BRYAN LEATHERMAN, M.D.

PATIENT DEMOGRAPHIC INFORMATION

Last Name _____ **First Name** _____ **Middle** _____

Preferred Name _____ **Maiden** _____ **Prefix** _____ **Suffix** _____

DOB _____ **Sex** _____ **SSN** _____ **Ethnicity** _____

Marital Status _____ **Driver's License #** _____ **Primary Language** □ **English** □ **Other** _____

Address Line 1 _____ **Line 2** _____

Zip _____ **City** _____ **State** _____ **County** _____

Home Phone _____ **Work** _____ **Cell** _____ **Email** _____

Preferred Communication: □ **Home** □ **Cell** □ **Work**

Employer _____ **Status** _____ **Occupation** _____

Primary Care Physician or Pediatrician _____

Preferred Pharmacy _____ **Phone** _____

RESPONSIBLE PARTY DEMOGRAPHIC INFORMATION

Last Name _____ **First Name** _____ **Middle** _____

Preferred Name _____ **Maiden** _____ **Prefix** _____ **Suffix** _____

DOB _____ **Sex** _____ **SSN** _____ **Ethnicity** _____

Marital Status _____ **Driver's License #** _____ **Primary Language** □ **English** □ **Other** _____

Address Line 1 _____ **Line 2** _____

Zip _____ **City** _____ **State** _____ **County** _____

Home Phone _____ **Work** _____ **Cell** _____ **Email** _____

Preferred Communication: □ **Home** □ **Cell** □ **Work**

Employer _____ **Status** _____ **Occupation** _____

PRIMARY INSURANCE INFORMATION

Insurance Company_____ Name of Insured_____

Address_____ Date of Birth_____

Phone_____ SSN#_____

Policy #_____ Driver's License #_____

Group#_____

Employer_____

Patient Relationship to Insured: □ Self □ Spouse □ Child □ Other

SECONDARY INSURANCE INFORMATION

Insurance Company_____ Name of Insured_____

Address_____ Date of Birth_____

Phone_____ SSN#_____

Policy #_____ Driver's License #_____

Group#_____

Employer_____

Patient Relationship to Insured: □ Self □ Spouse □ Child □ Other

ADDITIONAL INSURANCE INFORMATION

Insurance Company_____ Name of Insured_____

Address_____ Date of Birth_____

Phone_____ SSN#_____

Policy #_____ Driver's License #_____

Group#_____

Employer_____

Patient Relationship to Insured: □ Self □ Spouse □ Child □ Other

Bryan Leatherman, M.D.
Coastal Sinus and Allergy
Coastal Ear Nose and Throat Associates

POLICY FOR COLLECTIONS AND PAYMENTS

All office services are payable on the day services are rendered by personal check, cash or credit card. (Visa, MasterCard, American Express). We only accept assignment from Insurance Companies that we are contracted with. Patients who have insurance that we are not providers for will be expected to pay for their office visit the same day of service. We will file your insurance plan as a courtesy with reimbursement going to the patient. All procedures will be filed if insurance information is provided. All secondary insurance will be filed as a courtesy. If insurance does not pay within 30 days, the balance will be billed to the patient. All patients are required on the day of the visit to pay any deductibles or co-pays.

For minors (or patients under the financial/insurance guardianship of others) the person signing this form is ultimately responsible for paying the bill, despite any other financial relationships in the family.

REGARDLESS OF INSURANCE COVERAGE, THE BILL IS THE PATIENT'S ULTIMATE RESPONSIBILITY. ANY DISPUTES ARE BETWEEN THE PATIENTS THEIR INSURANCE C0MPANY.

Name Responsible Party (print):_____

Signature:_____

Date_____

Any accounts that are not paid in 30 days will be subject to being turned over to a collection agency.

Introduction

We maintain protocols to ensure the security and confidentiality of your personal information. We have physical security in our building, passwords to protect databases, compliance audits, and virus/intrusion detection software. Within our practice, access to your information is limited to those who need it to perform their jobs.

