ENT Specialists Of North Florida
SPECIALTY CARE YOU CAN TRUST

Please answer all questions completely. A Division of North Florida Surgeons

I. Patient Information

Name: **LAST** _____ **FIRST** _____ **MI**____
Sex ____ DOB ___/___/___ Age: _____ SS# _____-_____-_____
Patient Address: _____
City _____ ST _____ ZIP _____
Home Phone: _____ Cell Phone _____
Email Address _____
Person Responsible For Bill (If other than patient) _____
Race: White___ Black___ Native American___ Asian___ Pacific Islander___
Ethnicity: Hispanic or Latino___ Non-Hispanic___
Employer's Name: _____ Phone #: _____
Employer's Address: _____
City _____ ST _____ Zip _____
Spouse's Name: _____
Name of Emergency contact (other than spouse) _____
Relationship_____ Phone #: _____

II. Insurance

PRIMARY INSURANCE COVERAGE:
Policy holders (subscriber's) name: _____ DOB _____
Policy holder's SS#: _____ Sex: M F
Your relationship to policy holder: _____
Policy #: _____ GRP# _____
Policy holder's employer: _____
Employer's address: _____ Phone #: _____

SECONDARY INSURANCE COVERAGE:
Policy holders (subscriber's) name: _____ DOB _____
Policy holder's SS#: _____ Sex: M F
Your relationship to policy holder: _____
Policy #: _____ GRP# _____
Policy holder's employer: _____
Employer's address: _____ Phone #: _____

III. PHYSICIAN INFORMATION

Referring Physician_____
Primary Care Physician _____

I certify that, to the best of my knowledge, the above information is complete and accurate.
SIGNATURE: _____ Date: _____
Witness _____

Patient Name: _____ **Today's Date:** _____

Date of Birth: _____

Other treating physicians: _____

Pharmacy Name and Location: _____

Pharmacy Phone Number: _____

Why are you or your child seeing us today? (Describe in detail what is bothering you, when it started, treatments, and tests performed.)

_____

_____

_____

Medical History (List all hospitalizations and illnesses for which you have been treated, e.g. diabetes, hypertension, etc.)

_____

_____

_____

_____

Surgical History (List all operations and major injuries.)

_____

_____

_____

_____

Allergies and Adverse Reactions (Include allergies to antibiotics, Latex, X-ray, dye, skin preps, pain medications if applicable.)

_____

_____

Current Medications (Include insulin, steroids, inhalers, oxygen, eye drops, etc.)

Drug	Dose	Frequency	Drug	Dose	Frequency

SOCIAL HISTORY:

Marital Status:		**Tobacco:**		**Alcohol:**		**Drug Use:**	
Single	☐	None	☐	None	☐	Marijuana	☐
Married	☐	Yes	☐	Minimal	☐	Cocaine	☐
Divorced	☐	(Packs per day)	☐	Moderate	☐	Crack	☐
Widowed	☐	Past Use	☐	Heavy	☐	Heroin	☐
		Smokeless	☐	Previous	☐	Other	☐

Family History (Please include history of diabetes, heart disease, hypertension, or cancer, age, alive or deceased (cause of death).)

Father _____ Mother _____

Brothers/Sisters _____

General

	Yes?
Recent increase__ decrease__ in appetite	
Weight gain_____ or loss_____	
Fevers	
Chills	
Sweats	

Neurological	**Yes?**
Dizziness	
Loss of consciousness	
Transient loss of function	
Stroke	
Seizures	

Eyes	**Yes?**
Recent visual changes or double vision	
Presbyopia (need bifocals)	
Cataracts	
Glaucoma	

Head	**Yes?**
Occasional mild headaches	
Migraines	
Recent trauma or concussion	

Emotional	**Yes?**
Anxiety	
Depression	
Psychiatric therapy	
Current treatment?	

