Tampa Bay ENT

Adult and Pediatric Ear, Nose and Throat • Facial Plastic Surgery

"A Division of Select Physicians Alliance"

NASAL SINUS SURGERY
HEAD AND NECK SURGERY
FACIAL PLASTIC SURGERY
PEDIATRIC ENT
HEARING AIDS & BALANCE CENTER
DIZZINESS EVALUATIONS
SPEECH & SWALLOWING CENTER
ALLERGY EVALUATION & TREATMENT

DENNIS S. AGLIANO, M.D., F.A.C.S.
RENE A. BOOTHBY, M.D.
MIGUEL A. RIVERA, M.D.
SCOTT A. POWELL, M.D., M.B.A.
JEREMY B. ROGERS, M.D.
KRISTEN H. DECELLES, Au.D.
SOPHIA H. ESCOBAR, Au.D. CCC-A
LOURDES G. LUACES, M.S., CCC.

Tampa Bay ENT is a full-service ear, nose and throat practice, caring for both children and adults. Our professional staff has the expertise and experience to provide the skilled, compassionate care you should expect from a physician.

Complete this patient information packet prior to your arrival. Call with any questions you have. To better serve you on the day of your visit, you can fax to (813) 876-6504 or email back the forms at least 2 days prior to your appointment.

IMPORTANT PRE-APPOINTMENT CHECKLIST:

☐ Plan to arrive 20 minutes prior to your appointment time to finalize paperwork.
☐ Complete the name, phone number, and address of your preferred pharmacy (on form).
☐ Bring Healthcare Insurance ID Cards and Picture ID.
☐ Bring authorizations or referrals as required by your insurance carrier.
☐ Complete and sign the Patient Information, Notice of Privacy Practices, Medical History/Medication List, Policies and Guidelines, and Prescription Consent Form.
☐ Have your referring physician office fax pertinent medical records, diagnostics and lab testing, and MRI/CAT scan reports at least 2 days in advance of your appointment. If you have your reports, fax or bring them in with you.
☐ Bring a CD or Film of your most recent MRI and/or CT scan (if applicable).

5105 N. ARMENIA AVENUE
TAMPA, FLORIDA 33603
(813) 879-8045 FAX (813) 876-6504

4002 STATE ROAD 674, Unit 101
SUN CITY CENTER, FLORIDA 33573
(813) 649-4584 FAX (813) 685-2477

1139 NIKKI VIEW DR.
BRANDON, FLORIDA 33511
(813) 685-7761 FAX (813) 685-2477

Tampa Bay ENT- A Division of Select Physicians Alliance

Patient Information

Name	Last		First	MI	Suffix
Sex		Date of Birth	Age		
Address Line 1		Street			
Address Line 2	City		State	ZIP	
Social Security		Email			
Cell phone		Work phone		Home phone	
Language		Marital Status			
Guardian	Last	First		MI	Suffix
Emergency Contact		Emergency Relation			
Employer Name		Employer Phone			
Occupation					
Language		Race		Ethnicity	
I grant permission to Email Medical Information. Permission never expires unless revoked in writing.				YES	NO

Guarantor Information (Responsible Party)

Patient's Relationship to Guarantor				
Guarantor	Last	First	MI	Suffix
Date of Birth		Social Security		
Address Line 1	Street			
Address Line 2	City	State	ZIP	
Phone		Email		
Employer Name				

Insurance Information

Primary Insurance Plan Name			
Address Line 1	Street		
Address Line 2	City	State	ZIP
Phone			
Policy Holder Name			
ID/Certification #			
Policy/ Group #			
Issue Date		Expiration Date	
Secondary Insurance Plan Name			
Address Line 1	Street		
Address Line 2	City	State	ZIP
Phone			
Policy Holder Name			
ID/Certification #			
Policy/ Group #			
Issue Date		Expiration Date	

Patient Name: ______________________________

Primary Care and Specialty Physician Information

Primary Care Physician Name:			
City	State	Office phone	Office Fax
Referring Physician Name & Specialty:			
City	State	Office phone	Office Fax
Main pharmacy:			
City	State	Phone	Fax

I give permission to send medical information to physicians via email, fax, or regular mail. Yes☐ No ☐

How did you hear about us? (Circle one) Family Referring Physician Internet Newspaper Friend

Patient's preferred contact method: Home phone Cell phone Work phone Email

Assignment of Insurance Benefits

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and'/or dependents, and that I will be bound by this signature as though the undersigned has personally signed the particular claim. This authorization does not expire until revoked in writing by undersigned. I further authorize my insurance company to pay and hereby assign directly to Tampa Bay ENT all benefits, if any, otherwise payable to me for services as described on the attached forms. I understand that I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Tampa Bay ENT, will be credited to my account in accordance with the above said assignment.

