Benke Ear, Nose & Throat Clinic, P.A.

Personal Information

Today's Date: _____ Account #: _____ SSN: _____

First Name: _____ MI: _____ Last Name: _____

Address: _____

Zip Code: _____ City: _____ State: _____

Date of Birth: _____ Age: _____ Marital Status: _____

Sex: _____ May we leave information on your answering machine or voicemail? ○ Yes ○ No

Primary Phone: (number you wish to be reached at) _____ Other #: _____

Occupation: _____ Work No: _____

Employer: _____ Full Time Student: ○ Yes ○ No

In the event of an emergency please contact:

Name: _____ Relationship: _____ Phone No: _____

Minor Patients: Name of Parent/Guardian _____

Who Referred you? ○Physician ○Family ○Friend ○Phone Book ○Insurance Co. ◉Other _____

Referring Physician's Name: _____ Phone No: _____

Address: _____

Insurance Information:

Please present your insurance card(s) to the receptionist. Please give complete information.

Primary Insurance: _____ Insured's Name: _____

Patient's Relationship to Insured: ○ Self ○Spouse ○Child ○Other

Policy #: _____ Group#: _____

Employer: _____ SSN: _____ DOB: _____

Secondary Insurance: _____ Insured's Name: _____

Patient's Relationship to Insured: ○ Self ○Spouse ○Child ○Other

Policy #: _____ Group #: _____

Employer: _____ SSN: _____ DOB: _____

NOTICE REGARDING INSURANCE CLAIMS/PAYMENTS:

If we are filing insurance for your visit, we must have complete information and any required referral at the time of the visit. If you cannot provide the information, we will be unable to file your insurance, and payment in full will be required.

Payment of your charges cannot be determined until the claim is submitted to your insurance company. Payment will be based on your individual health plan, and the amount applied to your plan deductible and/or coinsurance will be your responsibility. Procedures which are excluded from coverage, based on your plan's determination of medical necessity, will also by your responsibility. Your office visit co-pay is due at the time of the visit and, in many cases, covers only the office visit charge. Any procedures performed will be considered surgery by your insurance company, and deductibles and coinsurance may apply.

For all other patients, payment is required at the time of service. We will provide you with the necessary documentation to file for reimbursement upon your request.

I have read the above information and understand that I am responsible for payment for services I receive.

Patient/Guardian Signature: _____ **Date:** _____

In accordance with privacy policies Benke ENT clinic must have written authorization to release any medical information to any persons other than parent(s) or legal guardian(s) of minors. This includes appointment information, financial information, and medical info.

RELEASE OF MEDICAL INFORMATION

I, _____, authorize BENKE EAR NOSE & THROAT CLINIC, P. A. to release information regarding my medical care to the following persons

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

X

SIGNATURE OF PATIENT OR GUARDIAN **DATE**

OR sign below if you DO NOT want your medical information shared.

☐ I DO NOT authorize release of medical information to anyone other than myself.

X

SIGNATURE OF PATIENT OR GUARDIAN **DATE**

ACKNOWLEDGEMENT OF FINANCIAL POLICY

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY OF BENKE EAR, NOSE & THROAT CLINIC, P.A.

X

SIGNATURE OF PATIENT OR GUARDIAN **DATE**

CANCELLATION POLICY

Benke Ear, Nose & Throat Clinic will charge a patient $50.00 when the patient fails to cancel a scheduled appointment in LESS than 24 hours before the patient's scheduled appointment time.
There will be no exceptions to this policy unless an emergency has occurred. Thank you for abiding to our office policy.

X

SIGNATURE OF PATIENT OR GUARDIAN **DATE**

I authorize Benke ENT Clinic to send communications via electronic or direct mail regarding special events, products, or services relevant to me.

X

SIGNATURE OF PATIENT OR GUARDIAN/DATE **E-MAIL**

Benke Ear Nose and Throat
PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.** It is important for your doctor to know you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcome to a copy of the report if you wish.

