EASTERN SHORE ENT & Allergy ASSOCIATES, P.A.

JAMES R. GAUL · MICHAEL J. KELLEHER · DANIEL J. KELLEY | M.D.,F.A.C.S.
Offices located in Salisbury & Berlin
phone: +1 (410) 742-1567 fax: +1 (410) 742-1906

Thank you for choosing EASTERN SHORE ENT & ALLERGY ASSOCIATES, P.A. for your medical care. Our Providers and staff look forward to serving you with the highest quality care.

To help expedite the check in process, we ask that you complete the enclosed forms. Please be certain to PRINT your answers legibly to all questions, including the yes or no questions on the medical history, and sign all forms. You will need to bring all of the completed forms, including a current medication list and your most recent insurance cards with you at the time of your appointment.

If your health insurance requires a referral, you must contact your Primary Care Physician to obtain the referral **PRIOR** to arriving for your appointment. Health insurance carriers requiring a referral will not authorize us to see you without this written referral.

First time patients under the age of 18 require a parent or legal Guardian to accompany the patient to the first office visit.

With our consent form completed, for follow-up visits, an adult other than a parent or legal guardian may accompany the patient. Please understand we will not be able to see the patient without this information. We must have this on file for future visits.

We always make every effort to see our patients as close to their appointment time as possible. However, we are a surgical practice and are subject to emergency circumstances that are beyond our control. We ask for your patience should any delays occur.

You may visit our website at www.easternshoreent.com for other forms and practice information.

Sincerely,

Drs. Gaul, Kelleher & Kelley
106 Milford St. Suite 101, Salisbury, MD 21804
Info.esenta@gmail.com
(410) 742-1567 ext. 105 for scheduling
(Please listen carefully to the prompts)

P.S. - In order to avoid a charge for a NO-SHOW fee, please notify us within 48 hours of your scheduled appointment time.

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PATIENT REGISTRATION

(PRINT ONLY, both sides)

____/____/_____
(Today's Date)

Last Name _____ First Name _____ M.I. ___

Street Address _____

City _____ State _____ Zip Code _____

S.S.N. _____-_____-_____ D.O.B ____ /____ /_____ Sex _____ Marital Status _____

****

Patient's **Mobile** Phone Number (_____) _____-_____

Patient's **Home** Phone Number (_____) _____-_____

Patient's **E-Mail** Address _____@_____

Patient Employer _____

Work Phone Number (_____) _____-_____

****

Primary Care Physician_____

Practice Phone Number (_____) _____-_____

Referring Physician _____

Practice Phone Number (_____) _____-_____

Pharmacy Name _____

Pharmacy Address _____

Pharmacy Phone Number (_____) _____-_____

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This section MUST BE COMPLETED if the patient is under 18 OR is not the insured

Insured Parent/Guardian Name _____

Insured's S.S.N. _____-_____-_____ Insured's D.O.B _____ /_____ /_____

Insured's Address _____

Insured's Employer _____

Insured's Work Phone Number (_____) _____-_____

****

Emergency Contact _____ Relation _____

Emergency Contact Primary Phone Number (_____) _____-_____

****

Would you like to receive text reminders from our practice? Y / N

Would you like to receive automated voice call reminders from our practice? Y / N

Would you like access to the patient portal* (must provide e-mail address)? Y / N

*The patient portal gives you access to certain patient files, visit summaries, upcoming appointment reminders, and messages from our doctors.

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PATIENT AUTHORIZATION

I authorize Eastern Shore ENT & Allergy, P.A (ESENTA) to provide medical care and treatment to myself or patient named above if under the age of 18. I authorize ESENTA to apply for benefits on the patient's behalf for services rendered. I request the insurance make payment directly to ESENTA. I certify that the insurance coverage is correct. I further authorize the release of information, including medical information of any care or treatment of this or any related claims. I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at any time in writing prior to future treatment. My signature below indicates I have read and understand this authorization. I understand and agree to be fully responsible for payment of any service provided, including deductibles, copayments, and non-covered services at the time of service, unless other arrangements have been made.

_____

Patient Signature (Guardian Signature if patient is under 18) Signature Date

Revised June 2019

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REVIEW OF SYSTEMS Date: _____/_____/_____

Patient Name: _____ DOB:____/____/____ SS#:_____

Are you having any of the following symptoms TODAY?

