Brookwood Baptist Health

Specialty Care Network
Ear, Nose and Throat

Patient Registration Form

Date:_____ Doctor: _____

PATIENT INFORMATION				
Name (Last, First, Middle)	Preferred Name	Social Security Number	Sex (M/F)	Date of Birth
Home Address		City/ State	Zip Code	Driver's License #
Email Address		Home Phone #	Cell Phone#	
Employer Name		Work Phone #	Marital Status Single Married Widowed Divorced	
Emergency Contact (Not living with you)		Relationship	Emergency Phone	

Ethnicity	☐ Hispanic	☐ Other	☐ Not Reported		
Race	☐ Caucasian	☐ African American	☐ Hispanic	☐ Asian	☐ American Indian ☐ Other
Primary Language	☐ English	☐ Spanish	☐ French	☐ Japanese	☐ Chinese ☐ Other
Gender	☐ Male	☐ Female			

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT THAN ABOVE)				
Name (Last, First, Middle)	Social Security Number	Date of Birth	Age	Sex
Local Address	City, State, Zip	Secondary Billing Address (if applicable)		
Home Phone #	Cell Phone #	Relationship to Patient		

PRIMARY INSURANCE		
Name of Insurance Company	Address (Street, City, St, Zip)	CoPay
Policy Holder Name	Social Security Number of Policy Holder	DOB
Contract #	Group #	Effective Date

SECONDARY INSURANCE (IF APPLICABLE)		
Name of Insurance Company	Address (Street, City, St, Zip)	CoPay
Policy Holder Name	Social Security Number of Policy Holder	DOB
Contract #	Group #	Effective Date

HOW DID YOU HEAR ABOUT US? (CHECK ALL THAT APPLY)

☐ Television	☐ Event	☐ Signage	☐ Rating Website (Vitals, HealthGrades, etc.)	☐ Word of Mouth
☐ Radio	☐ Zoc Doc	☐ Physician Referral	☐ Search Engine (Google, Yahoo, etc.)	☐ brookwoodbaptisthealth.com
☐ Billboard	☐ Mailer	☐ Social Media	☐ Magazine/Newspaper Ad	☐ bbhcarenetwork.com

I consent to treatment necessary for the care of the above named patient. I acknowledge full financial responsibility for services rendered by Brookwood Baptist Health Primary & Specialty Care Network, Inc. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment. I have read and fully understand the above consent for treatment and financial responsibility.

Signature of Patient/Guardian:_____ Date:_____

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NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGMENT

A Notice of Privac y Practices (NPP) is provided to all patients. This Notice of Privacy Practices identifies: 1) how medical information about you may be used or disclosed ;2) your rights to access your medical information.amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information; 3) your rights to complain if you believe your privacy rights have been violated; and
4) Our responsibilities for maintaining the privacy of your medical information.

The undersigned certifies that he/she has read the foregoing, received a copy of the Notice of Privacy Practices and is the patient,or the patient's personal representative.

Name of Patient

Signature of Patient/Date Signed

Name Patient's Personal Representative

Signature of Patient's Personal Representative/Date Signed

FOR INTERNAL USE ONLY

Name of Employee

Signature of Employee

If applicable, reason patient's written acknowledgment could not be obtained:

O Patient was unable to sign.
O Patient refused to sign.
O Other:

Version 1 Effective Date: 2/1/2018

Notice of Privacy Practices (NPP) Acknowledgement

Insert additional Patient Information as needed.

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PATIENT COMMUNICATION CONSENT

We may need to contact you regarding your medical care, appointments, test results, referrals, or any other reason. This is to acknowledge that you authorize Brookwood Baptist Health to contact you and how you wish to be contacted (check all that apply):

	ORDER OF PREFERENCE:	OK TO LEAVE VOICEMAIL?	PHONE NUMBER:
HOME PHONE	❒1 ❒2 ❒3 ❒4 ❒5	❒YES ❒NO	
CELL PHONE	❒1 ❒2 ❒3 ❒4 ❒5	❒YES ❒NO	
WORK PHONE	❒1 ❒2 ❒3 ❒4 ❒5	❒YES ❒NO	
ALTERNATE PHONE	❒1 ❒2 ❒3 ❒4 ❒5	❒YES ❒NO	
PATIENT PORTAL & SECURE EMAIL	❒1 ❒2 ❒3 ❒4 ❒5	**EMAIL ADDRESS:**	
□ None of the above			