At Coastal ENT, we are committed to treating and using protected health information about you responsibly. This Notice of Privacy Policies describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record

Each time you visit Coastal ENT, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- Tool in educating health professionals,
- Source of data for medical research,
- Source of information for public health officials charged to improve the health of the state and nation,
- Tool by which we can assess and continually work to improve the care we render and outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy; better understand who, what, when, where, and why others may access your health information; and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Coastal ENT, the information belongs to you. You have the right to:

- Obtain a paper or electronic copy of this notice of privacy policies upon request,
- Inspect and copy your health record as provided by 45 CFR 164.524,
- Amend your health record as provided by 45 CFR 164.526,
- Obtain an accounting of disclosures of your health information as provided by 45 CFR 164.528,
- Request confidential communications of your health information as provided by 45 CFR 164.522, and
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522 (the practice, however, is not required by law to agree to a requested restriction),
- Receive an accounting of disclosures that we have made of protected health information about you.

*CFR - Code of Federal Regulations

Our Responsibilities

Coastal ENT is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate your health information.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. We will keep a posted copy of the most current notice in our facility containing the effective date in the top, right-hand corner. In addition, each time you visit our facility for treatment, you may obtain a copy of the current notice in effect upon request.

We will not use or disclose your health information in a manner other than described in the section regarding Examples Of Disclosures For Treatment, Payment, And Health Operations, without your written authorization, which you may revoke as provided by 45 CFR 164.508(b)(5), except to the extent that action has already been taken.

For More Information Or To Report A Problem

If you have questions and would like additional information, you may contact our practice's Privacy Officer Lisa Barfield at (228) 896-1987.

If you believe your privacy rights have been violated, you can either file a complaint with Lisa Barfield, or with the Office for Civil Rights, U.S. Department of Health and Human Services (OCR). There will be no retaliation for filing a complaint with either our Privacy Officer or the OCR. The address for the OCR is as follows:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Examples Of Disclosures For Treatment, Payment, And Health Operations

We will use your health information for treatment.

We may use and disclose PHI about you to provide, coordinate, or manage your health care and related services. We may consult with other health care providers regarding your treatment and coordinate and manage your health care with others. For example, we may use and disclose PHI when you need a prescription, lab work, an X-ray, or other health care services.

We will also provide your other physician(s) or subsequent health care provider(s) (when applicable) with copies of various reports that should assist them in treating you.

We will use your health information for payment.

We may use and disclose PHI so that we can bill and collect payment for the treatment and services provided to you. Before providing treatment or services, we may share details with your health plan concerning the services you are scheduled to receive. We may use and disclose PHI for billing, claims management, and collection activities. At the patient's request, physicians generally may not disclose information about care the patient has paid for out-of-pocket to health plans.

For example, we may allow a health insurance company to review PHI for the insurance company's activities to determine the insurance benefits to be paid for your care.

We will use your health information for regular health operations.

Health care operations include doing things that allow us to improve the quality of care we provide and to reduce health care costs.

Business Associates
There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a transcription service we use to transfer dictated patient care into the medical record. Due to the nature of business associates' services, they must receive your health information in order to perform the jobs we've asked them to do. To protect your health information, however, when these services are contracted we require the business associate to appropriately safeguard your information.

Research
We may use and disclose PHI about you for research purposes under certain limited circumstances. We must obtain a written authorization to use and disclose PHI about you for research purposes, except in situations where a research project meets specific, detailed criteria established by the HIPAA Privacy Rule to ensure the privacy of PHI.

Coroners, Medical Examiners, Funeral Directors
We may disclose PHI to a coroner or medical examiner to identify a deceased person and determine the cause of death. In addition, we may disclose PHI to funeral directors, as authorized by law, so that they may carry out their jobs.

Organ and Tissue Donation
If you are an organ donor, we may use or disclose PHI to organizations that help procure, locate, and transplant organs in order to facilitate an organ, eye, or tissue donation and transplantation, consistent with applicable law.