Patient's Last Name _____First _____ MI _____

Sex ◯ Male ◯ Female **Date of Birth: _____Age: _____**

Name of Primary Care Physician and/or Referring: _____

Pharmacy Preference (include location): _____

REASON FOR TODAY'S VISIT: _____

Who is accompanying the patient to this appointment? _____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING INCLUDING ALL BLOOD THINNERS ie: Aspirin, Plavix, Coumadin and NSAIDS (USE BACK IF NECESSARY)

Name of Medication	Dosage	How Often Taken

ARE YOU ALLERGIC TO ANY MEDICATION? ◯ Yes ◯ No. If yes, please list below:

Name of Medication	Type of Reaction

DO YOU HAVE ANY NON-MED ALLERGIES? ie: Latex, Tape, Dye_____
Have you been to the ER or recently hospitalized for ASTHMA and/or allergic reaction related problems:
_____
Have you ever had any problems with general or local anesthesia? ◯ Yes ◯ No
If yes, please list type of problems: _____

CLINICAL STAFF USE ONLY:
Height_____ Weight_____ BP_____/_____Pulse:_____
Past Medical Hx reviewed: yes____ no____

Past Hx surgical Hx:_____
_____
Last flu vaccine given: _____ patient declined: _____ (over 65) last pneumonia vaccine: _____
(ages 50-75) Last colorectal screening, ie. Colonoscopy, flex sig, FOBT: _____
(ages 42-69) Last breast cancer screening: _____
(females only between ages 23-64) Last cervical screening: _____

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This practice, **BENKE EAR, NOSE & THROAT CLINIC, P.A.**, uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.
This notice describes our privacy practices. You can request a copy of this notice at any time. For more information about this notice or our privacy practices and policies, please contact Linda Tidwell.

Treatment, Payment, Health Care Operations

Treatment
We are permitted to use and disclose your medical information to those involved in your treatment. For example, the physician in this practice is a specialist. When we provide treatment, we may request that your primary care physician share your medical information with us. Also, we may provide your primary care physician information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any.

Payment
We are permitted to use and disclose your medical information to bill and collect payment for the services provide to you. For example, we may complete a claim form to obtain payment from your insurer or HMO. The form will contain medical information, such as a description of the medical service provided to you, that your insurer or HMO needs to approve payment to us.

Health Care Operations
We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered. For example, we may engage the services of a professional to aid this practice in its compliance programs. This person will review billing and medical files to ensure we maintain our compliance with regulations and the law.

Disclosures That Can Be Made Without Your Authorization

There are situations in which we are permitted by law to disclose or use your medical information without your written authorization or an opportunity to object. In other situations we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or taken in reliance on that authorization.

Public Health, Abuse or Neglect, and Health Oversight
We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like births and death), or injury by a public health authority. We may disclose medical information, if authorized by law, to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may disclose your medical information to report reactions to medications, problems with products, or to notify people of recalls of products they may be using.

We may also disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law requires physicians to report child abuse or neglect. Regulations also permit the disclosure of information to report abuse or neglect of elders or the disabled.

We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections which are all government activities undertaken to monitor the health care delivery system and compliance with other laws, such as civil rights laws.

Legal Proceedings and Law Enforcement

We may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the court (or the administrative decision-maker) or other appropriate legal process. Certain requirements must be met before the information is disclosed.

If asked by a law enforcement official, we may disclose your medical information under limited circumstances provided that the information:

- Is released pursuant to legal process, such as a warrant or subpoena;
- Pertains to a victim of crime and your are incapacitated;
- Pertains to a person who has died under circumstances that may be related to criminal conduct;
- Is about a victim of crime and we are unable to obtain the person's agreement;
- Is released because of a crime that has occurred on these premises; or
- Is released to locate a fugitive, missing person, or suspect.

We may also release information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.

Workers' Compensation

We may disclose your medical information as required by the Texas workers' compensation law.

Inmates

If you are an inmate or under the custody of law enforcement, we may release your medical information to the correctional institution or law enforcement official. This release is permitted to allow the institution to provide you with medical care, to protect your health or the health and safety of others, or for the safety and security of the institution.