Please circle "Yes" or "No" only

GENERAL/ CONSTITUTIONAL

Change in appetite	Yes	No
Chills	Yes	No
Fever	Yes	No

ALLERGY / IMMUNOLOGY

Hives	Yes	No
Itching	Yes	No
Rash	Yes	No
Wheezing	Yes	No
History of Immune deficiency	Yes	No

OPTHALMOLOGIC

Blurred vision	Yes	No
Dry Eye	Yes	No
Pain	Yes	No

ENDOCRINE

Cold intolerance	Yes	No
Excessive thirst	Yes	No
Frequent urination	Yes	No
Heat intolerance	Yes	No
Weight loss	Yes	No

RESPIRATORY

Coughing up blood	Yes	No
Pain with inspiration	Yes	No
Sputum production	Yes	No
Wheezing	Yes	No

CARDIOVASCULAR

Chest pain at rest	Yes	No
Difficulty laying flat	Yes	No
Irregular heartbeat	Yes	No

GASTROINTESTINAL

Abdominal pain	Yes	No
Blood in stool	Yes	No
Change in bowel habits	Yes	No
Constipation	Yes	No
Nausea	Yes	No
Vomiting	Yes	No

MUSCULOSKELETAL

Carpel Tunnel	Yes	No
Muscle Aches	Yes	No

PERIPHERAL VASCULAR

Ulceration of feet	Yes	No

SKIN

Hives	Yes	No
Itching	Yes	No
Rash	Yes	No

NEUROLOGIC

Tics	Yes	No
Loss of use of extremity	Yes	No
Tremor	Yes	No

PSYCHIATRIC

Mental or Physical abuse	Yes	No
Delusions	Yes	No

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PAST MEDICAL HISTORY **Date:** _____/_____/_____

PATIENT NAME _____ **DOB** ____/____/____ **SS#** _____

Acid reflux	yes	no	Hyperthyroidism	yes	no	Heart disease	yes	no
Heart attack	yes	no	Hypothyroidism	yes	no	Depression	yes	no
Sleep apnea	yes	no	Kidney disease	yes	no	Asthma	yes	no
Atrial fibrillation	yes	no	Lyme disease	yes	no	Lupus	yes	no
Carotid stenosis	yes	no	Malig. hyperthermia	yes	no	Epilepsy	yes	no
Cataracts	yes	no	Melanoma	yes	no	Thyroid Nodule	yes	no
Congestive heart failure	yes	no	Mitral valve prolapse	yes	no	High cholesterol	yes	no
COPD	yes	no	Multinodular goiter	yes	no	Hepatitis	yes	no
Deep vein thrombosis	yes	no	Organ Transplant	yes	no	High Blood pressure	yes	no
Diabetes	yes	no	Pulmonary embolism	yes	no	Cancer	yes	no
Emphysema	yes	no	Sarcoidosis	yes	no			
End stage renal disease	yes	no	Stroke	yes	no	Type of Cancer _____		
Grave's disease	yes	no	Bleeding disorder	yes	no	Other_____		

Do you have a pacemaker? Yes or no
Do you have a defibrillator? Yes or no
Do you use CPAP or BiPAP machine? Yes or no

Drug Allergies, including contrast dye: (if yes, list specific reaction)

_____

_____

Past Surgeries or Hospitalizations:

_____

_____

Past Family History: (if yes, specify relationship):

Allergies_____ Hearing loss_____ Malignant Hyperthermia_____
Cancer_____ Heart disease_____ Stroke_____
Diabetes_____ Hypertension_____ Other_____

Social History: (please circle answers)

SMOKING

Are you? Current Smoker Former Smoker Non-Smoker
How often do you smoke? Every day Some Days
How many cigarettes/cigars do you smoke a day? < 5 6-10 11-20 21-30 >31
How soon after you wake up do you smoke? 5 min 6-30 min 31-60 min >60 min
Are you interested in quitting? Yes No

ALCOHOL USE

Did you drink alcohol in the past year? Yes No
How often do you drink alcohol? Never Monthly 2-4 Times per Month 2-3 Times per Week >4 Times per Week
When you drink alcohol, how much do you typically drink? 1-2 Drinks 3-4 Drinks 5-6 Drinks 7-9 Drinks >10 Drinks
How often do you have more than 6 drinks on one occasion? Never < Monthly Monthly Weekly Daily

Do you have any religious beliefs, which prohibit Medical Treatment? Yes or No If yes, please explain_____

