

REGISTRATION

Date _____ Home Phone _____ Work Phone _____ Email _____
 Patient Last Name _____ First Name _____ Initial _____
 Street Address _____
 City _____ State _____ Zip _____
 Sex M F Age _____ Birth date _____ Single Married Widowed Separated Divorced
 Social Security # _____ Driver's License # _____

Insured Name _____ How and where did you learn about this clinic? _____
 Last Name First Name Initial
 Relationship To Insured Self Spouse Child Other
 Condition/ Illness Related To Illness Employment Auto Other

EMPLOYER	Company Name _____		Occupation _____	
	Address _____		Phone _____	Full-time _____ Part-time _____
	City _____	State _____	Zip _____	Years Employed _____

SPOUSE (PARENT)	Name _____		Birthdate _____		SSN: _____
	Last Name	First Name	Initial		
	Employer Name _____		Years _____	Employed _____	
	Address _____		Phone _____	Occupation _____	
	City _____	State _____	Zip _____	Full-time _____	Part-time _____

PATIENT INSURANCE INFORMATION	Please list any and all insurance and/or employee health care plan coverage you or your spouse may have				
	Insurance Company or Health Care Plan Name _____				
	Policy/Group #: _____	Effective Date: _____		ID #: _____	
Name of Insured: _____					

SPOUSE COINSURANCE INFORMATION	Please list any and all coinsurance and/or employee health care plan coverage you or your spouse may have				
	Insurance Company or Health Care Plan Name _____				
	Policy/Group #: _____	Effective Date: _____		ID #: _____	
Name of Insured: _____					

MEDICAL AND LEGAL INFORMATION	Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury <u>someone else might be legally liable for</u>? Yes No Your Initials: _____				
	If you answered yes, please fill out accident specific form, available at the front desk.				
	Pregnant	Yes	No	Pacemaker	Yes No Family Physician _____
	Person to contact in emergency (Name and Phone #) _____				
	Attorney _____	Telephone: _____		Address _____	

Patient Agreement & Authorization For The Release Of Medical And Health Plan Documents For The Claims Processing & Reimbursement As Required by Federal and State Laws	<p>Legal Assignment Of Benefits And Designation Of Authorized Representative</p> <p>In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to the above named healthcare provider(s), <u>as my designated Authorized Representative(s)</u>, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status. I understand that I am legally responsible for any and all actual total charges expressly authorized by me regardless of any applicable insurance or benefit payments. <u>I hereby authorize the above named provider(s) to release all medical information necessary to process my claims under HIPAA.</u> I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from such provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.</p> <p>I hereby convey to the above named provider(s), to the full extent permissible under the laws, including but not limited to, ERISA §502(a)(1)(B) and §502(a)(3), under any applicable employee group health plan(s), insurance policies or public policies, any benefit claim, liability or tort claim, chose in action, appropriate equitable relief, surcharge remedy or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s), with respect to any and all medical expenses legally incurred as a result of the medical services I received from the above named provider(s), and to the full extent permissible under the laws to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but are not limited to, (1) obtaining information about the claim to the same extent as the assignor; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by such provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, bring suit by such provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.</p>				
	Signature of Insured / Guardian _____		Date _____		

WEST HOUSTON ENT & SLEEP CENTER

12606 West Houston Center Blvd #220 Houston, Texas 77082
Phone: 281-556-1102 - Fax: 281-556-1340

Notice of Privacy Practices

Dr. James J. Ludwick

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.

This practice uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. This notice describes our privacy practices. You can request a paper copy of this at any time even if we communicate with you electronically.

A. Treatment, Payment, Health Care Operations

Treatment

We are permitted to use and disclose your medical information to those involved in your treatment. For example, we provide specialty care and may request that your primary care physician share your medical information with us. Also, we may provide your primary care physician information about your particular condition so that he/she can appropriately treat you for other medical conditions, if any.

Payment

We are permitted to use and disclose your medical information to bill and collect payment for the services we provide to you. For example, we may complete a claim form to obtain payment from your insurer or HMO. That form will contain medical information, such as a description of the medical services provided to you, that your insurer or HMO needs to approve payment to us.

Health Care Operations

We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered.

B. Disclosures That Can Be Made Without Your Authorization

There are situations in which we are permitted to disclose or use your medical information without your written authorization or an opportunity to object. In other situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or that rely on that authorization.

Public Health, Abuse or Neglect, and Health Oversight

We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like births and death), or injury by a public health authority. We may

disclose your medical information to report reactions to medications, problems with products, or to notify people of recalls of products they may be using.