Financial Agreement

In consideration of the services rendered to the patient, the undersigned agrees to accept full financial responsibility for the patient's account in accordance with the regular rates and terms of the facility. Should the account be referred for collection procedures, the undersigned shall pay responsible attorney's fees and collection expenses. At present, that fee is a minimum of 30% of charges collected and is payable before the patient is seen in the offices of Tampa Bay ENT at next visit.

Permission for Treatment

Permission is hereby granted for physicians, audiologists, employees, or agents of Tampa Bay ENT to render such medical treatment as is deemed necessary.

Authorization for Release of Confidential Information to Designee

I grant permission for the following individual(s) to receive or to pick up copies of my medical records:

Designated Person Name/Date	
Designated Person Name/Date	

Privacy Notice

The undersigned recognizes that he/she has been given the Tampa Bay ENT Notice of Privacy Policy.

Print patient Name/Date	
Signature and Date (Patient or Legal Guardian)	

Tampa Bay ENT

A Division of Select Physicians Alliance

Patient Name:	DOB:	Height:	Weight:
Drug Allergies:	Other Allergies:		
Reason For Appointment:			

SURGICAL /HOSPITALIZATION HISTORY

☐ See Attached List

Operation(s)	Year	Hospitalization(s)	Year

MEDICATION LIST

☐ See Attached List

Please list **ALL** medications (include over the counter drugs) you are taking now, include dosage & frequency

Medication	Dosage	Frequency	Medication	Dosage	Frequency

Alcohol Consumption:	☐Never ☐Rare ☐Occasionally ☐Socially **How Many Per Day?**	
Smoking History	☐Never ☐Former ☐Current **Smoking Type:** ☐Cigarettes ☐Cigar ☐Pipe ☐Chew	
How many packs a day:	When did you quit:	How many years did you smoke:

MEDICAL HISTORY Please indicate if you have/had a history of the following:

☐ Thyroid Disease
☐ Headaches
☐ Asthma
☐ Lung Disease
☐ Emphysema /COPD
☐ Rheumatic Heart Disease
☐ High Blood Pressure
☐ High Cholesterol
☐ Heart Disease
☐ Kidney Disease
☐ Diabetes
☐ Cancer
☐ Tuberculosis
☐ HIV
☐ Mental Illness
☐ Depression
☐ Stroke/CVA/TIA
☐ Arthritis
☐ Malignant Hyperthermia
☐ Blood/Bleeding Disorder
☐ Gastrointestinal/Stomach Problems
☐ Hepatitis/Liver Disease
☐ Could you be pregnant?
☐ Other: ____________________

REVIEW OF SYSTEMS Please indicate if you are currently having problems with any of the following:

☐ Fever
☐ Recent Weight Gain
☐ Recent Weight Loss
☐ Night Sweats/Chills
☐ Fatigue
☐ Skin Cancer
☐ Healing Problems
☐ Rash
☐ Discoloration
☐ Glaucoma
☐ Visual Disturbance
☐ Dry Eyes
☐ Double Vision
☐ Nosebleeds
☐ Hoarseness
☐ Ringing in Ears
☐ Allergies
☐ Runny Nose
☐ Sneezing
☐ Snoring
☐ Throat Pain
☐ Ear Drainage
☐ Hearing Loss
☐ Chest pain
☐ Irregular Heart Rhythm
☐ Murmur
☐ Leg Swelling
☐ Sleep Problems
☐ Temperature Intolerance
☐ Excessive Thirst
☐ Loss of Appetite
☐ Nausea or Vomiting
☐ Heartburn
☐ Change in Bowels
☐ Difficulty Swallowing
☐ Easy Bruising
☐ Bleeding Disorder
☐ Anemia
☐ Blood Clots in Legs
☐ Asthma
☐ Shortness of Breath
☐ Cough
☐ Spitting up Blood
☐ Headaches
☐ Stroke
☐ Paralysis/Weakness
☐ Tingling/Numbness
☐ Seizures
☐ Dizziness
☐ Memory Loss

I certify that I have disclosed all of my medical history known to me. I acknowledge that I am responsible to make your office aware of any changes to my medical health.

Patient Signature: ______________________________ Date: ______________

Tampa Bay ENT

Adult and Pediatric Ear, Nose and Throat • Facial Plastic Surgery

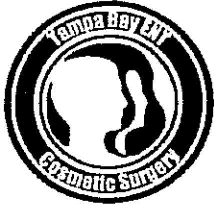
Patient name: ______________________________ Date: ____________

Thank you for choosing our doctors for your ENT care. While it is our desire to provide you with the best care possible, there are some limitations and restrictions that your managed care or insurance plan may impose which we cannot control. Because of this, there are certain policies and guidelines that we want you to be aware of and agree when dealing with our office as outlined below.