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Medication List as of _____/_____/_____

Patient Name _____ Date Of Birth:_____/_____/_____

Medication Name	Dosage Amount	Frequency

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PATIENT HIPAA ACKNOWLEDGMENT FORM

Use & Disclosure of Protected Health Information

Patient Name_____ **Date of Birth** ____/____/_____

Eastern Shore ENT & Allergy Associates, P.A.'s "Notice of Privacy Practices" provides information about how we may use and disclose protected health information about you. Please acknowledge review and receipt, if requested, of this office's **Notice of Privacy Practices** by initialing below:

_____ (Patient/Legal guardian)

Our **Notice of Privacy Practices** states that we reserve the right to change the terms described. Should this happen, you will receive a revised copy, if requested, either by mail or at your next appointment.

_____ (Patient/Legal guardian)

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions, but if we do, we are bound by our agreement with you.

_____ (Patient/Legal guardian)

By signing this form, you consent to our use, disclosure and receipt of protected health information about you for treatment, payment, and health care operations. Other than activities that have already occurred, you may revoke any further authorizations to use or disclose your health information.

Eastern Shore ENT & Allergy Associates, P.A. is authorized to discuss my medical health and treatment with:

_____
Name and Relationship of Individual (s) (if no one state "no one")

_____
Name and Relationship of Individual

_____
Name and Relationship of Individual

_____
Name and Relationship of Individual

_____
Signature Patient/Legal guardian ***Date***

Revised June 2019

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COLLECTION POLICIES, PROCEDURES, ACKNOWLEDGEMENTS & AGREEMENTS

Patient Name: _____ Date of Birth ____/____/____

ASSIGNMENT OF BENEFITS **-** I hereby authorize my insurance company(s) to make payment(s) as stipulated in my policy for any service furnished and that as such payment(s) be paid directly to the provider of service. I also understand that I am financially responsible for all services provided and agree to pay upon demand or as agreed for the related charges or remaining charges following my insurance payment(s).

CO-PAYS **-** I understand all co-pays will be collected at the time of service.

PRIOR BALANCES **-** All prior balances must be reconciled either by mail prior to, or at my next visit, whichever is sooner. The office accepts cash, check, money order, VISA, MASTERCARD and DISCOVER.

RETURNED CHECKS FEE **-** A $25.00 returned check fee will be applied to my account for all returned checks and we will NOT redeposit the check a second time. I will be required to pay the amount due by cash or money order.

MISSED APPOINTMENT FEE **-** I understand I may be charged a fee if I miss my appointment or do not cancel at least 48 hours prior to my appointment. This fee is not covered by my insurance carrier and must be paid prior to my next appointment.

COLLECTION FEES **-** I understand and acknowledge that if the patients account becomes delinquent (over 60 days), account balances (inclusive of all charges and reasonable collection costs including but not limited to reasonable collection agency/attorneys fees) may be sent to our collection agency/lawyer for legal collection action. The patient and/or guarantor or responsible party shall be responsible for and agree to pay all reasonable collection costs including but not limited to, reasonable collection agency fees, attorney's fees and court costs. In consideration of the acceptance of the patient named on this form by Eastern Shore ENT & Allergy Associates, PA and for services rendered or to be rendered to the patient, the undersigned promises to pay for and guarantees payment for all amounts due and any and all charges including collection costs described. If payments due are not made as agreed, Eastern Shore ENT & Allergy Associates, PA may, without notice or demand, declare the entire unpaid balance of the account including collection costs agreed to as described to be immediately due and payable. If court action is necessary to enforce payment, the venue for any such court action shall be Wicomico County, Maryland unless Provider elects otherwise. The undersigned waives any objection to venue or jurisdiction. A copy of this Agreement shall be made as valid as the original.

I HAVE READ, ACKNOWLEDGE AND AGREE TO ALL OF THE ABOVE COLLECTION POLICIES, PROCEDURES, ACKNOWLEDGEMENTS AND AGREEMENTS. Please print, sign and date below.

Patient/Guarantor Signature_____

Print Name _____Relationship to Patient: _____ Date: ___/___/___

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NOTICE OF PRIVACY PRACTICES (NPP) HIPAA

"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: Cindi Krempel, Practice Administrator, Eastern Shore ENT & Allergy Associates, P.A., 106 Milford Street, Suite 101, Salisbury, MD 21804 ** (410)742-1908.