PHI DISCLOSURE TO FAMILY MEMBERS

You may authorize us to contact a family member regarding your medical care or financial matters. This is to acknowledge that you authorize Brookwood Baptist Health to disclose your PHI to the following individuals (check all that apply):

Name:____**Relationship to Patient:** ___________________________
Telephone: (_____________)____________________ **Email:**____**Types of Information:** ❒ Appointment Reminders ❒ Results (lab test, X-Ray, etc) ❒ Financial ❒ Other: _________________
Okay to contact via: ❒ Telephone ❒ Leave a Voice Mail ❒ Patient Portal & Secure Email ❒ Other: _______________________

Name:____**Relationship to Patient:** ___________________________
Telephone: (_____________)____________________ **Email:**____**Types of Information:** ❒ Appointment Reminders ❒ Results (lab test, X-Ray, etc) ❒ Financial ❒ Other: _________________
Okay to contact via: ❒ Telephone ❒ Leave a Voice Mail ❒ Patient Portal & Secure Email ❒ Other: _______________________

Name:____**Relationship to Patient:** ___________________________
Telephone: (_____________)____________________ **Email:**____**Types of Information:** ❒ Appointment Reminders ❒ Results (lab test, X-Ray, etc) ❒ Financial ❒ Other: _________________
Okay to contact via: ❒ Telephone ❒ Leave a Voice Mail ❒ Patient Portal & Secure Email ❒ Other: _______________________

□ **None of the above** **Signature/Date:** ____

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Patient History

Patient Name: _____ **DOB:** _____ **Date:** _____

Primary Care Physician: _____

Please list any other Specialist that are involved in your medical care: _____

_____

Previous ENT Doctor: _____

Reason for today's visit: _____

_____

Rate the severity of today's symptoms on a 1-10 scale (10=worse): _____

How long have your symptoms been present? _____

What makes your symptoms worse or better? _____

Have you seen other providers for this illness? _____

What diagnostic tests have been performed so far? _____

What treatments have been tried so far (include operations done for this illness)? _____

_____

ALLERGIES ? ☐ **Yes** ☐ **No**

Medication Allergies:	Type of Reaction:	Medication Allergies:	Type of Reaction:

Have you ever had an allergy test? ☐ **Yes** ☐ **No**

Have you ever taken allergy Shots? ☐ **Yes** ☐ **No**

If yes, are you still taking them? ☐ **Yes** ☐ **No**

How much relief from shots? ☐ **Minimal** ☐ **Partial** ☐ **Significant**

LIST ALL MEDICATIONS YOU ARE TAKING (Prescription, over-the – counter or herbal)

Medication:	Dosage:	How often:	Medication:	Dosage:	How often:

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Pharmacy Name (Include Address and/or Phone): _____

MEDICAL/SURGICAL HISTORY ☐ No Medical/Surgical History Exists

Please list ALL prior surgical procedures: _____

_____

Have you been diagnosed with any of the following? Please check applicable box.

Cardiovascular:	Gastrointestinal:
☐ Coronary Artery Disease	☐ Hepatitis
☐ Elevated Cholesterol (Hyperlipidemia)	☐ Hernia
☐ High Blood Pressure	☐ Gastroesophageal Reflux
☐ Mitral Value Prolapse	☐ Irritable Bowel Syndrome
Genitourinary:	**Endocrine:**
☐ Prostate Enlargement	☐ Diabetes Type:_____
☐ Kidney Stones(Nephrolithiasis)	☐ Thyroid Excess(Hypo)
☐ Renal Failure (Acute)	☐ Thyroid Excess (Hyper)
Eye/Ear/Nose/Throat:	**Neoplastic:**
☐ Cataracts	☐ Cancer

☐ Glaucoma	**Neurologic**
☐ Chronic Ear Infections(Otitis Media)	☐ Migraine
☐ Hearing Loss	☐ Headache
☐ Sinus Problems(Chronic Sinusitis)	☐ Stroke
☐ Nasal Polyps	**Obstetric:**
☐ Nasal Allergies	☐ Pregnancy Date(s):_____
☐ Recurrent Tonsillitis	**Psychiatric:**
☐ Tinnitus	☐ Adjustment Disorder/Anxiety
☐ Vertigo	☐ Major Depression
Hematologic:	**Pulmonary:**
☐ Anemia	☐ Asthma
Immunologic:	☐ COPD