Because Texas law requires physicians to report child abuse or neglect, we may disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law also requires a person having cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation to report the information to the state, and HIPAA privacy regulations permit the disclosure of information to report abuse or neglect of elders or the disabled.

We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections, which are all government activities undertaken to monitor the health care delivery system and compliance with other laws, such as civil rights laws.

Workers' Compensation

We may disclose your medical information as required by workers' compensation law.

C. Your Rights Under Federal Law

The U. S. Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against patients who exercise their HIPAA rights.

Requested Restrictions

You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or health care operations. We do NOT have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances.

You also may request that we limit disclosure to family members, other relatives, or close personal friends who may or may not be involved in your care.

To request a restriction, submit the following in writing: (a) the information to be restricted, (b) what kind of restriction you are requesting (i.e. restrict the use of information, disclosure of information, or both), and (c) to whom the limits apply. Please send the request to Dr. James Ludwick, 12606 Old Westheimer Road, Suite 220 Houston, TX 77082.

Receiving Confidential Communications by Alternative Means

You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to the person listed below. We are required to accommodate only *reasonable* requests. Please specify in your correspondence exactly how you want us to communicate with you and, if you are directing us to send it to a particular place, the contact/address information.

Inspection and Copies of Protected Health Information

You may inspect and/or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that requests for copies be made in writing, and we ask that requests for inspection of your health information also be made in writing.

Texas law requires us to be ready to provide copies or a narrative within 15 days of your request. We will inform you when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing.

Amendment of Medical Information

You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to our office. We will respond within 60 days of your request.

Even if we refuse to allow an amendment, you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment, we will inform you in writing. If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we know have the incorrect information.

E. Complaints

If you are concerned that your privacy rights have been violated, you may contact me or you may send a written complaint to the U. S. Department of Health and Human Services. We will not retaliate against you for filing a complaint with us or the government.

F. Our Promise to You

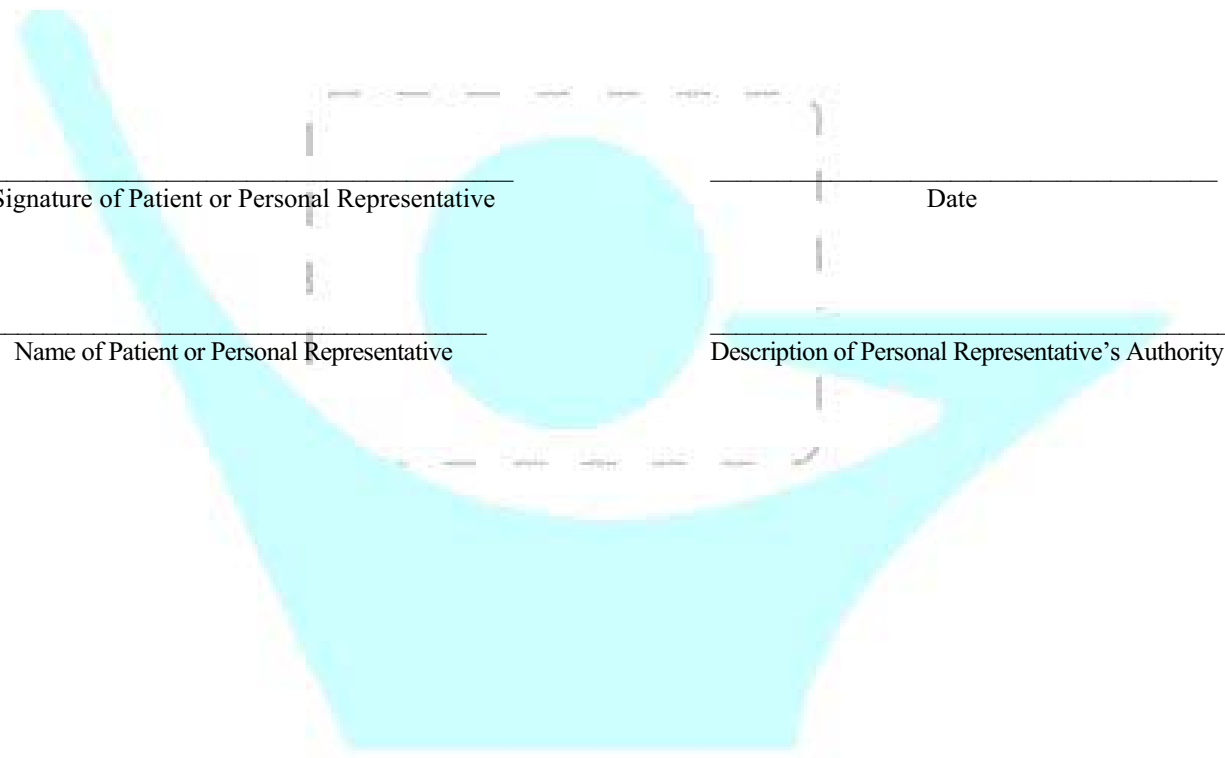
We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

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Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.



