PAPARELLA
EAR HEAD &
NECK INSTITUTE, P.A.

Instructions for Preparing For Your Appointment

To help us serve you better, please review the items below.

1. Please complete and bring all forms with you to your visit.

2. Please bring all insurance cards and your photo ID with you to your visit.

3. All co-pays and balances due must be paid at the time of check-in. **If you do not have insurance, a minimum down payment of $200.00 is required toward your visit. Any remaining balance from your visit will be billed to you.**

4. Some health plans require a referral for specialty care. Please check with your health, plan, and if necessary, obtain a referral prior to your visit.

5. Please allow **1 to 3 hours** for your examination and any diagnostic tests to be completed.

6. Please bring a **list of medications** you are currently taking.

7. We recommend that you park in the Blue Lot on 7th Street or the Red Ramp on 25th Avenue South in Minneapolis. We will stamp your parking card so that you may receive a discounted rate.

8. 24-hour advance notice is **REQUIRED** if you are unable to keep your appointment.

IF YOU HAVE QUESTIONS OR NEED TO RESCHEDULE OR CANCEL YOUR APPOINTMENT, PLEASE CALL 612-339-2836 OR TOLL-FREE 1-866-316-0769.

Contact Us

Contact Paparella Ear, Head & Neck Institute by calling our main office at 612-339-2836 or by calling us toll-free at 866-316-0769.

Clinic Locations and Maps

Clinic locations, maps and directions are available at **www.pehni.com/locations**.

Hours

Our phone hours and clinic hours are from 8 a.m. to 5 p.m., Monday through Friday.

PAPARELLA
EAR HEAD &
NECK INSTITUTE, P.A.

Patient Registration

Please complete the information requested below.

Patient Information

Patient's Legal First Name:______________________________ Mid Initial:_____ Last Name: ______________________________

Date of Birth: ______________________________ Age: __________ Social Security #: ____________________________________

Sex: M F Marital Status: ________________________ Student Status: FT PT N/A Primary Language: ______________

Current Address: Street/P.O. Box: ____

City: ____ State: ________________________ Zip: ________________

Email: ____

Home Phone: _____________________________ Cell: ______________________________ Work: _____________________________

Employer: ____ Occupation: ____

Spouse's Name: ____ **Date of Birth:** __________________________________

If patient is a minor,

Mother or legal guardian name: ______________________________ **Date of Birth:** __________________________________

Father or legal guardian name: ________________________________ **Date of Birth:** ________________________________

Race/Ethnicity

We strive to ensure our patients receive the highest quality of care possible. By providing your racial/ethnic background, you enable us to fully assess our clinical performance and improve the quality of care we provide.

Race:
❏ Alaskan Native
❏ American Indian
❏ Asian
❏ Black/African American
❏ Greek
❏ Hawaiian
❏ Hispanic
❏ Indian
❏ More than one race
❏ Multi-Racial
❏ Native American Indian
❏ Native Hawaiian/Other Pacific Islander
❏ Other Race
❏ Pacific Islander
❏ Unk/Not Reported
❏ White

Ethnicity: ❏ Hispanic or Latino ❏ Not Hispanic or Latino ❏ Unkown/Not Reported

Insurance Information

Primary Insurance: ____

Policy/ID #: _______________________________________ Group #: _______________________________________

Secondary Insurance: ____

Policy/ID #: _______________________________________ Group #: _______________________________________

Policyholder Information

Policyholder's Name: ____ **Date of Birth**: ______________________________

Social Security #: ________________________ Employer Name: ________________________ Phone: ______________________

Cell: ___________________________________ Email: ____

Home Phone: _____________________________ Policyholder's relationship to patient: Self Spouse Parent Guardian

Other: ______________________________

Emergency Contact Information

Who may we contact in case of emergency or if we need to change an appointment and cannot reach you?

Name: ____ Relationship: ______________________________

City: ______________________________ State: ________________ Zip: ________________

Home Phone: _____________________________ Work: _____________________________ Cell: _____________________________

Email: ____

07202017 All Contents Copyright © 2017 Paparella Ear Head & Neck Institute. All Rights Reserved.

Patient Name: ______________________________

Date of Birth: ______________________________

Releases/Authorizations

Please complete the information requested below.

Insurance Records Release

I hereby authorize the release of any information by Paparella Ear, Head & Neck Institute, P.A. to my referring doctor and insurance company.

Signature: ______________________________ Date: ____________________

Medicare Authorization

I request that payment of authorized Medicare benefits be made to me, or on my behalf to Paparella Ear, Head & Neck Institute, P.A. for any services provided to me by that physician/clinic/supervisor. I authorize any holder of my hospital or medical information to release any such information to the Health Care Financing Administration or its agents for the purpose of determining these benefits or benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

Signature: ______________________________ Date: ____________________

Privacy Practice Acknowledgement

I acknowledge that I have received Paparella Ear, Head & Neck Institute, P.A.'s Notice of Privacy Practices. I have had full opportunity to read and consider the content of this Notice of Privacy Practice.