Marketing
We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity your authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

Worker's Compensation
We may disclose PHI as authorized by worker's compensation laws or other similar programs that provide benefits for work-related injuries or illness.

Sale of Health Information
We will not sell your health information without your prior written authorization.

Incidental Disclosures
We may use or disclose PHI incident to a use or disclosure permitted by the HIPAA Privacy Rule so long as we have reasonably safeguarded against such incidental uses and disclosures and have limited them to the minimum necessary information.

Public Health
As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability, and child abuse or neglect or death.

Appointment Reminders
We may contact you or a family member at the phone number you have provided to us as a reminder that you have an appointment.

Disclosures Required by HIPAA Privacy Rule
We are required to disclose PHI to the Secretary of the United States Department of Health and Human Services when requested by the Secretary to review our compliance with the HIPAA Privacy Rule. We are also required in certain cases to disclose PHI to you upon your request to access PHI or for an accounting of certain disclosures of PHI about you.

Notification
We may use or disclose information to notify or assist in notifying a family member or personal representative (or other person responsible for your care) of your location and general condition.

Breach Notification
In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification.

Communication with Individuals Involved in Your Care or Payment
Health professionals, using their best judgement, may disclose to a family member, other relative, or close personal friend (or any other person you identify) health information relevant to that person's involvement in your care or payment related to your care without your written authorization for which you can agree or object.

Law Enforcement
We may use and disclose PHI as required by federal, state, or local law to the extent that the use or disclosure complies with the law and is limited to the requirements of the law.

Federal law makes provision for you health information to be released to an appropriate health oversight agency, public health authority, or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

COASTAL ENT ASSOCIATES, PLLC

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Promise to You, Our Patients

Your information is confidential.

Your information is important and confidential. Our ethics and policies require that your information be held in strict confidence.

Clay R. Bratton, M.D.
Bryan Leatherman, M.D.
Greg Meekin, M.D.
Vincent J. Pisciotta, M.D.
Samuel P. Robinson, M.D.
Michael Seicshnaydre, M.D.
Jason V. Smith, M.D.
Edward Willis, M.D.

Audiology Department
Allergy Department

Effective April 14, 2003

Notice of Privacy Practices

Acknowledgement of Receipt of notice of privacy practices and consent for use and disclosure of health information.

Notice of Privacy Practices of the Medical Practice named at the top of the page: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. We reserve the right to change our privacy practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Privacy Practices, including any revisions of our notice at any time by contacting Lisa Barfield, our privacy official. You have the right to revoke this consent at any time by giving us a written notice of your revocation submitted to Coastal ENT, Dr. Bryan Leatherman. Please understand that revocation of this Consent will NOT affect any action we took in reliance on this consent form.

Authorization to Release Information

Please list the name(s) of the Personal Representative(s) of the patient, below. List anyone you wish to have access to any of your personal health information, billing information, or any aspects of your medical care. If a person(s) name is not listed below, we will not be able to discuss and/or release any of your information with them (with the exception of appointment reminders as indicated below).

Name of representative:_____ Relationship to patient: _____

Second representative: _____ Relationship to patient: _____

Third representative: _____ Relationship to patient: _____

Authorization for Reminder Messages

I give my permission to leave appointment reminder voice messages on **answering machines/voice mailboxes** on my home phone, mobile phone, or any other contact numbers provided. I give my permission to leave voice messages about outstanding balances and co-pay requirements on **answering machines/voice mailboxes** on my home phone, mobile phone, or any other contact numbers provided. I give my permission to leave **verbal** appointment reminder messages to **anyone** who answers my home phone, mobile phone, or any other contact numbers provided.

I acknowledge receipt and understanding of the Notice of Privacy Practices and consent for use and disclosure of health information. I also give permission for release of information as indicated on this form.

Patient's name: _____ Patient's signature:_____

Representative name: _____ Relationship to patient: _____

Representative signature: _____

Patient Name:_____ **Age**:____ **Gender**: M F

Past Medical History: Check all that apply.

