EASTERN SHORE
ENT & Allergy
ASSOCIATES, P.A.

NATHAN DECKARD · MICHAEL KELLEHER
DANIEL KELLEY | M.D., F.A.C.S.
LAURA KING | P.A.
ETHAN CRAIG | P.A.-C

Salisbury Office: (410) 742-1567
Berlin Office: (410) 641-4582
Cambridge Office: (410) 901-3433

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 18 require a parent or legal guardian to accompany the patient to the first office visit.

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

106 Milford Street, Suite 101, Salisbury, MD 21804

Info.esenta@gmail.com

(410) 742-1567, ext. 124 for scheduling

(Please listen carefully to the prompts.)

P.S. To avoid a charge for a NO-SHOW fee, please notify us within 48 hours of your scheduled appointment time that you need to cancel/reschedule your appointment.

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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 (if over 18 years old) (_____) _____ - _____

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

Patient's Email Address _____ @ _____

Primary Care Physician _____ Phone Number _____

Referring Physician _____ Phone Number _____

Pharmacy Name _____

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 Phone Number _____ Insured's Work Phone Number _____

Emergency Contact _____ Relationship _____

Emergency Contact Primary Phone Number _____

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REVIEW OF SYSTEMS

_____ / _____ / _____
(Today's Date)

Patient Name _____

D.O.B. _____ S.S.N. _____

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

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

ALLERGY/IMMUNOLOGY

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

MUSCULOSKELETAL

Carpel tunnel	Yes	No
Muscle aches	Yes	No

OPHTHALMOLOGIC

Blurred vision	Yes	No
Dry eye	Yes	No
Pain	Yes	No

PERIPHERAL VASCULAR

Ulceration of feet	Yes	No

SKIN

Hives	Yes	No
Itching	Yes	No
Rash	Yes	No

ENDOCRINE

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

NEUROLOGIC

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

RESPIRATORY

Coughing up blood	Yes	No
Pain with breathing in	Yes	No
Sputum production	Yes	No
Wheezing	Yes	No

PSYCHIATRIC

Mental or physical abuse	Yes	No
Delusions	Yes	No

CARDIOVASCULAR

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

Revised December 2023

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PAST MEDICAL HISTORY

_____ / _____ / _____
(Today's Date)

Patient Name _____

D.O.B. _____ S.S.N. _____

Acid reflux	Yes	No	Cataracts	Yes	No	Emphysema	Yes	No
Hyperthyroidism	Yes	No	Melanoma	Yes	No	Sarcoidosis	Yes	No
Heart disease	Yes	No	Thyroid nodule	Yes	No	End-stage renal disease	Yes	No
Heart attack	Yes	No	Congestive heart failure	Yes	No	Stroke	Yes	No
Hypothyroidism	Yes	No	Mitral valve prolapse	Yes	No	Austim or other		
Depression	Yes	No	High cholesterol	Yes	No	developmental disorder	Yes	No
Sleep apnea	Yes	No	COPD	Yes	No			
Kidney disease	Yes	No	Multinodular goiter	Yes	No	Type of Cancer _____		
Asthma	Yes	No	Hepatitis	Yes	No	_____		
Atrial fibrillation	Yes	No	Deep vein thrombosis	Yes	No			
Lyme disease	Yes	No	Organ transplant	Yes	No	Grave's disease	Yes	No
Lupus	Yes	No	High blood pressure	Yes	No	Bleeding disorder	Yes	No
Carotid stenosis	Yes	No	Diabetes	Yes	No			
Malignant hyperthermia	Yes	No	Pulmonary embolism	Yes	No	Other _____		
Epilepsy	Yes	No	Cancer	Yes	No			

Do you have a pacemaker?	Yes	No	Do you have any metal clips, stents plates, or rods?	Yes	No
Do you have a defibrillator?	Yes	No	Are you claustrophobic?	Yes	No
Do you use a CPAP or BiPAP machine?	Yes	No	Any recent blood work done?	Yes	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 _____

SMOKING *(Please check box)*

Are you? ☐ Current Smoker ☐ Former Smoker ☐ Nonsmoker

How often do you smoke? ☐ Every Day ☐ Some Days

How many cigarettes/cigars do you smoke a day? ☐ <Five ☐ Six to 10 ☐ 11–20 ☐ 21–30 ☐ >31