Signature: ______________________________ Date: ____________________

Billing Policies

You are financially responsible for all charges, whether or not paid by insurance, including any charges for service rendered including hearing test(s), hearing aid(s) and referrals for CT's and MRI's which are denied, not prior authorized or for any reason, not covered by the applicable insurance company. In situations of divorce, separation, court orders, etc., the undersigned will be financially responsible for the account. For minors and other adult dependents, you accept full responsibility for all charges and payments due now or in the future. To help our office process the claim on your behalf, it is in your best interest to provide all information requested. The information you provide is Protected Health Information (PHI) and may be disclosed only to the extent necessary for treatment, payment activities, and healthcare operations.

We will file a claim with your insurance provider in order to help you achieve the maximum allowable benefits, but cannot extend credit beyond 60 days. If you believe you need more than 60 days to pay your charges, please speak to our billing office to make other arrangements. You authorize payment of medical benefits to Paparella Ear Head and Neck Institute, P.A. for services rendered. You agree to be contacted using any telephone number associated with your account for billing or collection purposes. This includes use of mobile telephone numbers. You may also be contacted via text message or email using any email address associated with your account. Telephone communications may include pre-recorded and artificial voice messages and/or use of an automatic dialing device as applicable.

If you do not have insurance, a minimum deposit of $200.00 is required towards your visit. Any remaining balance from your visit will be billed to you. If this results in a credit on your account after we receive payment from you or your insurance, we will either refund the payment or credit any outstanding balances due from other visits. Refunds are done once a month on or after the 15th of the month after we receive the insurance payment. All co-pays are due in full at the time of visit. Unpaid balances are subject to a monthly finance charge of 0.67%. Returned checks may be electronically presented to your bank along with a $30.00 returned check fee.If you have any questions, please feel free to call our business office at 612-339-2124.

Signature: ______________________________ Date: ____________________

07202017 All Contents Copyright © 2017 Paparella Ear Head & Neck Institute. All Rights Reserved.

Patient Name: ____________________________________

Date of Birth: ____________________________________

Medical History (Page 1)

Please complete the two-page medical history.

OFFICE USE ONLY

Who referred you to us? Provider Name/Clinic:

____

Reason for your visit today ______________________

____

Current Height/Weight

Height: _____ft _____in Weight:_____lbs

Past Medical History

Head or Neck Cancer	No	Yes	If yes, please describe: ______________________
Anesthesia Complications	No	Yes	If yes, please describe: ______________________

MRSA* skin infection	No	Yes	Autoimmune Disorder	No	Yes
**Methicillin-Resistant Staphylococcus Aureus*			AIDS or HIV	No	Yes
High Blood Pressure	No	Yes	Thyroid Disease	No	Yes
Hepatitis	No	Yes	History of Dizziness	No	Yes
Lung Disease	No	Yes	History of Falls	No	Yes
Diabetes	No	Yes	Other Chronic Illnesses	No	Yes
Heart Disease	No	Yes	If yes, please describe: ______________________		

Past Surgical History

❏ None

❏ Ear Surgery: ______________________ ❏ Nose Surgery: ______________________

❏ Sinus Surgery: ______________________ ❏ Neck Surgery: ______________________

Other: ____

Current Medications

Please include prescriptions, over the counter medications and supplements (name, dosage, frequency, purpose).

____

____

❏ None

Medication Allergies

❏ None ____

Social History

Occupation: ______________________

Are you currently pregnant or breastfeeding? No Yes

Do you use tobacco? No Yes If yes, what type? ❏ Smoke ❏ Chew ❏ Electronic

If yes, have you ever quit? ______________________

How much tobacco do you currently use? ______________

For how many years? ______________________

Do you drink alcohol? No Yes If yes, how many drinks per week? ______________

Do you consume caffeine? No Yes If yes, how much caffeine daily? ______________

Do you/have you had a problem with chemical dependency? No Yes

Do you have a history of falls or having fallen? No Yes If yes, approximately when and how often?______________

____

07202017 All Contents Copyright © 2017 Paparella Ear Head & Neck Institute. All Rights Reserved.

PAPARELLA
EAR HEAD &
NECK INSTITUTE, P.A.

Patient Name: ____________________________________

Date of Birth: ____________________________________

Medical History (Page 2)

Please complete the two-page medical history.

Vaccinations

Pneumonia Vaccination	No	Yes	If yes, date last received: ______________________
Influenza Vaccination	No	Yes	If yes, date last received: ______________________

Family History

Please consider grandparents, parents, siblings and children.