Ears	**Yes?**
Ringing	
Infection	
Drainage	
Pain	
Mild hearing loss	
Hearing impaired	
Use hearing aid	

Endocrine	**Yes?**

Nose/Throat	**Yes?**
Frequent nose bleeds	
Bleeding gums	
Sores in mouth or lips	
Difficulty swallowing	
Hoarseness	
Chronic sinus congestion	
Allergies	
Hay fever	
Loose/broken teeth	
Dentures	
Loud snoring	

Lung	**Yes?**
Wheezing	
Chronic cough	
Emphysema	
COPD	
Coughing up blood	
TB or positive skin test	
Sleep apnea	
Use CPAP	
Pulmonary embolus	
Asthma	

Hematologic	**Yes?**
Anemia	
Bruise easily	
Excessive bleeding	
Swollen glands	
Leukemia	
Lymphoma	
Transfusions	
Blood clots	
Phlebitis	
Deep venous thrombosis	

Skin	**Yes?**
Rash	
Psoriasis	
Non-healing lesions	

Thyroid disorder	
Taking thyroid medication	
Heat or cold intolerance	
Diabetes under treatment	
Excessive thirst, hunger, or urination	
Adrenal or pituitary disorder	

Digestive	**Yes?**
Abdominal pain	
Nausea or vomiting	
Bloating	
Heartburn or GERD	
Diarrhea or constipation	
Cirrhosis or jaundice	
Gallstones	
Black stools or blood in stool	
Hemorrhoid problems	
History of cancer, Crohn's disease	
Diverticulosis, or irritable bowel disease	

History of skin cancer or melanoma	

Infections	**Yes?**
HIV Positive	
History of hepatitis (type _____)	
Staph infections	
MRSA or ORSA	

Heart	**Yes?**
Chest pain or angina	
Heart skips	
Rapid heart rate	
Exertional shortness of breath	
Cardiac testing within last year	
Heart attack	
Atrial fibrillation	
Pacemaker	
Mitral valve prolapse	
Hypertension	

Patient's Signature:_____ **Date:** _____

Reviewed by: _____

ENT Specialists Of North Florida

A Division of North Florida Surgeons

Dr. Jason Meier Dr. Michele Hargreaves Dr. Saswata Roy
Phone: 904-880-0911 Fax: 904-880-9388

Nasal Endoscopy / Laryngoscopy Billing Information Form

Please be advised there are times when Dr. Meier, Dr. Roy or Dr. Hargreaves need to perform an in-office procedure to correctly diagnose and treat problems of the nose and throat. This is accomplished with the use of a **Nasal Endoscope/ Laryngoscopy**.

It is a specialized tool used to help diagnose or detect problems such as nasal polyps, nasal blockage, recurrent sinusitis and other diseases of the nose or throat.

An Endoscopy is a quick and painless in-office procedure. After spraying your nasal passages to anesthetize the lining and shrink tissue, a thin tube or endoscope is inserted into the nasal passage to visualize the internal anatomy of the nose, sinuses and throat.

Insurance companies always consider endoscopies a **surgical procedure**. We do not have control over how endoscopies are processed by insurance companies. This form is to notify you in advance so you are not surprised when you receive your explanation of benefits that states a Surgical Service was provided. Your insurance company may reimburse a surgical service at a different rate then an office visit.

The nasal endoscopy or Laryngoscopy procedure is often applied toward your deductible and co-insurance. You are responsible for the fee associated with the nasal endoscope at checkout. To find out what your financial responsibility for this procedure may be, contact your insurance carrier and request coverage information for CPT codes: **31231, 31575**.

I have read the above information and understand my insurance company may reimburse an endoscopy as a surgical service with the deductible and co-insurance guidelines applied. I also agree to the financial responsibility established by my insurance carrier according to my individual policy.

Patient Name: _____ Date: _____

Patient Signature: _____

Guardian Name: _____ Signature: _____

NORTH FLORIDA SURGEONS, P.A.
FINANCIAL AGREEMENT

PATIENT INFORMATION

DATE: _____

PATIENT'S NAME: _____
Last First M.I.

ADDRESS: _____

BIRTHDATE: ____/____/____ **DAYTIME TELEPHONE NUMBER:** _____
Month Day Year

SOCIAL SECURITY #: _____ **CELL PHONE*:** _____

E-MAIL*: _____

*If you provide your e-mail and/or cell phone to us, we may use such information to contact you by e-mail and/or text for marketing of services provided by North Florida.

