Health Care affiliates may use it for accurate identification, filing insurance claims, billing and collections, and compliance with federal and state laws.

Wireless Telephone Number

UNC Health Care affiliates, or their agents or representatives, may contact me by telephone at any number contained in my UNC Health Care affiliate's records, including wireless telephone numbers, for the purpose of servicing my account and collecting amounts due. Methods of contact may include pre-recorded or artificial voice messages and the use of automatic dialing services.

Personal Property

I understand that UNC Health Care affiliates do not assume responsibility for my personal belongings that I keep in my possession, and I release UNC Health Care affiliates from all liability for the loss or theft of, or damage to, such belongings.

Patient List

As a convenience to patients and visitors, UNC Health Care affiliates may keep a list of patients currently receiving services at its facility so that we may provide the location of the patient in the facility and the patient's general condition to people who ask for patients by name. Unless I have initialed below, I give permission for UNC Health Care affiliates to give my location and general condition to individuals who ask for me by name.

_____ *(initial)* I do not want to be included in UNC Health Care affiliates' patient lists. Please remove my name.

Religious Information

UNC Health Care affiliates may provide a patient list for community clergy when they request it. This list includes the name and location of the patient, the patient's general condition, and the patient's religious affiliation. Unless I have initialed below, I give permission for UNC Health Care affiliates to give my name, location, general condition, and religious affiliation to community clergy who request it.

_____ *(initial)* I do not want to be included in UNC Health Care affiliates' list provided for clergy. Please remove my name. I understand that those employed by a UNC Health Care affiliate as chaplains may still obtain this information.

Sharing Information with Family and/or Friends

As a courtesy, limited health information may be shared with family, friends and authorized representatives under the following conditions: (1) the information is related to that individual's involvement in the patient's care or payment for care, or (2) the information is needed to notify individuals responsible for the patient's care about the patient's location, general condition or death. Unless I have initialed below, I give permission for limited health information to be shared with my family, friends and authorized representatives under the conditions mentioned above.

_____ *(initial)* I do not want personal health information shared with family, friends, and/or representatives.

I UNDERSTAND THAT I MAY WITHDRAW THIS CONSENT IN WRITING. MY WITHDRAWAL WILL NOT BE EFFECTIVE FOR ACTIONS ALREADY TAKEN BY ANY UNC HEALTH CARE AFFILIATE, OR IN PROGRESS.

I AUTHORIZE UNC HEALTH CARE AFFILIATES TO RELEASE ALL RECORDS REQUIRED TO ACT ON THESE REQUESTS. I HAVE READ AND UNDERSTAND THIS FORM, RECEIVED A COPY, AND I AM THE PATIENT OR I AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS FORM.

_____ DATE: _____ TIME: _____

PATIENT SIGNATURE (or Authorized Representative)

_____

PRINTED NAME

RELATIONSHIP, if not patient: _____

GUARANTOR: If I sign below as guarantor (not as the patient, or spouse of the patient, or the parent of a minor child), I agree to pay all charges of any UNC Health Care affiliate not paid, **even if I am otherwise not legally obligated to pay**.

_____ DATE: _____ TIME: _____

GUARANTOR OF PAYMENT SIGNATURE

_____

PRINTED NAME

EXHIBIT A

Independent Contractors at UNC Health Care Affiliates

UNC Hospitals ("UNCH")

I am aware that physicians, nurse practitioners and physician assistants who provide services to UNCH patients may be independent contractors who provide services to UNC Hospitals patients in accordance with their professional judgment. These practitioners are not employees or agents of UNC Hospitals.

Rex Hospital, Inc. ("Rex")

I am aware that the emergency room physicians, anesthesiologists, CRNAs, neonatologists, pathologists, psychiatrists, radiologists, and radiation oncologists, and their nurse practitioners and physician assistants, are independent contractors who provide services to Rex patients in accordance with their professional judgment. These practitioners are not employees or agents of Rex.

High Point Regional Health ("High Point Regional")

I am aware that the emergency room physicians, anesthesiologists, CRNAs, pathologists, radiologists, hospitalists and radiation oncologists, and their nurse practitioners and physician assistants, are independent contractors who provide services to High Point Regional patients in accordance with their professional judgment. These practitioners are not employees or agents of High Point Regional.

Caldwell Memorial Hospital, Incorporated ("Caldwell")

I am aware that some providers, including but not limited to emergency room physicians, anesthesiologists, pathologist, radiologists, and medical and radiation oncologists, and their nurse practitioners and physician assistants, are independent contractors who provide services to Caldwell patients in accordance with their professional judgment. These practitioners are not employees or agents of Caldwell.

Chatham Hospital, Inc. ("Chatham")

I am aware that the emergency room physicians, anesthesiologists, CRNAs, hospitalists, pathologists, and radiologists, and their nurse practitioners and physician assistants, are independent contractors who provide services to Chatham patients in accordance with their professional judgment. These practitioners are not employees or agents of Chatham.