Head or Neck Cancer	No	Yes	If yes, please describe: ______________________
Bleeding Disorder	No	Yes	
Anesthesia Complications	No	Yes	
Hearing Loss	No	Yes	

Review of Systems

Do you currently or frequently have any of these symptoms? *(Circle answers)*

Constitutional

Fatigue	No	Yes		
Fever	No	Yes		
Weight loss	No	Yes		
Weight gain	No	Yes		

Ears

Ear Pain	No	Yes	R	L
Ear drainage	No	Yes	R	L
Ringing in Ears	No	Yes	R	L
Dizziness	No	Yes		
Hearing Loss	No	Yes	R	L

Nose

Nasal Congestion	No	Yes
Post Nasal Drainage	No	Yes
Sinus Infections	No	Yes

Throat

Change in Voice	No	Yes
Trouble Swallowing	No	Yes
Sore Throat	No	Yes
Snoring	No	Yes

Lungs

Shortness of Breath	No	Yes
Wheezing	No	Yes
Persistent Cough	No	Yes

Heart

Chest pain	No	Yes

Gastrointestinal

Persistent Vomiting	No	Yes
Heartburn	No	Yes

Neurological

Frequent Headaches	No	Yes
Blurred or Double Vision	No	Yes

Psychiatric

Depression	No	Yes
Anxiety	No	Yes

Skin

Rash	No	Yes

Musculoskeletal

Muscle Aches	No	Yes

Blood

Easy Bleeding or Bruising	No	Yes

Allergic

Seasonal Allergies	No	Yes
Food Allergies	No	Yes
Latex Allergy	No	Yes

OFFICE USE ONLY

VITALS TODAY

Height: _____ft _____in Weight:_____lbs

Pulse: ___________ bpm Temp: ___________ ° F

Blood Pressure: ___________/___________ mmHg

Respirations: ___________ bpm

Pulse Oximetry: ___________ %

Patient Education Provided No Yes

Reviewed by: ______________________________

(Physician Signature)

07202017 All Contents Copyright © 2017 Paparella Ear Head & Neck Institute. All Rights Reserved.

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. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

PURPOSE STATEMENT

The Health Insurance Portability and Accountability Act ("HIPAA") requires Paparella Ear, Head, and Neck Institute, P.A., including its affiliates (collectively referred to as "PEHNI") to maintain the privacy of an Individual's Protected Health Information ("PHI"), and to provide individuals with notice of its legal duties and privacy practices with respect to PHI, as well as individuals' rights regarding their PHI. The following defines PEHNI's privacy policy and practices:

OUR DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION

Individually identifiable information about your past, present, or future health or condition, or the provision of healthcare is considered "Protected Health Information" or "PHI." We are required to extend certain protections to your PHI. Except in specified circumstances, we must use or disclose only the minimum necessary PHI to accomplish our intended purpose.

We are required to follow the privacy practices described in this Notice, but we reserve the right to change our privacy practices and the terms of this Notice at any time. The revised Notice will be available at PEHNI's office and will also be posted on our Web site at www.pehni.com.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

We use and disclose PHI for a variety of reasons. If we disclose your PHI to an outside entity in order for that entity to do something on our behalf, we must have in place an agreement from the outside entity that it will protect the privacy of your information to the same extent that we do. We have a limited right to use and/or disclose your PHI for purposes of treatment, payment and for our healthcare operations. For uses beyond that, we must have your written authorization (or permission) unless the law permits or requires us to make the use or disclosure without your authorization. The law provides that we are permitted to make some uses/disclosures without your consent or authorization. The following describes and offers examples of our potential uses/disclosures of your PHI.

USES AND DISCLOSURES RELATING TO TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

Generally, we may use or disclose your PHI as follows:

For treatment: We may use your PHI to treat you and disclose your PHI to doctors, nurses, and other healthcare personnel who are involved in treating you. For example, your PHI will be shared among members of your healthcare team.

To obtain payment: We may use/disclose your PHI in order to bill and collect payment for your healthcare services. For example, we may contact your insurer to get paid for services that we delivered to you. We may release information to collection agencies for the purpose of payment.

For healthcare operations: We may use/disclose your PHI in the course of operating our centers. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. For example, we may use your PHI in evaluating the quality of services provided, or disclose your PHI to our accountant or attorney for audit purposes.

USES AND DISCLOSURES OF PHI REQUIRING AUTHORIZATION

For uses and disclosures for purposes other than treatment, payment and operations, we are required to have your written authorization, unless the use or disclosure falls within one of the exceptions described below. Most uses and disclosures of psychotherapy notes, uses and disclosures for marketing purposes, and disclosures that constitute the sale of PHI require your authorization. Authorizations can be revoked at any time to stop future uses/disclosures except to the extent that we have already relied on your authorization.

