ADULT

EAR, NOSE & THROAT SPECIALIST OF TULSA, L. L. P.

6802 SOUTH OLYMPIA AVE. WEST, SUITE 200
TULSA, OKLAHOMA 74132
(918) 388-9740 • FAX (918) 388-9741
TOM A. HAMILTON, D.O.

TODAYS DATE: _____ **REASON FOR VISIT:** _____

DEMOGRAPHICS

LAST NAME : _____ **ADDRESS:** _____

FIRST NAME: _____ _____

MIDDLE NAME: _____ _____

SOCIAL SECURITY # _____ **PREFER TO BE CALLED:** _____

DATE OF BIRTH: _____ **AGE:** _____ **HOME PHONE:** _____ **CELL PHONE:** _____

MARITAL STATUS: _____ **SEX:** _____ **E-MAIL:** _____ **FAX:** _____

EMPLOYER: _____ **WORK #:** _____ **JOB TITLE:** _____

REFERRING PHYSICIAN: _____ **PRIMARY CARE PHYSICIAN:** _____

RESPONSIBLE PARTY (If other than patient)

LAST NAME : _____ **ADDRESS:** _____

FIRST NAME: _____ **RELATIONSHIP TO PATIENT:** _____

MIDDLE NAME: _____ **HOME PHONE:** _____ **WORK #:** _____

EMPLOYER: _____ **CELL PHONE:** _____ **PAGER #:** _____

PRIMARY HEALTH INSURANCE (Insured's Information)

INSURED'S NAME: _____ **INSURED'S RELATIONSHIP TO PATIENT:** _____

INSURANCE CO: _____ **POLICY OR ID NO:** _____

INSURED'S DATE OF BIRTH: _____ **INSURED'S SOCIAL SECURITY NO:** _____

GROUP NO: _____ **PLAN TYPE:** _____ **AUTHORIZATION REQUIRED?** _____

POLICY EFFECTIVE DATE: _____ **EMPLOYER:** _____

SECONDARY HEALTH INSURANCE (Insured's Information)

INSURED'S NAME: _____ **INSURED'S RELATIONSHIP TO PATIENT:** _____

INSURANCE CO: _____ **POLICY OR ID NO:** _____

INSURED'S DATE OF BIRTH: _____ **INSURED'S SOCIAL SECURITY NO:** _____

GROUP NO: _____ **PLAN TYPE:** _____ **AUTHORIZATION REQUIRED?** _____

POLICY EFFECTIVE DATE: _____ **EMPLOYER:** _____

SIGNATURE: _____ **DATE:** _____

EAR, NOSE & THROAT SPECIALISTS OF TULSA, L.L.P.
6802 S. Olympia Ave. West, Suite 200 • Tulsa, Oklahoma 74132
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TOM A. HAMILTON, D.O.

FINANCIAL POLICY

We are committed to providing you with the best possible care. If you have medical insurance, we are here to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our financial policy.
You must realize, however that:

Payment is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, MasterCard, Visa, American Express or Discover. For patients with no insurance, we do allow a discount on self-pay patients if paid at the time of the service.

A $35 fee will be charged for all returned checks plus if any bank fee and your account will be placed on a "cash only" basis.

Your insurance is a contract between you, your employer and the insurance company. If you have any questions regarding network providers, referrals, covered services, benefits and/or financial obligation please contact member services through your insurance company in a timely manner. All charges not covered by your insurance company will be your responsibility.

While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. If we do not have your correct information, insurance cards or referral, then we will be unable to properly file a claim to your insurance company in a timely manner. All charges not covered by your insurance company will be your responsibility.

Should your account balance become uncollectable due to bankruptcy, we will allow 30 days of medical care after which you will be dismissed from our practice.

The accompanying parent or adult is responsible for full payment at the time of service. In case of divorce, we are not responsible for billing multiple parties. It is the responsibility of the parent/guardian whom brings the child in to work out the payment arrangements between custodial and non-custodial parents.

I AGREE THAT IF IT BECOMES NECESSARY TO FORWARD MY ACCOUNT TO A COLLECTION AGENCY, I WILL ALSO BE RESPONSIBLE FOR THE FEE CHARGED BY THE AGENCY FOR THE COSTS OF COLLECTION IN ADDITION TO THE ORIGINAL AMOUNT DUE.

We realize that financial problems may affect timely payment on your account. If such problems do arise, we encourage you to contact our Billing Office promptly to resolve any issues on your account (918) 388-9090.

