



Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Date of last physical: \_\_\_\_\_  
 Drug Allergies: \_\_\_\_\_  
 Other Allergies: \_\_\_\_\_

**REASON FOR APPOINTMENT:**

Previous surgery, including cosmetic surgery (please list)

Operation	Year	Type of Anesthesia

Serious illnesses or hospitalizations, including childbirth (please list)

List all the medications you are now taking, please include dosage/frequency. Include over the counter drugs (ie. Aspirin, vitamins, herbal supplements, etc...)

What is your daily consumption of the following:

Tobacco: \_\_\_\_\_ Alcohol: \_\_\_\_\_

If you smoked in the past; how much, how long, and when did you quit?

**Medical History: Please indicate if you have/had a history of the following:**

- |  |  |   |  |
|--|--|---|--|
| Have you ever had a blood transfusion? | <input type="checkbox"/> No <input type="checkbox"/> Yes | Lung Disease                            | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Malignant hyperthermia                 | <input type="checkbox"/> No <input type="checkbox"/> Yes | Kidney Disease                          | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Radiation therapy to the face          | <input type="checkbox"/> No <input type="checkbox"/> Yes | Heart Disease                           | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Tuberculosis                           | <input type="checkbox"/> No <input type="checkbox"/> Yes | Asthma                                  | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| High blood pressure                    | <input type="checkbox"/> No <input type="checkbox"/> Yes | Mental illness                          | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Rheumatic Heart Disease                | <input type="checkbox"/> No <input type="checkbox"/> Yes | Diabetes                                | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Blood/bleeding disorders               | <input type="checkbox"/> No <input type="checkbox"/> Yes | Depression                              | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Gastrointestinal/stomach problems      | <input type="checkbox"/> No <input type="checkbox"/> Yes | Cancer                                  | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Hepatitis/Liver disease                | <input type="checkbox"/> No <input type="checkbox"/> Yes | HIV                                     | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Thyroid disease                        | <input type="checkbox"/> No <input type="checkbox"/> Yes | Could you be pregnant<br>(females only) | <input type="checkbox"/> No <input type="checkbox"/> Yes |

**I acknowledge that I have disclosed all of my medical history known to me.**

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

MD Reviewed \_\_\_\_\_

## OFFICE POLICIES

***We are committed to providing the highest quality of medical care to all our patients. Our goal is to work together to ensure that you receive the best possible care.***

### APPOINTMENTS

You are responsible for remembering your own scheduled appointment dates and times. Reminder calls are only provided upon your request. If you do not arrive on time for your appointment, your appointment may have to be rescheduled.

If you **must** cancel an appointment, please provide us with **24 hour notice**. If appropriate notice is not given for your cancelled appointment, a **\$25.00 fee** will be charged.

If you **NO SHOW** for your appointment there will also be a **\$25.00 fee** charged to your account. Multiple no shows for appointments may result in being discharged from our practice.

If a scheduled elective surgery is not cancelled at least **10 days prior** to the procedure date, your 25% surgical deposit **will not** be refunded.

Cancelling appointments without an appropriate notice and no showing on scheduled appointments, causes other patient's to be denied an appointment in a time slot that could have been filled. Your cooperation in handling all your appointments appropriately is greatly appreciated.

It is your responsibility to make sure proper referral authorizations are obtained from your primary care provider, if required by your insurance plan. If necessary authorization is not received by your scheduled appointment, your appointment will have to be rescheduled.

### INSURANCE

Insurance is a contract between you and your insurance company. It is your responsibility to know and understand your insurance policy and your benefits. As a courtesy to you we will bill your insurance company for our services.

It is your insurance company that makes the final determination of your financial responsibility. Regardless of your insurance coverage, you are responsible for all bills being paid in a timely manner. You are financially responsible for all deductibles, coinsurances, copays, and non-covered service amounts. Copayments are due at the time services are rendered. Deductible and coinsurance amounts will be billed when they become due or when determined by your insurance company.

