CAPITAL OTOLARYNGOLOGY
Your home for complete, up-to-date, down-to-earth ENT care.

NEW PATIENT INFORMATION

Patient Information

Last Name _____ First Name _____ M.I. _____

Date of Birth: ___/___/_____ SSN: ____-____-_____ Marital Status: _____ Sex: ____

Race: _____ Ethnicity: _____ Primary Language: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Employer / School Name: _____ Phone #: (____) _____

Email address: _____

Would you like to receive newsletters/specials on:

☐ Sleep & Snoring ☐ Facial Cosmetics ☐ Hearing Loss/Care

Emergency Contact

1st Name: _____ Phone number: _____ Relationship: _____

2nd Name: _____ Phone number: _____ Relationship: _____

Guarantor / Responsible Party ☐ Same as above

Relationship to Patient: _____

Last Name _____ First Name _____ M.I. _____

Date of Birth: ___/___/_____ SSN: ____-____-_____ Driver's License / State: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Work Phone: (____)_____ Cell Phone (____)_____

Employer / School Name: _____ Phone #: (____)_____

Insurance Information

Subscriber / Employee's Name: _____ Employer:_____

Date of Birth: ___/___/_____ SSN: ____-____-_____ Patient's Relationship to Insured: _____

Insurance Co Name: _____ Phone (____) _____

ID #: _____ Group #: _____

Do you have a Secondary Insurance? ☐ No, Initial _____

☐ Yes, Subscriber / Employee's Name: _____ Employer: _____

Date of Birth: ___/___/_____ SSN: ____-____-_____ Patient's Relationship to Insured: _____

Insurance Co Name: _____ Phone (____) _____

ID #: _____ Group #: _____

Referral Information

How did you hear about us?

Dr. Referral Family/Friend Internet Insurance Yellow Pages Radio Magazine _____ Other _____

Referring Person: Last Name_____ First Name: _____ Phone number: _____

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ACKNOWLEDGEMENTS /CONSENTS / FINANCIAL RESPONSIBILITY/ DISCLOSURES

____ (initial) RECEIPT OF HIPAA PRIVACY NOTICE AND PATIENT NOTICES

I have reviewed a copy of Capital Otolaryngology's ***HIPAA PRIVACY NOTICE AND PATIENT NOTICES*** (Also available at www.capoto.com under patient forms.)

____ (initial) CONSENT TO TREATMENT

I consent to the performance of examinations, diagnostic procedures, and rendering of treatment by the medical provider and their designated medical office staff as is deemed necessary in the medical provider's judgment. I understand that I have the right to refuse any medical or surgical treatment that I do not want.

____ (initial) FINANCIAL RESPONSIBILITY, RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS

I understand that copays, deductibles/co-insurance will be collected at the time service. I further understand that I am financially responsible for all charges, and as a courtesy, my charges will be filed with my insurance carrier including Medicare. I understand that my insurance may process certain services (e.g. nasal endoscopy, nasal debridement) as a ***diagnostic*** or ***surgical procedure*** and may be applied towards my deductible/coinsurance.
I authorize the release of any medical information necessary to process an insurance claim on my behalf. I request that my medical insurance carrier make payment directly to Capital Otolaryngology for services rendered to me. I understand I will be responsible for these charges if the claim is denied or is not paid in a timely manner.

Should my account become a collection problem, I understand I will be financially responsible for any additional fees incurred during the collection process. I also understand that all past due accounts must be paid in full prior to making any future appointments.

I understand, when required by my insurance plan, I am responsible for obtaining referrals from my Primary Care Physician prior to receiving treatment from a Capital Otolaryngology provider. If said referral is not on file with Capital Otolaryngology at the time of my visit, and I choose to proceed with treatment, I understand I am responsible for all charges incurred during that visit, payable at the time of service.

I authorize Capital Otolaryngology to discuss my healthcare account with the following person(s). Any changes to this document must be made in writing. I release Capital Otolaryngology and its employees from any liability in connection with the use or disclosure of the information and records released to any party pursuant to this Authorization.

_____

First Name Last Name Date of Birth relationship to patient

____ (initial) DISCLOSURE OF PHYSICIAN OWNERSHIP

Please carefully review the information contained in this notice and feel free to ask any questions.

- Christopher Thompson, MD has ownership interest in Texan Allergy, PLLC and Sinus & Allergy Specialists of Texas.
- Zachary Wassmuth, MD, & Christopher Thompson, MD have ownership interest in The Hospital at Westlake.
- You have the right to choose the provider of your health care services. Therefore, you have the option to use a health facility other than Texan Allergy and The Hospital at Westlake. You may also choose to have CT scans or sleep studies done at a location other than Capital Otolaryngology. You may ask the front desk for a list of alternate locations in our area, if you choose.
- The physicians here will not treat you differently if you choose to obtain health care services at a facility other than those listed above.
- LAKEWAY OFFICE ONLY – Audiology services provided at the Lakeway office will be billed by AHL Audiology, LLC or LG Audiological Enterprises, LLC, not by Capital Otolaryngology.

If you have any questions concerning this notice or anything in it, please feel to ask your physician or any representative here.
Please acknowledge your receipt and understanding of this notice by your signature below.

My signature below indicates that I have read and am in agreement with all statements that I have initialed above.