If you have any questions about the above information or any uncertainty regarding your insurance coverage, PLEASE do not hesitate to ask us. We are here to help you. We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH BY ENT SPECIALISTS OF TULSA.

Please Sign and Date to show that you understand and have received a copy

_____
Patient Name and Date of Birth

_____
Print Name of Responsible Party/Patient

_____
Signature of Responsible Party/Patient Date

If, at any time, the responsible party provides a wireless telephone number where he/she may be contacted, he/she consents to receive calls (including auto-dialed calls and pre-recorded messages) at that wireless number from {hospital, doctors office, collection agency}, its successors and assignees, and the affiliates, agents, and independent contractors, including servicers and collection agents, of each of them regarding the services rendered, or your related financial obligations.

_____
Patient or Responsible Party Signature Date

Confidential Communication Request

EAR, NOSE & THROAT SPECIALISTS OF TULSA, L.L.P.
6802 SOUTH OLYMPIA AVE. WEST, SUITE 200
TULSA, OKLAHOMA 74132

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) you have a right to request that communication concerning your personal health information be made through confidential channels. This medical practice will not ask you why you are making your request, and will try to accommodate all reasonable requests.

I,_____(print your name) hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment or payment for treatment. **This request supersedes any prior request for confidential channel communications I may have made.**

Telephone Contact Information:

Home #:_____ ❑Do ❑Do not leave messages on my voice mail

Work #:_____ ❑Do ❑Do not leave messages with any other person

Cell #:_____ ❑Do ❑Do not leave messages with any other person

Please list other persons that may be contacted with confidential communications

Name:_____ Relationship to patient:_____ Phone #:_____
Phone #:_____

Name:_____ Relationship to patient:_____ Phone #:_____
Phone #:_____

Signed:_____ Date:_____

Print Name:_____

If not signed by the patient, please indicate:
Relationship:

- ❑ parent or guardian of minor patient
- ❑ guardian or conservator of an incompetent patient
- ❑ beneficiary or personal representative of deceased patient
- ❑ other (specify)_____

For office use only:

Date Granted:_____ Initials:_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND PATIENT AGREEMENTS RELATED TO TREATMENT

CONSENT FOR ROUTINE MEDICAL TREATMENT

Ear, Nose and Throat Specialist of Tulsa, L.L.P. and its employees are hereby authorized to collect medical history information, obtain vital signs and perform other routine procedures for purposes of providing care to you. You have the right to consent or refuse consent to any proposed procedure or therapeutic course, absent emergency or extraordinary circumstances. Under emergency circumstances, we will take necessary and available actions to meet your medical needs.

CONSENT TO DISCLOSURE OF INFORMATION

Patient medical records and billing information are created and retained by Ear, Nose and Throat Specialist of Tulsa, L.L.P. and are accessible to its personnel and medical staff for use in my care. Ear, Nose and Throat Specialist of Tulsa, L.L.P. personnel and physicians may use and disclose medical information for its business operations and to any other physician or health care personnel involved in providing care. Safeguards are in place to discourage improper access. Ear, Nose and Throat Specialist of Tulsa, L.L.P. is authorized to disclose all or part of my medical record to any insurance carrier, workers compensation carrier, or administrator of a self-insured employer group which is responsible for any part of Ear, Nose and Throat Specialist of Tulsa, L.L.P. charges and to any health care provider who is or is expected to become involved with a patient's care. These disclosures are for treatment or payment purposes. Oklahoma law requires that we advise you that the information authorized for disclosure may include information which may be considered a communicable or venereal disease, including, but not limited to, Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (AIDS). By signing this agreement, you are consenting to such disclosure. You may revoke this consent in writing addressed to Ear, Nose and Throat Specialist of Tulsa, L.L.P., except to the extent we have already acted in reliance on it.

ASSIGNMENT OF INSURANCE BENEFITS

You agree that insurance benefits for Ear, Nose and Throat Specialist of Tulsa, L.L.P. charges payable to the insured are to be made payable to Ear, Nose and Throat Specialist of Tulsa, L.L.P. and that insurance benefits for services provided by physicians in the hospital setting otherwise payable to the insured are to be made payable to the physicians(s) responsible for your care. Any payment received for this episode of care may be applied to any unpaid bills for which you are liable, subject to the rules of coordination of benefits.

PRECERTIFICATION POLICY

You understand that Ear, Nose and Throat Specialist of Tulsa, L.L.P. will assist with insurance precertification requirements which are the responsibility of the policyholder and/or hospital, but will not assume responsibility for precertification or any impact which it may have on insurance payment.