Military, National Security and Intelligence Activities, Protection of the President

We may disclose your medical information for specialized governmental functions such as separation or discharge from military service, requests as necessary by appropriate military command officers (if you are in the military), authorized national security and intelligence activities, as well as authorized activities for the provision of protective services for the President of the United States, other authorized government officials, or foreign heads of state.

Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors

When a research project and its privacy protections have been approved by an Institutional Review Board or privacy board, we may release medical information to researchers for research purposes. We may release medical information to organ procurement organizations for the purpose of facilitating organ, eye, or tissue donation if you are a donor. Also, we may release your medical information to a coroner or medical examiner to identify a deceased or a cause of death. Further, we may release your medical information to a funeral director where such a disclosure is necessary for the director to carry out his duties.

Required by Law

We may release your medical information where the disclosure is required by law.

Your Rights Under Federal Privacy Regulations

The United States Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against a patient that exercises their HIPAA rights.

Requested Restrictions

You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or healthcare operations. We do NOT have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances.

To request a restriction, submit the following in writing: (a) The information to be restricted, (b) what kind of restriction you are requesting (i.e. on the use of information, disclosure of information or both), and (c) to whom the limits apply. Please send the request to the address and person listed below.

You may also request that we limit disclosure to family members, other relatives, or close personal friends that may or may not be involved in your care.

Receiving Confidential Communications by Alternative Means

You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to the person listed below. We are required to accommodate only *reasonable* requests. Please specify in your correspondence exactly how you want us to communicate with you and, if you are directing us to send it to a particular place, the contact/address information.

Inspection and Copies of Protected Health Information

You may inspect and/or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that requests for copies be made in writing and we ask that requests for inspection of your health information also be made in writing. Please send your request to the person listed below.

We can refuse to provide some of the information you ask to inspect or ask to be copied if the information:

- Includes psychotherapy notes.
- Includes the identity of a person who provided information if it was obtained under a promise of confidentiality.
- Is subject to the Clinical Laboratory Improvements Amendments of 1988.
- Has been compiled in anticipation of litigation.

We can refuse to provide access to or copies of some information for other reasons, provided that we provide a review of our decision on your request. Another licensed health care provider who was not involved in the prior decision to deny access will make any such review.

Texas law requires that we are ready to provide copies or a narrative within 15 days of your request. We will inform you of when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing.

HIPAA permits us to charge a reasonable cost based fee. The Texas State Board of Medical Examiners (TSBME) has set limits on fees for copies of medical records that under some circumstances may be lower than the charges permitted by HIPAA. In any event, the *lower* of the fee permitted by HIPAA or the fee permitted by the TSBME will be charged.

Amendment of Medical Information

You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the person listed below. We will respond within 60 days of your request. We may refuse to allow an amendment if the information:

- Wasn't created by this practice or the physicians here in this practice.
- Is not part of the Designated Record Set?
- Is not available for inspection because of an appropriate denial.
- If the information is accurate and complete.

Even if we refuse to allow an amendment you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment we will inform you in writing. If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we know have the incorrect information.

Accounting of Certain Disclosures

The HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by you or your representative. Please submit any request for an accounting to the person listed below. Your first accounting of disclosures (within a 12 month period) will be free. For additional requests within that period we are permitted to charge for the cost of providing the list. If there is a charge we will notify you and you may choose to withdraw or modify your request *before* any costs are incurred.

Appointment Reminders, Treatment Alternatives, and Other Health-related Benefits

We may contact you by telephone or mail to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

Complaints

If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the United States Department of Health and Human Services. We will not retaliate against you for filing a complaint with the government or us. The contact information for the United States Department of Health and Human Services is:

U.S. Department of Health and Human Services
HIPAA Complaint
7500 Security Blvd., C5-24-04
Baltimore, MD 21244

Our Promise to You

We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

Questions and Contact Person for Requests

If you have any questions or want to make a request pursuant to the rights described above, please contact:

Sarah Wallace
1317 Glenwood Dr
Cleburne, Texas 76033
(Phone) (817) 641-3750
(Fax) (817) 641-3754

This notice is effective on the following date: April 14, 2003.

We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen.