PRIVACY NOTICE ACKNOWLEDGMENT

North Florida Surgeons, P.A. consists of wholly-owned subsidiaries where medical services are provided (collectively referred to herein as "**North Florida**"). I acknowledge that I have received and read a copy of **North Florida** Privacy Notice ("Notice") to review. **North Florida** has the right to revise this Notice at any time and will post a copy of the current Notice in the office in a visible location and on their website at www.nflsurgeons.com at all times. **North Florida** will provide me with a copy of its most recent Notice upon my request.

E-MAIL CONSENT

I acknowledge that I have received and read a copy of **North Florida** E-mail Consent. I understand that if I want to correspond with **North Florida** by e-mail that I must agree to the terms of the E-mail Consent, check the appropriate box and sign below.

☐ **I WANT** to correspond with **North Florida** by e-mail. I understand the risks associated with the communication of e-mail between **North Florida** and me. I consent to the conditions outlined in the E-mail Consent. Any questions I may have had were answered to my satisfaction.

Patient Signature: _____ **Date:** _____
Parent, Guardian or Legal Representative Signature: _____
Relationship to Patient: _____

☐ **I DO NOT** want to correspond with **North Florida** by e-mail.

RESPONSIBILITY TO PROVIDE PROOF OF INSURANCE AND OBTAIN REFERRAL

I understand that it is my responsibility to provide **North Florida** with a copy of my current insurance card and to obtain a referral from my Primary Care Physician (if required by my insurance). **North Florida** is not obligated to see patients without a valid referral. If I do not have insurance, I will be considered a Private Pay patient and be financially responsible for the total amount of the services provided. I will notify **North Florida** immediately upon any change in my insurance.

FINANCIAL RESPONSIBILITY

I understand that in consideration of the services provided to the patient, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered at **North Florida**. I am responsible for any applicable deductible or co-payments prior to the provision of services. **North Florida** will provide me with an estimate of my total financial responsibility and the date by which this amount must be paid in full. I understand that due to the individual needs of each treatment, or procedure this fee is only an estimate. In the event my care exceeds the amount of the estimate, I will be financially responsible for the balance. I further understand that such payment is not contingent on any insurance, settlement or judgment payment. **North Florida** may file a claim for payment with my insurance company as a courtesy to me. If the insurance company fails to pay **North Florida** in a timely manner for any reason, then I understand that I will be responsible for prompt payment of all amounts owed to **North Florida**. Should the account be referred to a collection agency or attorney for collection, the undersigned agrees to pay the collection agency's fee (based on a percentage of your account balance, the current percentage is 33%) and all costs of collection, including a reasonable attorney's fee.

CREDIT CARD ON FILE

I provide a valid credit card (the credit card has not expired and has not reached its available credit limit) to be retained on file to pay any balance owed for my medical services. In the event that my credit card expires or has reached its limit, I am responsible to provide a new valid credit card. I further understand that the billing address for the credit card on file must match the address that appears on my monthly credit card bill or bank statement. I agree to pay such total amount charged in accordance with the agreement governing the use of such credit card. I hereby authorize **North Florida** to charge my credit card for payment of the medical services rendered. If I have entered into a payment plan, I authorize **North Florida** to charge my credit card to pay the payments owed under the payment plan.

Exact name as it appears on credit card: _____
Circle Card Type: __ VISA __ M/C __ AMEX __ DISCOVER
Card #: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __
Verification #: _____
[*Visa & MasterCard number appears as 3 digit number on the back of the card. American Express number appears as a 4 digit number printed on the front of the credit card after and to the right of the card number.]
Expiration Date: _ _ / _ _
Cardholder's Signature: _____ Date: ___ / ___ / ___

NON-COVERED SERVICES WAIVER

I understand that charges for my care will be filed with my insurance carrier as a courtesy by **North Florida**. There may be a service that I desire that is not covered under my insurance plan ("Non-Covered Services"). I understand that I will be financially responsible for the cost of any Non-Covered Services. A separate waiver will be completed for each Non-Covered Service. If I have Medicare, I will complete an Advance Beneficiary Notice ("ABN") form.

INSURANCE WAIVER

I understand that if I do not have a copy of a current insurance card and valid referral, if required, that I can be seen as a "Private Pay" patient. I agree that neither **North Florida** nor I will file a claim for the visit. A waiver will be completed for each visit that I am seen as a Private Pay patient. I will be required to pay the total cost of the visit in advance.