Henderson County Hospital Corporation d/b/a Margaret R. Pardee Memorial Hospital ("Pardee")

I am aware that the emergency department physicians, radiologists, anesthesiologist group, radiation oncologists, and pathologists, and their nurse practitioners and physician assistants, are independent contractors who provide services to Pardee patients in accordance with their professional judgment. These practitioners are not employees or agents of Pardee.

Johnston Health Services Corporation ("Johnston")

I am aware that most physicians providing care at Johnston, and their nurse practitioners and physician assistants, are independent contractors who provide services to Johnston in accordance with their professional judgment. These practitioners are not employees or agents of Johnston.

Nash Hospitals, Inc. ("Nash")

I am aware that the physicians, including but not limited to emergency room physicians, anesthesiologists, CRNAs, pathologists, radiologists, medical and radiation oncologists, and their nurse practitioners and physician assistants, are independent contractors who provide services to Nash patients in accordance with their professional judgment; and I understand that these practitioners are not employees or agents of Nash, and that Nash is not liable for their actions.

Premier Surgery Center, LLC ("Premier")

I am aware that the providers at Premier are independent contractors who provide services to Premier patients in accordance with their professional judgment; and I understand that these practitioners are not employees or agents of Premier, and that Premier is not liable for their actions.

REX EAR NOSE AND THROAT SPECIALSISTS

Patient's Name _____ Birth Date _____

I plan to make payment of my medical expenses as follows:

____ Cash/Check

____ Master Card/Visa

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT:

I authorize treatment of the person named above and agree to pay all charges for such treatment. I agree to pay all charges for me and all dependents shown by statements, promptly upon presentation thereof, unless credit arrangements are agreed upon in writing. It is agreed that payment will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof. (A copy of this assignment is as valid as the original.)

Signature _____ Date _____

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize the physician to release any information acquired in the course of my examination or treatment to specific insurance carriers, third party payers or others involved in processing and collection of this claim.

Signature _____ Date _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES:

I hereby acknowledge that I have received a copy of _____ Notice of Privacy Practices. This notice describes how information about me may be used or disclosed, in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

Signature _____ Date _____

REQUEST # _____ FIN # _____

Rex Healthcare
4420 Lake Boone Trail
Health Information Management
Raleigh, North Carolina 27607
919-784-3158; Fax 919-784-3343

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize:		Rex Healthcare	OR		Other facility:

To use or disclose to:

Name of Person or Facility:		
Address, City, State, Zip:		
Phone:	Fax:	Email:

The protected health information of:

Patient Name:	Date of Birth:	Mother's Maiden Name:
Address:	City, State, Zip	
Phone:	Medical Record #	

Dates of Service: _____
Be as specific as possible

Information to be disclosed (please check (√) information requested)**:**

	Facesheet		Pathology Reports		MAR
	Discharge Summary		Progress Notes		Laboratory reports
	History and Physical		Physician Orders		Urgent Care Center Notes
	Consultations		Emergency Dept.		All Medical Records
	Operative / Procedure notes		Nursing Notes		Patient Billing records
	Pictures		Radiology Reports		Radiology - Film / CD
Other (describe)					

I understand that the information released may include sensitive information related to behavior and/or mental health, drugs and alcohol (including records of a program that provides alcohol or drug abuse diagnosis, treatment, or referral, as defined by federal law at 42 C.F.R. Part 2), HIV/AIDS and other communicable diseases, and genetic testing. This authorization does not include permission to release psychotherapy notes (defined as records from private, joint, group, or family counseling sessions that are separated from the rest of the patient's medical record). Release of psychotherapy notes requires a separate authorization.

The purpose of the use or disclosure is (please check (√) appropriate box)**:**

	Attorney/Legal		Continued Patient Care		Social Services / Disability
	Personal Use		Insurance		Other:

* R E Q 1 2 3 4 5 *

Rex Ear, Nose & Throat Specialists

	Worker's Compensation		Personal

I understand that:

- I may revoke this authorization at any time
- The revocation will not apply to information that has already been released in response to this Authorization.
- The revocation will not apply to my insurance company and that the law provides my insurer with the right to contest a claim under my policy.

I understand that:

- If I revoke this Authorization, I must do so in writing.
- The procedure for revoking this Authorization is to present my written revocation to the Health Information Management Department at Rex Hospital.

I also understand that:

- I may refuse to sign this Authorization.
- Rex ENT Specialists LLC will **not** condition the patient's treatment (or any payment, enrollment in a health plan, or eligibility for benefits) upon receiving my signature on this Authorization.

I have been informed and understand that information disclosed pursuant to this Authorization may be subject to redisclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information will no longer be protected under federal medical privacy law.

I understand a fee may be charged for copying the protected health information.

Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire automatically ninety (90) days from the date of signature.

_____ **OR** _____ _____

Signature of Patient | Authorized Representative | Date

_____ _____

Witness | Date

Please explain the Representative's authority to act on behalf of the patient:

_____

Office use only

Date Completed: _____ Completed By: _____

Total Pages: _____ Sent Via: Mail Courier Certified Mail Fax Picked-Up

Fax Number: _____ ❑ Fax Verified ❑ I.D. Checked: _____