How soon after you wake up do you smoke? ☐ Five min ☐ Six to 30 min ☐ 31–60 min ☐ >60 min

Are you interested in quitting? ☐ Yes ☐ No

ALCOHOL USE *(Please check box)*

Did you drink alcohol in the past year? ☐ Yes ☐ No

How often do you drink alcohol? ☐ Never ☐ Monthly ☐ Two to Four Times per Month
☐ Two to Three Times per Week ☐ >Four Times per Week

When you drink alcohol, how much do you typically drink? ☐ One to Two Drinks ☐ Three to Four Drinks
☐ Five to Six Drinks ☐ Seven to Nine Drinks ☐ >10 Drinks

How often do you have more than six drinks on one occasion? ☐ Never ☐ <Monthly ☐ Monthly ☐ Weekly ☐ Daily

Do you have any religious beliefs that prohibit medical treatment? ☐ Yes ☐ No
If yes, please explain. _____

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Medication List as of _____/_____/_____

Patient Name _____ Date Of Birth _____

Medication Name	Dosage Amount & Frequency	Reason

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COLLECTION POLICIES, PROCEDURES, ACKNOWLEDGEMENTS, AGREEMENTS & AUTHORIZATIONS

Patient Name _____ D.O.B. _____

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 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 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, checks, money orders, Visa, Mastercard and Discover.

RETURNED CHECK FEE—We will apply a $25.00 returned check fee to my account for all returned checks and will NOT redeposit the check a second time. I will be required to pay the amount due by cash or money order.

COLLECTION FEES—I understand and acknowledge that if a patient's account becomes delinquent (over 60 days), account balances (inclusive of all charges and reasonable collection costs, including but not limited to a reasonable collection agency/attorneys' fees) may be sent to our collection agency/lawyer for legal collection action. The patient, 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, attorneys' fees and court costs.

In consideration of the acceptance of the patient named on this form by Eastern Shore ENT & Allergy Associates, P.A., 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, P.A. 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 the 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.

PATIENT AUTHORIZATION—I authorize Eastern Shore ENT & Allergy, P.A. (ESENTA) to provide medical care and treatment to myself or the patient named above if they are under 18. I authorize ESENTA to apply for benefits on the patient's behalf for services rendered. I request the insurance make payments 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 the payment of any service provided, including deductibles, copayments and noncovered services at the time of service, unless other arrangements have been made.

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 Tammy Mascara, Office Manager, 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, they record your symptoms, examination, test results, diagnosis, treatment and a plan for future care. 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 understand 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. The use or disclosure of your medical information will follow the more stringent of the state or federal laws. Our office reserves the right to change its practices and may be required to do so in order to enhance the privacy standards of all patients from time to time. You may call our office to request that a revised copy of this Notice of Privacy Practices be mailed to you or ask for a revised copy at 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 rights 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 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 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 Tammy Mascara, Office Manager, 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 our office staff or physicians may make.

Treatment—Information obtained by your health care provider in this office will be recorded in your medical record and used to determine the best treatment plan 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 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 any procedures performed. This may include the release of information to obtain eligibility for coverage or preapproval for planned procedures and treatments, as well as medical necessity and utilization review activities required by your health insurance plan.

Health Care Operations—The physicians and staff in this office will use your 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 associate 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 described in the examples below. Other than activities that have already occurred, you may revoke any further authorizations to use or disclose your health information.

- Contact you and leave a message with appointment reminders
- Contact you regarding treatment information and leave a message to call the 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
- Workers' 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 to provide faster access and 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 via mail, fax or 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.

Revised June 2019

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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 your protected health information. Please acknowledge your 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") Phone Number

_____

Name and Relationship of Individual Phone Number

_____

Signature Patient/Legal Guardian Date

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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, P.A. to discuss and provide medical treatment for the above-named minor with the following authorized adult(s) (e.g., grandparents, adult siblings, adult aunts/uncles, stepparents, etc.):

Name _____ Relation to Minor _____

Name _____ Relation to Minor _____

Name _____ Relation to Minor _____

_____ _____
Signature of Parent or Guardian Witness

_____ _____
Date Date

Revised December 2023