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☐ Allergies Type:_____ Management_____	☐ Emphysema
Infectious Disease:	☐ Sleep Apnea
☐ Mononucleosis ☐ STD Type:_____	☐ Tuberculosis

FAMILY AND SOCIAL HISTORY- Please check applicable box

	Father	Mother	Sister	Brother	Other
ALLERGIES					
ALZHEIMER DISEASE					
ASTHMA					
BLOOD DISEASE					
CAD					
CANCER: Type					
STROKE					
DIABETES MELLITUS					
HEARING LOSS					
HYPERLIPIDEMA					
HYPERTENSION(SYSTEMIC)					
MIGRAINE HEADACHE					

OTHER FAMILY HISTORY NOT LISTED: _____

TOBACCO USE: ☐Yes ☐NO ☐ Former

Type	Packs	#Years	Year Quit
CIGARETTES			
OTHER (Please List)			

ALCOHOL USE: ☐Yes ☐ No ☐ Former

Type	Frequency	AMT	Last Drink
ALCOHOL			
OTHER (Please List)			

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Review of Systems: **Please mark where applicable:** ☐ **No Problems Exists**

General Health Problems
□ Fatigue
□ Fever
□ Night Sweats
□ Weight Loss
□ Weight Gain

Eyes
□ Double Vision
□ Itchy Eyes
□ Redness

Ear Problems
□ Drainage
□ Hearing loss
□ Infections
□ Dizziness
□ Exposure to Excessive Noise
□ Ear pain
□ Ringing/Noise in Ears

Nose &Sinus Problems
□ Congestion
□ Facial Pain
□ Mouth Breathing
□ Nose Bleeds
□ Sneezing
□ Runny Nose
□Postal Nasal Drainage

Mouth & Throat Problems
□ Difficulty Swallowing
□ Sleep Apnea
□ Snoring
□ Hoarseness
□ Sores/Ulcers in Mouth

Heart or Circulation Problems
□ Heart Murmur
□ Chest Pain
□ Swelling in Ankles/Edema
□ Blacking Out
□ Irregular Heartbeat/Palpitations

Lung or Respiratory Problems
□ Cough
□ Shortness of Breath
□ Wheezing

Musculoskeletal
□ Leg Pain
□ Back Pain

Skin
□ Itchy/Skin
□ Rash
□ Contact Allergy

Stomach Problems
□ Nausea
□ Vomiting
□ Constipation
Abdominal Pain
□ Diarrhea
□ Heartburn

Blood or Lymph Nodes Problems
□ Easy Bleeding
□ Easy Bruising

Neurologic System
□ Seizures
□ Numbness
□ Headaches
□ Focal Weakness

Glands & Hormones
□ Heat Intolerance
□ Cold Intolerance
□ Neck Enlargement/Goiter

Allergy Problems
□ Food Allergies
□ Bee Sting Allergies
□ Environmental Allergies
□ Urticaria/Hives

Patient Name:	**DOB:**
Responsible Party:	**Date:**

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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 INFORMATON. PLEASE REVIEW IT CAREFULLY.

We are committed to protecting the confidentiality of your medical information, and are required by law to do so. This notice describes how we may use your medical information at Brookwood Baptist Health and how we may disclose it to others outside of Brookwood Baptist Health. This notice also describes the rights you have concerning your own medical information. Please review it carefully and let us know if you have questions.

For purposes of this notice, Brookwood Baptist Health includes the following:

Brookwood Baptist Health Primary & Specialty Care Network
Brookwood Baptist Health Physician Alliance
Shelby Baptist Ambulatory Surgery Center, LLC
Brookwood Baptist Medical Center
Citizens Baptist Medical Center
Princeton Baptist Medical Center
Shelby Baptist Medical Center
Walker Baptist Medical Center

Permissible Uses and Disclosures without Your Written Authorization

Treatment: We may use your medical information to provide you with medical services and supplies. We may also disclose your medical information to others who need that information to treat you, such as doctors, physician assistants, nurses, medical and nursing students, technicians, therapists, emergency service and medical transportation providers, medical equipment providers, and others involved in your care.

For example, we will allow other physicians treating you to have access to your medical record. To assure that your other treatment providers have quick access to your latest health information, we may participate in a community-based electronic health information exchange. We also may use and disclose your medical information to contact you to remind you of an upcoming appointment, to inform you about possible treatment options or alternatives, or to tell you about health-related services available to you, or to perform follow-up calls to monitor your care experience.