ASSIGNMENT OF BENEFITS

I hereby authorize and assign all payments and/or insurance benefits for medical services and/or surgical procedures rendered to patient, directly to **North Florida**. I hereby authorize **North Florida** to release medical information necessary to obtain payment. I understand that I am financially responsible for all charges not covered by my insurance plan.

ASSIGNMENT OF MEDICARE BENEFITS

I hereby authorize and assign all payments of authorized Medicare benefits for medical services and/or surgical procedures rendered to patient, directly to **North Florida**. I hereby authorize **North Florida** to release medical information necessary to obtain payment. I understand that I am financially responsible for all charges not covered by Medicare for which I have signed an ABN.

ARBITRATION

THIS ARBITRATION AGREEMENT is made between **North Florida Surgeons, P.A.**, for and on behalf of itself and its subsidiaries, affiliated professional associations, physicians (including physicians providing medical services through a subsidiary of North Florida Surgeons, P.A.), agents, employees, servants, or any of the foregoing, referred to hereinafter as "Doctor" and the above referenced patient ("Patient"). It is the intention of the parties to this Arbitration Agreement to bind not only themselves, but also their heirs, personal representatives, guardians and any persons deriving claims through or on behalf of the patient.

It is understood by the Patient that he or she is not required to use **North Florida Surgeons, P.A**. or any Doctor and that there are numerous other physicians located near Patient who are qualified to provide care to Patient.

In the event of any controversy or dispute, which might arise between Doctor and the Patient, regardless of whether the dispute concerns the medical care rendered, including any negligence claim relating to the diagnosis, treatment, or care of the Patient, or payment of surgical fees, or any other matter whatsoever, then the parties agree that the dispute shall be resolved by arbitration as provided by the Federal Arbitration Act, 9 U.S.C. §§ 1-16.

Other than what may be in conflict with this Arbitration Agreement, the laws of the State of Florida shall apply to any dispute between Doctor and the Patient. The Florida Rules of Civil Procedure shall apply for discovery purposes only.

Prior to commencing any action under this Arbitration Agreement, Patient must comply with the presuit notice and investigation requirements of Chapter 766, Florida Statutes. Any arbitration under this Arbitration Agreement must be commenced by the filing of an application for arbitration within the applicable statute of limitations for the controversy or dispute at issue.

This arbitration shall be in lieu and instead of any trial by Judge or Jury. Each party shall choose one arbitrator and the two arbitrators shall choose a third arbitrator. All arbitrators shall be selected from the following Florida counties: Alachua, Clay, Duval, Nassau, St. Johns and Volusia. The panel of arbitrators shall hear and decide the controversy, and the decision shall be binding on all parties and may be enforced by a court of law if necessary. Arbitration shall be conducted in Duval County, Florida.

In the event that either party to this Arbitration Agreement refuses to go forward with arbitration, the party compelling arbitration reserves the right to proceed with arbitration, including the appointment of the arbitrator and hearings to resolve the dispute, despite the refusal to participate or the absence of the opposing party. The arbitrators shall render a binding decision without the participation of the party opposing arbitration or despite his or her absence at the arbitration hearing.

ARBITRATION - Continued

Except for legal reporting requirements, all arbitration proceedings and outcomes under this Arbitration Agreement will be confidential and private. The parties shall be required to attend non-binding mediation in Duval County, Florida prior to arbitration.

The Patient understands that the Patient has a constitutional right under Article 1, Section 21 of the Florida Constitution of Access to Courts as follows: "The courts shall be open to every person for redress of any injury, and justice shall be administered without sale, denial or delay." The Patient understands and acknowledges that signing this Arbitration Agreement waives this constitutional right.

Should any sentence(s) of this Arbitration Agreement be declared unenforceable or in conflict with the law, the sentence(s) shall be severed and the validity of the remaining parts and provisions shall not be affected by such holding.

The Patient has had an opportunity to read this Arbitration Agreement, or to have it read to him or her if necessary. The Patient understands English or has had this Arbitration Agreement translated for him or her by _____. The Patient has had an opportunity to ask questions about this Arbitration Agreement. The Patient understands this Arbitration Agreement and has no unanswered questions.