FINANCIAL RESPONSIBILITY

As consideration for the services provided to you, payment is guaranteed for any amount due for such services provided by Ear, Nose and Throat Specialist of Tulsa, L.L.P. Charges for services and goods shall be at Ear, Nose and Throat Specialist of Tulsa, L.L.P.'s billed charges rates unless otherwise agreed to in writing by Ear, Nose and Throat Specialist of Tulsa, L.L.P.

PATIENT'S CERTIFICATION

I hereby certify that I have read each of the above statements, have had each item explained to my satisfaction, and have received a copy of this Patient Agreement. I further certify that I am the patient or legally authorized by the patient to accept the terms of this Patient Agreement. A photocopy of this document has the same effect as an original.

_____

Signature of Patient or Patient's Legally Authorized Representative (*Documentation Must Be Provided*)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

A complete description of how your medical information will be used and disclosed by Ear, Nose and Throat Specialist of Tulsa, L.L.P. is in our NOTICE OF PRIVACY PRACTICES, which you should read before signing this Acknowledgement. The Notice is posted throughout our office and you will be given a copy for your personal use.

I have received a copy of Ear, Nose and Throat Specialist of Tulsa, L.L.P. Notice of Privacy Practices dated_____

_____ _____ _____

Patient or Representative | Legal Authority of Representative | Date Signed

Basis for refusal, if refused: _____

Ear, Nose & Throat Specialists of Tulsa
Tom A. Hamilton, D.O.
6802 S. Olympia Ave. West
Suite 200
Tulsa, OK 74132

DISCLOSURE OF PHYSICIAN OWNERSHIP
NOTICE TO PATIENTS

Please carefully review the information contained in this notice.

I, **Tom A. Hamilton**, am committed to providing the best quality healthcare to every patient I treat. I am pleased to inform you of the following:

1. I have ownership interest in Tulsa Spine & Specialty Hospital.

2. You have the right to choose the provider of your healthcare services. Therefore, you have the option to use a healthcare facility other than Tulsa Spine & Specialty Hospital.

3. You will **not** be treated differently by me if you choose to obtain healthcare services at a facility other than Tulsa Spine & Specialty Hospital.

There may be other physicians, including radiologists and anesthesiologists, involved in your care that have an ownership, or investment interest, in Tulsa Spine & Specialty Hospital. Physician owners are listed on our website and a list of owners can be provided to you on request. If you have questions concerning this notice, please feel free to ask me or any representative of Tulsa Spine & Specialty Hospital. We welcome you as a patient and value our relationship with you.

Acknowledgement of Disclosure

By signing this Disclosure of Physician Ownership, you acknowledge that you have read and understand the foregoing notice and hereby understand that your physician has an ownership interest in Tulsa Spine & Specialty Hospital.

_____
Signature of Patient/Guardian

_____
Print Name of Patient/Guardian

_____
Date

EAR, NOSE & THROAT SPECIALISTS OF TULSA, L.L.P.
TOM A. HAMILTON, D.O.

HISTORY FORM

Patient Name: _____ **Date of Birth:** _____

Reason for Visit: _____

_____

Pharmacy: _____ **Phone #:** _____

Allergies: Medications _____

Latex _____ **Shellfish** _____ **X-Ray Dye** _____

Current Medications: _____

_____

_____

Past Medical History: _____

_____

_____

Past Surgical History: _____

_____

Weight: _____ **Height:** _____

Health History: Please circle any of the following illness that apply to you.

Allergy Problems	Asthma	Shortness of Breath	Sleep Apnea	Chronic Cough
Thyroid Disease	Goiter	Reflux/Heartburn	Cancer	Hepatitis
Bleeding Disorders	Heart Disease	Heart Attack	Seizure/Stroke	Diabetes
Lung Disease	Glaucoma	High Blood Pressure	Kidney Problems	

Other: _____

Social History:

Do you smoke/or use smokeless tobacco? Yes No Alcohol Use: None / Rare / Minimal / Moderate / Heavy

Family History: Please circle whether any relatives have/had any of the following illnesses.

Asthma Bleeding Disorder Heart Disease Cancer Diabetes
High Blood Pressure Seizures / Stroke Hearing Loss

Please circle any symptoms that apply:

Ears	Nose	Throat
Ear Drainage	Altered Sense of Smell	Altered Sense of Taste
Earaches	Bleeding	Hoarseness
Ear Itching	Congestion	Sore Throat
Hearing Loss	Nasal Drainage	Throat Dryness
Dizziness	Sinus Pain / Pressure	Difficulty Swallowing
Vertigo	Snoring	Difficulty Talking