### FINANCIAL

For your convenience, we except Cash, Check, Debit, Visa, MasterCard, AMEX, and Discover as forms of payments. All elective surgeries require a 25% deposit in order to schedule procedure. Remaining balance must be paid in full 2 weeks prior to surgery. All cosmetic services are due in full, at time of service. All unpaid balances over 30 days are subject to collection fees and interest charges of 1.5% per month. Unpaid balances will be forwarded to a collection agency and reported to the credit bureau. There will be a \$25.00 fee charged on any checks returned for insufficient funds. All outstanding balances must be paid in full or have had financial arrangements established with our practice, before being seen for future appointments.

### PRESCRIPTIONS & TEST RESULTS

If you need a refill on a prescription you are already taking, you must call 2 WEEKS PRIOR TO RUNNING OUT. Request for refills will be responded to only during office hours. Only refills for prescription(s) you have been prescribed by Dr. Lee and are currently being treated for will be considered. If you have not returned for your recommended follow-up care, your refill will be denied.

When possible you will be contacted by telephone for final test results. Our office will contact you with results as soon as possible. Some test may require you to return to our office for results. We will contact you to schedule an appointment if that is necessary. If you do not hear from us within 10 days after receiving test, please make sure to contact us directly.

***I acknowledge that I have read and agree to all the policies and procedures listed above.***

Name : \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Westchase ENT & Facial Plastic Surgery, P.A.

Janet I. Lee, M.D.

**AUTHORIZATION TO RELEASE, RECEIVE, OR EXCHANGE INFORMATION**

I authorize Westchase ENT & Facial Plastic Surgery, P.A. and Janet Lee, M.D. to:

***EXCHANGE, RECEIVE, AND/OR RELEASE TO:***

***ALL PHYSICIANS AND ANY OTHER HEALTHCARE PROVIDERS***

***ANY AND ALL NECESSARY MEDICAL RECORDS NEEDED FOR ON GOING HEALTHCARE***

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that if that organization authorized to receive the information is not a health plan or healthcare provider; the released information no longer be protected by federal privacy regulations.

I understand that this consent shall be valid from the date of authorization and may be revoked at anytime upon written notice, except to the extent that the information has already been released in reliance upon this authorization.

I further understand that the confidentiality of this information may be protected by the Federal Regulations (42CFR, Part II), prohibiting any further disclosure of this information without specific written authorization of the undersigned, or as otherwise regulated.

**DESIGNATED RELATIVE(S)**

I authorize discussion of my general medical condition and diagnosis (including treatment, payment, and healthcare operations) with:

*Please list the family member(s) or significant other(s), if any, whom WE MAY inform or discuss YOUR MEDICAL CONDITION with.*

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

***I do not want my medical information discussed with anyone but myself***

***I acknowledge that I have read and agreed to all the information provided above.***

Name : \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **NOTICE OF PRIVACY PRACTICES**

### **ACKNOWLEDGEMENT OF RECEIPT:**

Federal law requires that we seek your acknowledgment of receipt of this Notice of Privacy Practices. Please sign below.

I acknowledge that I have received this Notice of Privacy Practices with an effective date of April 14, 2003, and that I understand that if I have any questions regarding this Notice, I may contact the Privacy Officer.

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Parent/Guardian (responsible for patient under 18)

(Print) \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

At any time you may request a copy of the organization's Notice of Privacy Practices for your records. Please notify staff, if you would like them to supply you with an additional copy.

### **FOR OFFICE USE ONLY**

Signed Acknowledgment of Receipt received on \_\_\_\_\_  
Initials \_\_\_\_\_

Notice of Privacy Practices sent/delivered on \_\_\_\_\_  
Initials \_\_\_\_\_

Patient Refused or Failed to Acknowledge Receipt on \_\_\_\_\_  
Initials \_\_\_\_\_