USES AND DISCLOSURES OF PHI NOT REQUIRING CONSENT OR AUTHORIZATION

Federal law provides that we may use/disclose your PHI without your consent or authorization in the following circumstances. If the laws of your state are more restrictive, we will follow state law.

When required by law: We may disclose PHI when required by a law, for law enforcement purposes or when necessary in connection with the commission of a crime. We may also disclose PHI to authorities that monitor compliance with these privacy requirements.

For public health activities: We may disclose PHI when we are required to collect information about disease or injury, or to report vital statistics to the public health authority, such as the Food and Drug Administration (FDA).

Victims of abuse, neglect or domestic violence: We may report information to a government authority, including a social service or protective services agency, about suspected abuse, neglect or domestic violence.

For health oversight activities: We may disclose PHI to our corporate office or an agency responsible for monitoring the healthcare system for such purposes as reporting or investigation of unusual incidents, and monitoring of government healthcare programs, such as Medicare and Medicaid.

Relating to decedents: We may disclose PHI related to a death to coroners, medical examiners or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.

To avert threat to health or safety: In order to avoid a serious threat to health or safety, we may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.

For specific government functions: We may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government benefit programs relating to eligibility and enrollment, and for national security reasons, such as protection of the President.

For workers' compensation: We may disclose health information to the extent authorized by and necessary to comply with laws relating to workers' compensation or other similar programs established by law.

For research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

To respond to lawsuits and legal actions: We may disclose your PHI in response to a court or administrative order.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have the following rights relating to your PHI:

07202017 All Contents Copyright © 2017 Paparella Ear Head & Neck Institute. All Rights Reserved.

NOTICE OF PRIVACY PRACTICES

CONTINUED

To request restrictions on uses/disclosures: You have the right to ask that we limit how we use or disclose your PHI for healthcare treatment, payment and operations, or to individuals involved in your care. Such uses and disclosures do not typically require your permission because PEHNI may need to use or disclose the information in for order to provide services to you. We will consider your request for a restriction, but, in most cases, we are not legally required to agree to the restriction. PEHNI is only required to agree to a requested restriction if (1) the disclosure is for payment or healthcare operations and (2) the information pertains solely to any item or service that you (or another person on your behalf, other than a health plan) paid for out of pocket, in full. To the extent that we do agree to any restriction on our use/disclosure of your PHI, we will put the agreement in writing and abide by it except in emergency situations. We cannot agree to limit uses/disclosures that are required by law.

To choose how we contact you: You have the right to ask that we send you information at an alternative address or by an alternate means. We will agree to your request as long as it is reasonably easy for us to do so.

To inspect and request a copy of your PHI: Unless your access to your records is restricted for clear and documented treatment reasons, you have a right to see your protected health information upon your written request. We will respond to your request within 30 days or sooner if required by the laws of your state. If we deny your access, we will give you written reasons for the denials and explain any right for the denial to be reviewed. If you want copies of your PHI, a charge for copying may be imposed, depending on your circumstances. You have a right to choose what portions of your information you want copied and to have prior information about any charges for copying. If your information is stored electronically, you have a right to receive it in an electronic format.

To request amendment of your PHI: If you believe that there is a mistake or missing information in our record of your PHI, you may request, in writing, that we correct or add to the record. We will respond within 60 days of receiving your request or sooner if required by the laws of your state. We may deny the request if we determine that the PHI is (1) correct and complete; or (2) not created by us and/or not part of our records.

To find out what disclosures have been made: You have a right to get a list of when, to whom, for what purpose, and what content of your PHI has been released by us other than pursuant to your written authorization. We will respond to your written request for such a list within 60 days of receiving it or sooner if required by the laws of your state. Your request can relate to disclosures going back six years. We will provide you with one list each year free but may charge you a reasonable cost-based fee for more frequent requests.

To find out if there has been a breach of your PHI: We are required to notify you when there has been an acquisition, access, use, or disclosure of your PHI that is not permitted under HIPAA and that compromises the security or privacy of your PHI.

YOU HAVE THE RIGHT TO RECEIVE THIS NOTICE

You have a right to receive a paper copy of this Notice.

CONTACT PERSON FOR INFORMATION OR TO SUBMIT A COMPLAINT

For any complaints regarding PEHNI's privacy practices or additional information' about its privacy practices, contact PEHNI's Privacy Officer by calling 866-316-0769.

Non-Retaliation: If an Individual believes his/her privacy rights have been violated, the Individual may complain to PEHNI's Privacy Officer or to the Secretary of the Department Of Health and Human Services, without fear of retaliation by the organization.

Effective Date: This Notice is effective January 6, 2017.

07202017 All Contents Copyright © 2017 Paparella Ear Head & Neck Institute. All Rights Reserved.