1. **Cancellation Policy:** We require that you give our office at least 24-hour notice if you need to cancel or reschedule an appointment. For office visits you will be subject to a **$35.00** charge, and for all in office procedures, such as, Videonystagmography (VNG), allergy testing, and speech evaluations you will be subject to a **$100.00** charge. All surgery cancellations also require at least 72 hours notice or you will be subject to a **$100.00** charge.
2. Obtain authorization (if necessary) prior to your visit to avoid delays or rescheduling.
3. We expect that any lab test, x-rays, surgery, or other diagnostic exams that we order will be done in within 7-10 days. We are not party to or agree with your insurer or managed care plan if they deny authorization or coverage. If your plan denies authorization for our recommendations we ask that you initiate an appeal with them immediately and notify us in writing. If they require a letter from us, we will provide it.
4. Make a follow-up appointment within one week after you have done any diagnostic test (i.e. lab, x-ray, CT scans, biopsies, etc.) to discuss the results and recommendations. Do not wait for us to call you.
5. You are responsible to contact the physician or his staff for an appointment if your condition does not improve within two weeks.
6. Your condition may require further procedures and examinations as part of the workup for your medical problem, however, most insurance carriers require prior approval. You will be financially responsible for all fees that your healthcare insurance deems as a non-covered service or not medically necessary.
7. Self-pay patients initial payment is for consultation only. You will be responsible for in-office procedures. The patient, child's parent, or responsible person will be made aware of any additional out-of-pocket expenses prior to the provider performing the procedure.
8. Managed care with its multiplicity of rules that govern the practice of medicine make it difficult for even us to be sure that they are being followed. It is not our intention to bill contrary to your plan. If you discover any errors in billing (surgical, laboratory, x-ray, or even ours) please inform us so that we can correct or help you to correct them.
9. There will be a charge for any and all medical leave papers (FMLA) filled out by this office. As a courtesy, a one page diagnostic report will be furnished upon request.
10. You can expect to be treated with respect and professionalism at all times. If you have a problem with any of our staff, please notify the doctor or the office manager.

____
Signature of patient, parent or guarantor

____
Name of parent or guarantor's (If applicable)



Tampa Bay ENT

Adult and Pediatric Ear, Nose and Throat • Facial Plastic Surgery

"A Division of Select Physicians Alliance"

Confidential Prescription Information – Authorization of Release

Patient Name: Patient Date of Birth:

Parent or legal representative (if applicable):

I hereby authorize all pharmacies and insurers as may have access to my medication history for the past two years as may exist in a privacy respecting database to release information to Tampa Bay ENT. Optimizing our ability to care for you and lowering your risk of adverse reaction to medications and other treatment is the goal of obtaining your medication information. This consent grants permission to health care providers, pharmacists and the active staff of the above named prescription data management services to release a list of all medications for which these entities have medication records which may be of a personal and private nature. Note that these databases may be incomplete if your pharmacy does not participate in database sharing. Neither will this list include over-the-counter medications and supplements/vitamins which you use. This list will not contain information on how well you utilized the prescriptions or why you may have stopped the prescription. To the degree you have supplied allergy information, this database should provide an allergy list but if you have developed an allergy which you have not told a participating pharmacy service about, it will not be listed. Thus, we still need you to bring us a list of all medications and supplements which you use and a complete list of your allergies, including the type of allergic reaction you experienced to the degree that you can give that information to us. Please sign below indication that all prescription information is to be released.

The patient or legal representative may revoke this consent at any time by written notice to the Tampa Bay ENT. Returning a copy of this notice with a signature on the next line is sufficient: authorization revoked: ____________________ Date: __________ . Revoking this release-of-information consent will not have any effect on any information already used or disclosed before the written notice is received. This authorization form expires on Date: __________ or when the above specified information has been transmitted/received, or not later than a year from the date of signature. The patient or legal representative may inspect and/or request a copy of all medical records but a copying charge may be assessed. The patient or legal representative may refuse to sign or to allow the above specified information to be released or transmitted with recognition that lack of information can affect diagnosis and treatment. The physician will not refuse to care for a patient without this information unless it is viewed by the physician to be critical information in which case the physician may suggest an alternative provider.

Patient signature & date: ______________________________

Guardian signature & date: ____________________________

Witness signature & date: _____________________________

5105 N. ARMENIA AVENUE
TAMPA, FLORIDA 33603
(813) 879-8045 FAX (813) 876-6504

4002 STATE ROAD 674, Unit 101
SUN CITY CENTER, FLORIDA 33573
(813) 649-4584 FAX (813) 685-2477

1139 NIKKI VIEW DR.
BRANDON, FLORIDA 33511
(813) 685-7761 FAX (813) 685-2477

Tampa Bay ENT

Adult and Pediatric Ear, Nose and Throat • Facial Plastic Surgery

NOTICE OF PRIVACY PRACTICES (NPP)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED ALSO HOW YOU MAY GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

Select Physicians Alliance is dedicated to protecting your medical information. We are required by law to maintain the privacy of protected health information and to provide you with this Notice of our duties and privacy practices with respect to protected health information. We are required by law to abide by the terms of this Notice.