__ Diabetes
__ High blood pressure
__ Heart disease
__ heart failure
__ heart attack
__ abnormal beat
__ Lung disease
__ asthma
__ emphysema
__ pneumonia
__ bronchitis
__Eyes
__ frequent infections
__ glaucoma
__ Stomach problems
__ ulcers
__ hiatal hernia
__ gastric reflux
__ Neurologic disorders
__ stroke
__ seizures
__ convulsions
__ Thyroid disorders
__ low thyroid
__ high thyroid
__ goiter
__ Allergy testing / shots
__ Immunologic
__ rheumatoid arthritis
__ lupus
__ immune deficiencies
__Muscle/skeletal
__ arthritis
__ gout
__ neck or back injury
__ Psychiatric
__ depression
__ excessive anxiety
__ Urologic
__ kidney stones
__ prostate enlargement

ARE YOU PREGNANT? Yes / No
Cancer (List type)_____
Other _____

Past Surgical History: Please check all that apply.

__ Sinus surgery
__ Nose surgery
__ Neck surgery
__ Ear surgery
__ Tonsillectomy
__ Adenoidectomy
__ Pressure equalizing tubes (ear tubes)
__ Other_____

Medications: (List all medications you take regularly, prescription and over-the-counter)

_____ _____
_____ _____
_____ _____

Allergies: (drugs, food , insects, etc)

_____ _____
_____ _____

Environmental Exposures: (circle as applies to you)

Do you have a pet or care for farm animals……..Y / N
List types (indoor or outdoor):_____
Are you regularly exposed to second hand smoke…Y / N
Are you regularly exposed to chemicals……..Y / N

Family Medical History: (**Check** only if mother, father, siblings, or children have condition)

__ Diabetes
__ High blood pressure
__ Stroke
__ Heart disease
__ Hypertension
__ Asthma
__ Allergies
__ Anesthesia problems
__ Early hearing loss
__ Bleeding disorders
__ Cancer (list type)_____

Social History: (Check / fill in numbers where apply)
Alcohol Use: __ Never __ Several times a week
__ Occasionally __ Daily

Tobacco Use: __ Use now __ Never used __ Quit (how long?_____)
Type: __ Cigarettes __ Cigars __ Chewing tobacco
Daily amount_____ Number years used_____

Type of occupation_____ Retired? Y / N

Review of Systems Please check all that apply in the ***last 6 months***.

Constitutional Symptoms
__ Unexplained weight change
__ Frequent fever
__ Frequent fatigue

Psychiatric
__ Memory loss or confusion
__ Excessive daytime sleepiness
__ Trouble sleeping

Eyes
__ Wear glass / contacts
__ Itchy eyes
__ Burning eyes
__ Red eyes
__ Watery eyes
__ Dry eyes

Ears Nose and Throat
__ Hearing loss
__ Earache
__ Ear drainage
__ Ringing in ears
__ Nasal drainage
__ Nasal itching
__ Nasal obstruction
__ Frequent sneezing
__ Altered sense of smell
__ Facial pressure/pain
__ Frequent nose bleeds
__ Voice change/hoarseness
__ Frequent sore throat

Cardiovascular
__ Chest pain (angina)
__ Fluttering heartbeat

Pulmonary
__ Frequent cough
__ Coughing up blood
__ Shortness of breath
__ Wheezing
__ Snoring

Musculoskeletal
__ Joint pains
__ Muscle weakness

Gastrointenstinal
__ Heartburn
__ Frequent burping
__ Difficulty swallowing
__ Stomach pains
__ Feels like something stuck in throat

Genitourinary
__ Difficulty urinating
__ Frequent urination

Neurological
__ Frequent headaches
__ Light headedness / dizziness

Integumentary (skin)
__ Rash / itching
__ Hives (urticaria)
__ Change in skin color
__ Change in nails

Hematologic/Lymphatic
__ Bleeding / bruising tendency
__ Anemia
__ Enlarged glands

Immunologic / Allergies
__ Bad reaction to foods
__ Bad reaction to insect bite

Patient Signature_____ Date_____

Physician Signature:_____ Date_____