Family Members and Others Involved in Your Care: We may disclose your medical information to a family member or friend who is involved in your medical care, or to someone who helps to pay for your care. We also may disclose your medical information to disaster relief organizations to help locate a family member or friend in a disaster. During visits with family members and other visitors, let your physician and other personnel know if you do not want them to disclose your medical information during the visit.

Payment: We may use and disclose your medical information to get paid for the medical services and supplies we provide to you. For example, your health plan or Health Insurance Company may ask to see parts of your medical record before they will pay us for your treatment.

Health Care Operations: We may use and disclose your medical information if it is necessary to improve the quality of care we provide to patients or to run Brookwood Baptist Health. We may use your medical information to conduct quality improvement activities, to obtain audit, accounting or legal services, or to conduct business management and planning. For example, we may look at your medical record to evaluate the care provided by our personnel, your doctors, or other health care professionals.

Organized Health Care Arrangement: Each of the Brookwood Baptist Health hospitals have medical staff, which include physicians and other medical professionals who are not employees of the hospital. In addition, Brookwood Baptist Health Physician Alliance is an arrangement between Brookwood Baptist Health and physicians from each medical staff, including physicians employed by the Brookwood Baptist Health Primary & Specialty Care Network. These covered entities are participants in an organized health care arrangement, which permits protected health information to be shared for purposes of treatment, payment, and/or health care operations (as described above) relating to the organized health care arrangement.

Research: We may use or disclose your medical information for research projects, such as studying the effectiveness of a treatment you received. These research projects must go through a special process that protects the confidentiality of your medical information.

Required by Law: Your PHI may be used and disclosed when required to do so by any other law not already referred to in the preceding categories; such as required by the FDA, to monitor the safety of a medical device. We also are required to give information to the State Workers' Compensation Program for work-related injuries.

Victims of Abuse, Neglect or Domestic Violence. Your PHI may be disclosed to a governmental authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence if there is a reasonable belief that you are a victim of abuse, neglect or domestic violence.

Public Health: We also may report certain medical information for public health purposes. For instance, we are required to report births, deaths, and communicable diseases to the State. We also may need to report patient problems with medications or medical products to the FDA, or may notify patients of recalls of products they are using.

Public Safety: We may disclose medical information for public safety purposes in limited circumstances. We may disclose medical information to law enforcement officials in response to a search warrant or a grand jury subpoena. We also may disclose medical information to assist law enforcement officials in identifying or locating a person, to prosecute a crime of violence, to report deaths that may have resulted from criminal conduct, and to report criminal conduct. We also may disclose your medical information to law enforcement officials and others to prevent a serious threat to health or safety.

Health Oversight Activities: We may disclose medical information to a government agency for oversight purposes, such as the State Department of Health, the federal agencies that oversee Medicare, the Board of Medical Examiners or the Board of Nursing. These agencies need medical information to monitor compliance with state and federal laws.

Coroners, Medical Examiners and Funeral Directors: We may disclose medical information concerning deceased patients to coroners, medical examiners and funeral directors to assist them in carrying out their duties.

Organ and Tissue Donation: We may disclose medical information to organizations that handle organ, eye or tissue donation or transplantation.

Military, Veterans, National Security and Other Government Purposes: If you are a member of the armed forces, we may release your medical information as required by military command authorities or to the Department of Veterans Affairs. We may also disclose medical information to federal officials for intelligence and national security purposes, or for presidential Protective Services.

Judicial Proceedings: We may disclose medical information if ordered to do so by a court or if we receive a subpoena or a search warrant. You will receive advance notice about this disclosure in most situations so that you will have a chance to object to sharing your medical information.

Uses and Disclosures for Which Your Authorization is Required: With limited exceptions, we must obtain your written authorization before we disclose your medical information in the following circumstances: (1) to disclose psychotherapy notes, (2) to conduct marketing activities, or (3) to sell your medical information to a third party.

Information with Additional Protection: Certain types of medical information have additional protection under state or federal law. For instance, medical information about communicable disease and HIV/AIDS, and evaluation and treatment for a serious mental illness is treated differently than other types of medical information. For those types of information, we are required to get your permission before disclosing that information to others in many circumstances.

Other Uses and Disclosures Requiring Authorization: If we wish to use or disclose your medical information for a purpose that is not discussed in this Notice, we will seek your written authorization. If you give your authorization, you may take back that authorization any time, unless we have already relied on your authorization to use or disclose the information. If you ever would like to revoke your authorization, please notify us in writing.