Each time you visit a physician or other health care provider, a record of your symptoms, examination and test results, diagnosis, treatment, and a plan for future care are recorded. This information is most commonly referred to as your "medical record", and serves as the basis for planning your care and treatment. Your medical record serves as a means of communication among the health professionals providing your care. Understanding your medical record and its contents will help you ensure its accuracy and under what circumstances others may access your health information. This effort is being made to assist you in making informed decisions before authorizing disclosure of your medical information to others. Use or disclosure of your medical information will follow the more stringent of State or Federal laws. Our office reserves the right to change its practices and may be required to in order to enhance the privacy standards of all patients from time to time. You may call our office to request a revised copy of this **Notice of Privacy Practices** be mailed to you or ask for a revised copy at the time of your next appointment.

Understanding your health information rights

You have the right to request restrictions on certain uses and disclosures of your information, and to request, in writing, amendments be made to your health record. Your right include being able to review or obtain a copy of your health information, as well as an account of all disclosures. Other than activities that have already occurred, you may revoke any further authorizations to use or disclose your health information.

Our responsibilities

Our office is required to maintain the privacy of your health information and to provide you with notice of our legal commitment and privacy practices with respect to the information we collect and maintain about you. This office is required to abide by the terms of this notice and to notify you if we are unable to grant your requests or reasonable desires in communicating your health information.

To receive additional information or report a problem

For further explanation of this notice, you may contact Cindi Krempel, Practice Administrator at (410)742-1908. If you believe your privacy rights have been violated, you have the right to file a complaint with this office by contacting the individual above, or by contacting the Secretary of Health and Human Services with no fear of retaliation by this office.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)

You will be asked to sign a consent form authorizing this office to use and disclose your PHI for treatment, payment, and health care operations. Your PHI may be used and disclosed by our physicians or office staff involved in providing your care and treatment.

Your health information will be used for treatment, payment, and health care operations. The following describes examples of uses and disclosures that may be made by our office staff or physicians.

Treatment – Information obtained by your health care provider in this office will be recorded in you medical record and used to determine the plan of treatment best for you. We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. We may disclose your PHI to other physicians who may be treating you or to a physician to whom you are being referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment – Your health care information will be used in order to receive payment for services rendered by this office. A bill or claim may be sent to either you or a third-party payer with accompanying information that identifies you, your diagnosis, and procedures performed. This may include the release of information to obtain eligibility of coverage and/or pre-approval for planned procedures and treatments as well as medical necessity and utilization review activities required by your health insurance plan.

Healthcare Operations – The physicians and staff in this office will use you health information to assess the care you received and the outcomes of your care. Your information may be reviewed for risk management or quality improvement purposes in our efforts to continually improve the quality and effectiveness of the care and services we provide. We will share your PHI with third party "business associates" that perform various activities (e.g. billing and transcription services) for this office. Whenever an arrangement between our office and a business associates involves the use or disclosure of your PHI, we will have a written contract incorporating privacy standard requirements.

Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted, required by law, or examples as described below. Other than activities that have already occurred, you may revoke any further authorizations to use or disclose your health information.

- Contact you and/or leave a message with appointment reminders
- Contact you regarding treatment information, leave message to call office if you are unavailable
- Contact a family member or friend designated by you in case of emergencies
- Required by law (e.g. subpoena, reporting of communicable diseases, reporting of abuse or neglect)
- Food and Drug Administration
- Workmen's Compensation

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

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PARENTAL DESIGNATION FORM AUTHORIZING TREATMENT OF A MINOR

I, _____am the:

Print your name

- ○ **Natural or adoptive parent of**
- ○ **Guardian of**
- ○ **Person, who, under court order, is authorized to give consent for**

The minor, _____Date of birth___/___/___

Print the name and date of birth of the minor

I authorize, Eastern Shore ENT & Allergy Associates, PA, to discuss and provide medical treatment of the above named minor with the following authorized adult(s) (ie: grandparents, adult siblings, adult aunt/uncles, step-parents, etc):

Name:_____ Relation to Minor:_____

Name:_____ Relation to Minor:_____

Name:_____ Relation to Minor:_____

Name:_____ Relation to Minor:_____

Name:_____ Relation to Minor:_____

_____ _____

Signature of Parent or Guardian | Witness

_____ _____

Date | Date

Revised June 2019