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed Benke Ear, Nose & Throat Clinic, P.A.'s Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____
Signature of Patient or Personal Representative

_____
Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

_____
Witness Title

_____
Date

BENKE
EAR NOSE & THROAT
CLINIC

FINANCIAL POLICY

Payment is due at the time services are rendered – this includes co-pays, co-insurance and deductibles. The patient will be responsible for non-covered services.

We accept payment by cash, personal check, MasterCard, Visa, and Discover. All returned checks will be subject to a $25.00 returned check fee due immediately from the patient or responsible party.

Self Pay: New patients should be prepared to pay $190.00 to $370.00 for the first visit. There will be an additional fee for any procedure or diagnostic testing. (example: hearing test, cerumen removal, etc.)

HMO and PPO: Patients covered by a Health Maintenance Organization (HMO) or Participating Provider Organization(PPO), of which Benke Ear, Nose & Throat Clinic is a participant, must bring the HMO/PPO card and be prepared to pay the CONTRACT CO-PAY AMOUNT at the time of service. Also, the patient is responsible for any referral required from the patient's PCP required by the insurance company.

MEDICARE: We accept assignment on all Medicare Claims. Patients covered by MEDICARE PART B must bring their Medicare card. We will also file MEDICARE SUPPLEMENT claims. We do not accept Medicare or any Medicare replacement with Medicaid as a supplement.

MEDICAID AND MANAGED CARE MEDICAID: We accept Medicaid for children up to 18 years of age only. We DO NOT accept Medicaid as a secondary insurance. The Medicaid managed care plans that we currently accept are the Cooks, Superior, and Molina Health plans.

WE WILL FILE PRIVATE INSURANCE CLAIMS AS A COURTESY TO OUR PATIENTS. If you wish us to file for you, please bring your insurance card and proper photo identification to your first visit so we may verify your coverage. Payment for the UNINSURED PORTION is due at the time services are rendered. This includes DEDUCTIBLE and COINSURANCE as verified by the insurance carrier. Due to the large amount of insurance policies we accept, it is the member's responsibility to ensure that Dr. Benke is a contracted **in-network** physician with your insurance. Any cost incurred due to out of network deductibles and/or coinsurance will be the member's responsibility. Your Insurance Policy is a contract between you and your Insurance carrier. We are not a party to the contract. As medical care providers, our relationship is with you not your Insurance Carrier. Not all services are a covered benefit in all policies. Some insurance carriers select services that will not be covered. We recommend you inform yourself of any policy exclusions. THE PATIENT WILL BE RESPONSIBLE FOR NON-COVERED SERVICES.

UNCOLLECTED/PAST DUE BALANCES AND FEES: We make every effort to **estimate** your patient portions according to your health plan. However, it is becoming increasingly difficult to ask enough questions to find out every limitation, exclusion and percentage on the many insurance plans we see. This can sometimes result in additional amounts due after your claim has been paid. You will receive a statement if there is any remaining balance after your insurance has paid. Any balances not paid after 60 days will acquire an additional "collections" fee and will be forwarded to a collection agency for further action.

*****OUR OFFICE POLICY REGARDING DIVORCED PARENTS – THE PARENT BRINGING THE CHILD TO OUR OFFICE IS RESPONSIBLE FOR PAYMENT AT THE TIME SERVICES ARE RENDERED. WE DO NOT COLLECT PAYMENTS FROM BOTH PARENTS. OUR OFFICE WILL PROVIDE THE PARENT A RECEIPT OF PAYMENT AT CHECKOUT*****

Our fees fall within the reasonable, usual and customary range considered by most carriers.
You may request a copy of this policy from the receptionist

BENKE EAR NOSE AND THROAT CLINIC
TELEMEDICINE INFORMED CONSENT

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
    a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
    a. I may revoke my right at any time by contacting Benke Ear, Nose and Throat Clinic at 817-641-3750.
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
    a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
    b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.
    c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
7. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of Texas and will be in Texas during my telemedicine visit(s).

_____ _____

Patient/Parent/Guardian Printed Name Patient/Parent/Guardian Signature

_____ _____

Witness Signature Date