HOW YOUR MEDICAL INFORMATION WILL BE USED AND DISCLOSED:
We will use your medical information as part of rendering patient care. For example, your medical information may be used by the doctor or nurse treating you, by the business office to process your payment for the services rendered and by administrative personnel reviewing the quality of the care you receive.

We may also use and/or disclosed your information in accordance with federal and state laws for the following purposes:

Appointment Reminders: We may contact you to provide appointment reminders.

Treatment Information: We may contact you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Disclosure to Department of Health and Human Services: We may disclose information when required by the United States Department of Health and Human Services as apart of an investigation or determination of our compliance with relevant laws.

Family and Friends: Unless you object, we may disclose your medical information to family members, other relatives or close friends when the medical information is directly relevant to that person's involvement with your care.

NOTICE OF PRIVACY PRACTICES

Notification: Unless you object, we may use or disclose your medical information to notify a family member, a personal representative or another person responsible for your care of location, general condition or death.

Disaster Relief: We may disclose your medical information to a public or private entity, such as the American Red Cross, for the purpose of coordinating with that entity to assist in disaster relief efforts.

Health Oversight Activities: We may use or disclose your medical information for public health activities, including the reporting of disease, injury, vital events and the conduct of public health surveillance, investigation and/or intervention. We may disclose your medical information to a health oversight agency for oversight activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions, administrative and/or legal proceedings.

Abuse or Neglect: We may disclose your medical information when it concerns abuse, neglect or violence to you in accordance with federal and state law.

Legal Proceedings: We may disclose your medical information in the course of certain judicial or administrative proceedings.

Law Enforcement: We may disclose your medical information for law enforcement purposes or other specialized government functions.

Coroners, Medical Examiners and Funeral Directors: We may disclose your medical information to a coroner, medical examiner or a funeral director.

Organ Donation: If you are an organ donor, we may disclose your medical information to an organ donation and procurement organization.

Research: We may use or disclose your medical information for certain research purposes if an Institutional Review Board or privacy board has altered or waived individual authorization, the review is preparatory to research or the research is on only decedent's information.

Public Safety: We may use or disclose your medical information to prevent or lessen a serious threat to the health or safety of another person or to the public.

NOTICE OF PRIVACY PRACTICES

Business Associates: We may disclose your medical information to a business associate with whom we contract to provide services on our behalf. To protect your health information, we require our business associates to appropriately safeguard the health information of our patients.

AUTHORIZATIONS: We will not use or disclose your medical information for any other purpose without your written authorization. Once given, you may revoke your authorization in writing at ant time. To request a Revocation of Authorization, you may contact: Tampa Bay ENT, 5105 N. Armenia Ave., Tampa, FL 33603

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION:

You have the following rights with respect to your medical information:

- You may ask us to restrict certain uses and disclosures of your medical information. We are not required to agree with your request, but if we do, we will honor it.
- You have the right to receive communications from us in a confidential manner. Generally, you may inspect and obtain a copy of your medical information. This right is subject to certain specific exceptions, and you may be charged a reasonable fee for any copies of your records.
- You may ask us to amend your medical information. We may deny your request for certain specific reasons. If we deny your request, we will provide you with a written explanation for the denial and information regarding further rights you may have.
- You have the right to receive an accounting of the disclosures of your medical information made by Select Physicians Alliance during the last six years.
- Except for disclosures for treatment, payment or healthcare operations, disclosures which you authorized and certain other specific disclosure types.
- You may request a copy of this Notice of Privacy Practices for Protected Health Information.
- You have the right to complain to us and/or to the U.S. Dept. of Health Inspector General if you believe that we have violated your privacy rights at: U.S. DOH Inspector General, 4052 Bald Cypress Way, Tallahassee, FL 32399 (850) 245-4141.

If you choose to file a complaint, you will not be retaliated against in any way. Please contact us at: Tampa Bay ENT, 5105 N. Armenia Ave., Tampa, FL 33603, Telephone: (813) 879-8045.

THIS NOTICE IS EFFECTIVE AS OF November 1, 2011.

REVISION OF NOTICE OF PRIVACY PRACTICES

We reserve the right to change the terms of this Notice, making any revision applicable to all the protected health information we maintain. If we revise the terms of this notice, we will post notice and will make copies of the revisions available upon request.