WHAT ARE YOUR RIGHTS?

Right to Request Your Medical Information: You have the right to look at your own medical information and to get a copy of that information. (The law requires us to keep the original record.) This includes your medical record, your billing record, and other records we use to make decisions about your care. To request your medical information, please contact the local facility where you receive care. Federal and state laws permit a

reasonable cost-based fee to be charged for the copying of patient records. You will be notified in advance what this copying will cost. You can look at your record at no cost.

Right to Request Amendment of Medical Information You Believe Is Erroneous or Incomplete: If you examine your medical information and believe that some of the information is wrong or incomplete, you may ask us to amend your record. To ask us to amend your medical information, write to the local facility where you receive care.

Right to Get a List of Disclosures of Your Medical Information: You have the right to request a list of the disclosures we make of your medical information. If you would like to receive such a list, write to the local facility where you receive care. We will provide the first list to you free, but we may charge you for any additional lists you request during the same year. We will tell you in advance what this list will cost.

Right to Request Restrictions on How We Will Use or Disclose Your Medical Information for Treatment, Payment, or Health Care Operations: You have the right to request us from making uses or disclosures of your medical information to treat you, to seek payment for care, or to operate. In many cases, we are not required to agree to your request for restriction, but if we do agree, we will comply with that agreement. However, we must agree to your request not to disclose to your health plan any medical information about items or services for which you have paid in full, unless such disclosure is required for treatment or by law. If you do not want us to notify your health plan, you must notify us at the time of your registration as well as make immediate arrangements to pay in full for your treatment or visit.

Right to Revoke Your Authorization. You may revoke Your Authorization, Your Marketing Authorization or any written authorization obtained in connection with your PHI, except to the extent that the facility and/or Health Professionals have taken action in reliance upon it, by delivering a written revocation statement to the local facility where you receive care.

Right to Request Confidential Communications: You have the right to ask us to communicate with you in a way that you feel is more confidential. For example, you can ask us not to call your home, but to communicate only by mail. To do this, write to the local facility where you receive care. At your request, you can also ask to speak with your health care providers in private outside the presence of other patients or family.

Right to a Paper Copy: If you have received this notice electronically, you have the right to a paper copy at any time. You may download a paper copy of the notice from our Web site, at **BBHCARENETWORK.COM,** or you may obtain a paper copy of the notice from the local facility where you receive care.

DUTIES OF BROOKWOOD BAPTIST HEALTH

We are required by law to protect the privacy of your medical information, give you this Notice of Privacy Practices, and follow the terms of the Notice that is currently in effect. We are also required to notify you if there is a breach of your unsecured medical information.

WHICH HEALTH CARE PROVIDERS ARE COVERED BY THIS NOTICE?

Brookwood Baptist Health

Specialty Care Network
Ear, Nose and Throat

This Notice of Privacy Practices applies to Brookwood Baptist Health and its personnel, volunteers, students, and trainees.

CHANGES TO THIS NOTICE

From time to time, we may change our practices concerning how we use or disclose patient medical information, or how we will implement patient rights concerning their information. We reserve the right to change this Notice and to make the provisions in our new Notice effective for all medical information we maintain. If we change these practices, we will publish a revised Notice of Privacy Practices. You can get a copy of our current notice of Privacy Practices at any time by contacting the local facility where you receive care.

DO YOU HAVE CONCERNS OR COMPLAINTS?

Please tell us about any problems or concerns you have with your privacy rights or how we use or disclose your medical information. If you have a concern, please contact the Ethics Action Line at 1-800-8-ETHICS.

If for some reason we cannot resolve your concern, you may also file a complaint with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, the Privacy and Security Office will provide you with the correct address for the Director. We will not penalize you or retaliate against you in any way for filing a complaint with the federal government.

PRIVACY OFFICIAL CONTACT INFORMATION

Corporate Compliance & Privacy Office
Tenet Healthcare
1445 Ross Avenue, Suite 1400
Dallas, Texas 75202
E-mail:PrivacySecurityOffice@tenethealth.com
Ethics Action Line (EAL) 1-800-8-ETHICS

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Parking Directions for the Professional Office Building (POB):

- Turn into the Patient Parking Deck located across the street from the Emergency Room.
- Park in the Blue section of the parking deck.
- The crosswalk is located on the 2nd level. Take it over to the POB.
- Our office is located on the 3rd floor, Suite 314.