Siegel and Bosworth Ear, Nose, and Throat Center

15204 Omega Drive, Suite 310, Rockville, MD 20850
Phone (240)361-9000 Fax (240) 361-9001

Patient Registration

If Patient is 18 Years or Older, the PATIENT Must Sign Registration Forms
If Patient is a Minor, Please Fill Out Guardian's Work/Cell Phone Numbers

Last Name _____First Name_____ MI___ Male___Female___

Address _____City/State _____Zip_____

Home Phone #_____Work #_____

Cell # _____ Date of Birth_____ Social Sec #_____-_____-_____

If you would like to enroll in text reminders for future appointments please circle Yes No

E-Mail Address_____

Please circle all that apply:

Marital Status: Single Married Divorced Widowed Other **Language:** English Spanish Other

Emergency Contact _____Relationship_____ Phone#_____

Primary Care Physician _____Phone# _____Location_____

Name of Referring Physician or Other Referral Source: _____
Referral source is: Physician Family Member Friend Insurance Company Other_____

If a Minor, **First and Last Name of Parent(S) _____
Name of authorized person(s) to whom we may release your protected health information.

_____

****Including billing inquiries****

Print Name of Person Completing Form	Relationship to Patient	Signature of Person Completing Form
Print Name of Policy Holder	Date of Birth of Policy Holder	Policy Holder Employer (Name)

OPTIONAL QUICK-PAY Paperless Billing-PLEASE READ CAREFULLY

In order to provide you with the highest quality services while keeping our billing costs low, we offer paperless billing through **QUICK-PAY**. This enrollment is **OPTIONAL**, unless you are selfpay. We simply maintain your credit card or debit card number on file to satisfy your copayment, deductible, and co-insurance, per your insurance policy. We accept Visa, MasterCard and Discover. If you prefer, one of our staff will personally call you to explain any balance due prior to transferring your balance.
SELF PAY PATIENTS & NON-CONTRACTED PLANS We ***require*** that you enroll in **QUICK-PAY (see below)** to guarantee your account.
We accept **VISA**, **MASTERCARD, DISCOVER AND AMERICAN EXPRESS**

Cardholder Signature _____ Account #_____Exp. Date _____

____Transfer Balance ____Call First

If you do not check an option, your credit card will automatically be billed for all applicable deductibles, co-insurances, and/or co-pays according to your insurance policy.
By signing above, I authorize Siegel & Bosworth ENT Center to maintain my credit card on file and I assign my benefits to the Siegel & Bosworth ENT Center. This agreement/consent will remain in effect unless revoked by me in writing. A duplicate of this statement is considered the same as the original. THANK YOU!

Siegel and Bosworth Ear, Nose, and Throat Center Policies

1. I understand that I am responsible for charges not covered by my insurance company. I agree, in the event of non-payment, to assume the costs of all interest and fees due to collection legal action. One statement will be sent to you as a courtesy. **For each additional statement sent due to non-payment, a $10 billing fee will be added to your account**. **If you need to arrange a payment plan, a credit card is required to be kept on file for automatic monthly billing. Payment for self-pay patients is due in full at the time of service.**

2. I authorize my insurance carrier to release information regarding my insurance coverage to Dr. Michael Siegel and Dr. John Bosworth. I also authorize agents of any hospital, treatment facility or previous physicians to furnish Dr. Siegel and Dr. Bosworth copies of any and all records of my medical history. I authorize the release of my medical records to any federal, state or accreditation agency. I agree to a review of my records for purpose of internal audits, research and quality assurance reviews within the office.

3. My right to payment for all procedures, tests, supplies and services including major medical benefits are hereby assigned to Dr. Siegel and Dr. Bosworth. This assignment covers any and all benefits under Medicare, all government sponsored programs private insurance companies and other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment for services. In the event my insurance carrier does not accept assignment of benefits, or if payments are made directly to my representative, or me, I will endorse such payments to Dr. Siegel and Dr. Bosworth.

4. I understand that when paying by check to Siegel & Bosworth ENT Center, I will be responsible for a $30.00 fee if a check is returned. This does not include any other fees applied by your bank.