_____ _____ _____ _____ _____

Signature of Patient (or Guardian) **PRINTED Name of Patient** **Date of Birth** **PRINTED Name of Guardian** **Date**

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Capital Otolaryngology - Health History Form

Last Name _____ First Name _____ M.I. _____ Date of Birth: ____/____/_____

Primary Number: (_____) _____ Alt Phone: (_____) _____

Family Doctor: _____ Referring Doctor: _____

Name of Pharmacy: _____ Pharmacy phone # or location: _____

Have you been seen by any of the physicians at Capital Otolaryngology? Yes No

Has a member of your family been seen by any of the physicians at Capital Otolaryngology? Yes (specify) _____ No

How did you hear about us? (Circle all that apply): Doctor Referral Internet Insurance Radio Friend Other _____

Reason for today's visit: _____

Height: _____ Weight: _____

Past Medical History (check all that apply)

___ Sleep apnea
___ Diabetes
___ Thyroid disease
___ Asthma
___ Emphysema/COPD
___ Cancer, type: _____
___ Bleeding disorder
___ High blood pressure
___ Heart disease
___ High Cholesterol
___ Depression
___ Other: _____
___ Kidney disease
___ Liver disease/Hepatitis
___ Stroke
___ Seizures
___ HIV
___ Other: _____

Do you have any of the following concerns?

___ Nasal/Sinus Problems ___ Sleep/Snoring problems ___ Hearing problems ___ Voice problems

Surgical History	**Year**
**____NONE **	

Current Medication(s) (For additional space, use back of paper)	**Dose**	**Frequency**
**____NONE **		

Do you take any aspirin, ibuprofen, Advil, Motrin, Vitamin E or blood thinners? ___Y ___N (circle which one(s))

Allergies:

Drug Allergies: **____NONE ** ☐ Penicillin ☐ Sulfa Other _____

Seasonal Allergies/Food Allergies: _____

Family History

Medical Illness	Relation to patient
**____NONE **	

Social History:

Occupation: _____

Do you Smoke: ___ Yes, I have smoked ___ packs of cigarettes per day for ____ year(s)
___ No, I quit ___ years ago. At that time I was smoking ___ packs a day for ___ years
___ No, I have never smoked

Do you drink alcohol: ___ No, never/rarely
___ No, but I used to
___ Yes: ___ Daily ___ 1 or more times a week ___1 or more times a month

For Women only:
Are you currently pregnant or breastfeeding? ___Yes ____No

REVIEW OF SYSTEMS - Are you *currently* having problems with: (check all that apply)

General
____Fever
____Chills
____Night Sweats
____Feeling Tired (Fatigue)
____Recent Weight Gain
____Recent Weight Loss

Eyes
____Double Vision
____Blurry Vision
____Discharge from Eyes
____Dry Eyes
____Eyes Itch

Ear, Nose, Throat
____Ringing in Ears
____Loss of Hearing
____Nosebleeds
____Nasal Congestion
____Trouble Swallowing

Cardiovascular
____Chest Pain
____Palpitations (fast heart beat)
____Lower Extremity Swelling

Respiratory
____Difficulty Breathing
____Wheezing
____Cough
____Snoring
____Bloody Sputum

Gastrointestinal
____Vomiting
____Nausea
____Blood in Stool
____Diarrhea
____Constipation

Skin
____Rash
____Skin Lesion Change

Neurological
____Dizziness
____Numbness
____Fainting
____Memory Loss

Psychiatric
____Depression
____Anxiety

Endocrine
____Cold Intolerance
____Heat Intolerance
____Excessive Thirst

Hematological/Lymphatic
____Easy Bruising
____Excessive Bleeding

****____NONE ****

I certify that the information in this document is, to my knowledge, accurate.

XX_____

Patient Signature / Guardian Signature Print Name Date

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NO-SHOW/LATE CANCELLATION POLICY

Capital Otolaryngology cultivates a doctor-patient relationship that is based on trust, focusing on patients as individuals. Our physicians and excellent support staff strive to be fair and courteous in all of our dealings.

- The following policy has been established to help us serve you better. It is necessary for us to make appointments in order to see our patients as efficiently as possible. No-Shows and Late Cancellations cause problems that go beyond any financial impact to our practice. When an appointment is made, it takes an available time slot away from another patient in need of medical care. Not cancelling an appointment in a timely fashion is unfair to other patients, some of whom may be quite ill and may unnecessarily delay the delivery of health care. For these reasons we have developed the following No-show/Late Cancellations policy.

- A No-Show is defined as missing a scheduled appointment without calling us in advance to cancel the appointment. A Late Cancellation is defined as failing to cancel or reschedule a scheduled appointment by 3:00 P.M. the day before your scheduled appointment. We request that if you need to cancel or reschedule your appointment, you must contact our office no later than 3:00 P.M. the day before your scheduled appointment so that we may offer the appointment time to another patient who is in need of medical attention.

- We understand that everyone might have unforeseen event in which you cannot make your appointment with us so we have allotted you one grace appointment each calendar year in which you will not be charged a fee, as described below, for that sudden emergency.

- For each subsequent No-Show or Late Cancellation during the same calendar year, we are charging the nominal fee of $25 to cover for the staff that is on hand to provide your needs, this charge will apply to each appointment that a Late Cancellation or No-Show occurs. This office will not submit this charge to your insurance carrier or Medicare, as applicable. These fees are your financial responsibility and they must be paid prior to making any new appointment. A patient who No-Shows three times (3) within a twelve month period, regardless of whether it is in the same calendar year, is subject to dismissal from the practice.

- Please understand that the intent of this policy is to aid us in offering a high standard of care to our patients and that this policy is in place to help us achieve that goal. We pledge to do our part to keep our schedule moving as efficiently as we possibly can. We value you as a patient and appreciate your understanding and cooperation.

I acknowledge that I have read and understand this No-show/Late Cancellation Policy. I further understand that I will incur fees in the event I fail to notify this office before 3:00 P.M. the day before my scheduled appointment or if I fail to show up for my scheduled appointment. Any fees incurred are my responsibility to pay and in the event I incur a fee, such fee shall be paid prior to making any new appointment.

_____ _____

Patient Signature or Legally Responsible Person **Print Name**