Patient Initials: _____

ARBITRATION - Continued

The Patient has not been coerced or compelled to sign this Arbitration Agreement, and does so of his or her own free will. The Patient may consult with an attorney before signing this Arbitration Agreement.

BY SIGNING THIS ARBITRATION AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO ALL OF THE ABOVE TERMS AND CONDITIONS.

Patient Signature: _____ **Date:** _____

Parent, Guardian or Legal Representative Signature: _____

Relationship to Patient: _____

Witness Signature: _____

Physician Signature: _____

SIGNATURE

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO ALL OF THE TERMS AND CONDITIONS CONTAINED IN THIS AGREEMENT.

Patient Signature: _____ **Date:** _____

Parent, Guardian or Legal Representative Signature: _____

Relationship to Patient: _____

Witness Signature: _____

ENT Specialists
OF NORTH FLORIDA
SPECIALTY CARE YOU CAN TRUST

A Division of North Florida Surgeons

11701-32 San Jose Boulevard Suite 103~Jacksonville~Florida~32223
Phone: 904.880.0911 Fax: 904.880.9388

Medical Information Release Form
(HIPAA Release Form)

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

Release of Information

[ ] I authorize the release of information including the diagnosis, records; Examination rendered to me and claims information. This information may be released To:

[ ] Spouse_____

[ ] Child (ren) _____

[ ] Other_____

[ ] Information is not to be released to anyone.

Messages

[ ] Please call [ ] my home [ ] my work [ ] my cell number: _____
If unable to reach me:

[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] _____

[ ] Please email me at: _____

Signed: _____ Date: ____/____/_____

Witness: _____ Date: ___/____/_____

ENT Specialists
OF NORTH FLORIDA
SPECIALTY CARE YOU CAN TRUST

A Division of North Florida Surgeons

11701-32 San Jose Blvd · Suite 103 · Jacksonville, FL 32223 · (904)880-0911
Fax (904)880-9388

Medical Release Form

Date_____

I, _____, hereby authorize the release of
records from (Doctor or Office) _____
at (address) _____
to (Doctor or Office)_____
at (address) _____
Information released is to include the diagnosis and records of any treatment
or examination rendered to me during the period from_____.
to _____.

Patient name (at the time services rendered): _____

Date of Birth: _____ SS#: _____

_____
Signature of Patient or Guardian

_____
Address

_____
Telephone

ENT Specialists Of North Florida

A Division of North Florida Surgeons

Dr. Jason Meier Dr. Michele Hargreaves Dr. Saswata Roy
Phone: 904-880-0911 Fax: 904-880-9388

NASAL ENDOSCOPY /LARYNGOSCOPY CONSENT FORM

How do we look into your nose, sinuses and throat? When you come to ENT Specialists Of North Florida with a nose or throat related problem, the doctors may want to perform an endoscopy. This is a surgical procedure using sterile small cameras to look through the nostrils into the deeper places of the nose and throat. This may allow your doctor to:

- Better evaluate your nose, sinuses and throat
- evaluate previous surgery, scar, openings, masses, polyps, causes of blockage
- evaluate healing or complications of surgery
- remove old blood, foreign material, packing, and scabs/scar/blockage

The staff will have you sign this permission form first and then offer to spray your nose to make the procedure easier. The spray is a combination of Afrin (to shrink tissue) and Pontacaine (to numb). This spray does taste bad and can cause teeth/throat numbness that wears off in about 20-30 minutes. Some patients may also have a sensation that they can't swallow - do NOT panic – this will pass.

YOUR CONSENT:

The procedure and description of this procedure, the more common risks associated with it and the potential complications have been described to me. This includes: a small amount of pain/pressure, a mild amount of bleeding, and a reaction to the nasal spray. I have had an opportunity to ask questions. I am satisfied with my understanding and the responses that I have received. I hereby authorize ENT Specialists of North Florida personnel to perform a nasal endoscopy/ laryngoscopy. I hereby authorize the doctor or his/her associates, to provide such additional services as he or they may consider being medically advisable, including but not limited to suctioning, culturing the drainage, biopsies and packing if needed.

Patient Name: _____

Patient Signature: _____ Date: _____

Guardian Name: _____ Guardian Signature: _____