5. **This office is NOT a party to your divorce decree**. **The responsibility for minors rests with the accompanying adult**. **A legal guardian must be present at each and every appointment unless the legal guardian provides this office with Written authorization for someone else to make all necessary medical decisions on behalf of the minor patient.**

6. **Deposits/Fees for Surgical Scheduling** –There is a $250 fee for canceling or rescheduling surgery within 2 weeks of the scheduled procedure unless it is due to a documented emergency or unexpected illness. We will require documentation to prove the validity of the reason. This fee increases to $350 if the procedure is scheduled during Prime Time. Prime Time is defined as the week between Christmas and New Year's, Spring Break, Month of August, and the weeks of Memorial Day and Labor Day. A $100 deposit is required to schedule a procedure more than 3 months in advance.
If you were to cancel your or your child's scheduled procedure within 2 weeks prior to the surgery date, due to other reasons not related to an emergency or unexpected illness, you will be required to pay a deposit up to $500.00 to re-schedule the procedure. A valid credit card will be required at the time of re-scheduling and will be charged that day. This amount will depend upon the type of procedure that is being scheduled.
All deposits are non-refundable if surgery is cancelled within 14 days of the procedure. The deposit will be applied to your financial responsibility for the procedure, if there is any; otherwise it will be refunded to you once the claim for the procedure has been processed by your insurance company.
These fees are not covered by Medicare or any insurance company.

7. I acknowledge receipt of the Notice of Privacy Policies provided by Siegel & Bosworth ENT Center. I am responsible for reviewing all information.

8. I authorize Siegel & Bosworth ENT Center to contact me for the following reasons:

- Permission to call me at home, office, or mobile to confirm or reschedule an appointment, to provide me with test results, or to return my message(s)
- Permission to leave appointment reminders or appointment cancellation notifications on an answering machine, voicemail, with a family member, secretary, or household employee
- Permission to leave "your test results were normal" on an answering machine

9. Missed appointments are subject to a $50 fee. We require appointments to be cancelled or rescheduled by 3PM the day prior to your appointment to avoid a $50 late cancellation fee.

10. We have chosen to participate in the Chesapeake Regional Information System for our Patients (CRISP), a regional health information exchange serving Maryland and D.C. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may "opt-out" and disable access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org Public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug monitoring Program (PDMP), will still be available to providers.

Name of Patient and/or Guardian (please print):_____

Signature of Patient or Guardian_____ Date _____

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Patient Name: **Primary Care Physician:** **Referring Physician:**

DOB: **Age:** **Height:** **Weight:** **Today's Date**

Pharmacy:

_____

_____

What are your concerns for today's visit?

_____

_____

_____

Please list any ALLERGIES to MEDICATIONS and your reactions. Check here if none ☐

_____

Please list any FOOD or ENVIROMENTAL allergies. Check here if none ☐

_____

Flu Vaccine- YES___NO___ Date:_____ Pneumonia Vaccine- YES___NO___Date:_____

PAST MEDICAL HISTORY:

Please indicate by checking whether you have any of the following conditions. If YES, please explain:

Check here if none ☐

☐ Diabetes_____

☐ Hypertension (High Blood Pressure)_____

☐ Thyroid Problems_____

☐ Heart Disease_____

☐ Respiratory Problems_____

☐ Stomach/Intestinal Problems_____

☐ Kidney Disorders_____

☐ Neurological Problems_____

☐ Other Medical Diagnosis_____

Please list ANY OPERATIONS (AND DATES OF SURGERY) you have ever had. Check here if none ☐

_____

_____

_____

Please list ANY MEDICATIONS (AMOUNTS/PER DAY) you are taking (THIS INCLUDES ASPIRIN and VITAMINS). Check here if none ☐

_____

_____

_____

SOCIAL HISTORY:

Do you smoke? ☐ No ☐ Yes If Yes, how much? _____If No, did you smoke previously? ☐ No ☐ Yes Provide details: _____

Do you drink alcohol? ☐ No ☐Yes If yes, how often? _____What is your alcohol preference?_____

What is your occupation? _____(If Child) Does your child attend daycare? ☐ No ☐ Yes

Does your home have a fireplace? ☐ No ☐ Yes (Female patients) Are you currently pregnant? ☐ No ☐ Yes

Do you have any pets? ☐ No ☐ Yes If Yes, what kind?_____

FAMILY HISTORY:

Please indicate by checking ☐ whether you have any relatives who have/had these conditions. If Yes, **please indicate what family member and whether they are Maternal or paternal relatives.(example)Maternal Aunt, Paternal Uncle, Maternal Grandmother etc...**

Check here if none ☐

☐Hearing Problems_____ ☐ Allergies_____

☐Diabetes_____ ☐ Cancer_____

☐Bleeding Disorders_____ ☐ Anesthesia Problems_____

☐Heart Problems_____ Reviewed by:_____

Name: **Date:** **DOB:**

Review of Systems: **PLEASE PROVIDE THE FOLLOWING INFORMATION TO THE BEST OF YOUR ABILITY.**

Please check ***YES or NO*** to indicate whether you are **presently** having any of the following symptoms:

GENERAL
Yes No

☐ ☐ Chills

☐ ☐ Fatigue

☐ ☐ Weight Loss

☐ ☐ Weight Gain

☐ ☐ Daytime Sleepiness

SKIN
Yes No

☐ ☐Rash

☐ ☐Itching

☐ ☐Hives

☐ ☐Skin or Hair Changes

HEENT
Yes No

☐ ☐Hearing Loss

☐ ☐Dizziness

☐ ☐Nasal Congestion

☐ ☐Sense of Smell Problems

☐ ☐Hoarseness

☐ ☐Throat Clearing

☐ ☐Ear Noises

☐ ☐Ear Pain

☐ ☐Lightheaded

☐ ☐Sinus Pressure or Pain

☐ ☐Problem Snoring or Apnea

☐ ☐Throat Pain (Sore Throat)

☐ ☐Throat Dryness/Itching

☐ ☐Eye Pain

☐ ☐Watery or Itchy Eyes

RESPIRATORY
Yes No

☐ ☐Sneezing

☐ ☐Environmental Allergy

☐ ☐Post Nasal Drip

☐ ☐Cough

☐ ☐Wheezing

☐ ☐Coughing Blood

☐ ☐Shortness of Breath

CARDIAC
Yes No

☐ ☐Chest Pain

☐ ☐Palpitations

GASTROINTESTINAL
Yes No

☐ ☐Difficulty Swallowing

☐ ☐Heartburn

URINARY
Yes No

☐ ☐Frequent Urination

☐ ☐Painful Urination

MUSCULAR/SKELETAL
Yes No

☐ ☐Joint Aches

☐ ☐Muscle Aches

NEUROLOGICAL
Yes No

☐ ☐Headache

☐ ☐Fainting

PSYCHOLOGOCAL
Yes No

☐ ☐Depression

☐ ☐Mental Health Problems

ENDOCRINE
Yes No

☐ ☐Feel warmer than others (Heat Intolerance)

☐ ☐Feel cooler than others (Cold Intolerance)

HEMOTOLOGIC/LYMPHATIC
Yes No

☐ ☐Swollen Glands

☐ ☐Bleeding Disorders

☐ ☐Sweating at night

☐ ☐Easy Bruising

Privacy

June 11, 2002

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. If you have any questions about this Notice please contact our Privacy Officer at (240)361-9000.

This **Notice of Privacy Practices** describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information Based Upon Your Written Consent

You will be asked by your office to sign a consent form. Once you have consented to use and disclosure of your protected health information for treatment, payment and health care operations by signing the consent form, your physician will use or disclose your protected health information as described in this Section 1. Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice.

Following are examples of the types of uses and disclosures of your protected health care information that the physician's office is permitted to make once you have signed our consent form. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided consent.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you when we have the necessary permission from you to disclose your protected health information. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, marketing, and conducting or arranging for other business activities.

For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities

(e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization
Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your physician or another physician in the practice is required by law to treat you and the physician has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

Communication Barriers: We may use and disclose your protected health information if your physician or another physician in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the physician determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

2. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain

a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice use for making decisions about you.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewed. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Contact if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by sending a written request to our office.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Contact to determine if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

You have the right to opt out of regional health information exchange CRISP. We have chosen to participate in the Chesapeake Regional Information System for our Patients (CRISP), a regional health information exchange serving Maryland and D.C. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may "opt-out" and disable access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org Public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers.

3. Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Contact, at (240)361-9000 for further information about the complaint process.

This notice was published and becomes effective on June 11, 2002.