_____ Signature of Patient or Personal Representative	_____ Date
_____ Name of Patient or Personal Representative	_____ Description of Personal Representative's Authority

Payment Policy

***** Please note: ALL PAYMENT IS DUE AT THE TIME OF SERVICE *****

In order for Dr. James Ludwick to adequately evaluate and diagnose your complaint/illness you may require an in-office procedure. Common diagnostic procedures include:

- Nasal Endoscopy/Nasopharyngoscopy
- Flexible Laryngoscopy
- Removal of impacted cerumen to allow visualization of the ear drum
- Use of microscope

In addition, common in-office therapeutic procedures include:

- Inferior turbinate reduction
- removal of nasal or ear foreign bodies
- cerumen removal
- Pillar Procedure
- biopsies
- nasal debridement

You may be responsible for the charges associated with these procedures which typically range from \$50 - \$250 (\$90 - \$1500 for therapeutic procedures). This will depend on your specific health care benefits from your insurance provider. As a courtesy, at the time of your visit we will do our best to notify you of any co-insurance or deductibles which apply to your policy, *but it is ultimately your responsibility to know what your health care policy covers.*

These payments are expected at the time of service unless prior written arrangements have been made with our office. If, upon receiving your explanation of benefits (EOB) from your insurance carrier, an overpayment was made on your part, a refund will be mailed to the address on file with our office.

Please feel free to ask the receptionist if you have any questions regarding this policy so we can minimize any confusion concerning our charges.

Thank you,

West Houston ENT & Sleep Center
Billing and Insurance Dept.

I acknowledge that I may be responsible for payment due at the time of service other than my office visit co-pay or deductible due to my benefit plan.

X _____

Patient/Guardian Signature

X _____

Date

X _____

Patient name

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New Pediatric ENT Patient Health History

IN YOUR OWN WORDS, WHAT BRINGS YOUR CHILD TO SEE US TODAY? _____

PLEASE TELL US YOUR CHILD'S: HEIGHT _____ **WEIGHT** _____ **lbs**

PAST HEALTH HISTORY: Have your child ever been diagnosed with the following?

Cancer: Type: _____

- Ears**
- Recurrent Ear Infections No Yes When? _____
 - Ear Fluid No Yes When? _____
 - Failed Hearing Screen No Yes When? _____
 - Hearing Loss No Yes When? _____
 - Cholesteatoma No Yes When? _____
 - Outer Ear Infections No Yes When? _____

- Nose & Sinus:**
- Nasal Allergies No Yes When? _____
 - Sinusitis No Yes When? _____
 - Nasal Polyps No Yes When? _____
 - Nose Bleeds No Yes When? _____

- Cardiovascular:**
- Arrhythmia No Yes When? _____
 - Heart Defects No Yes When? _____
 - High Blood Pressure No Yes When? _____

- Pulmonary:**
- Asthma No Yes When? _____
 - Sleep Apnea No Yes When? _____
 - Tuberculosis No Yes When? _____
 - Croup No Yes When? _____
- If so, how many times? _____

- Has your child ever had:**
- Hepatitis No Yes When? _____
 - HIV No Yes When? _____
 - CMV No Yes When? _____
 - Infectious Mono No Yes When? _____
 - In-Utero Infections No Yes When? _____

- Stomach/Digestive:**
- Reflux No Yes When? _____
 - Feeding Problems No Yes When? _____
- Kidney:**
- Kidney Disease No Yes When? _____
- Type: _____

- Endocrine**
- Diabetes No Yes When? _____
 - Hyperthyroidism No Yes When? _____
 - Hypothyroidism No Yes When? _____

- Blood/Lymph Nodes:**
- Anemia No Yes When? _____
 - Bleeding Disorder No Yes When? _____
 - Leukemia/Lymphoma No Yes When? _____

- Other/Genetics:**
- Failure to Thrive No Yes When? _____
 - Developmental Delay No Yes When? _____
 - Down's Syndrome No Yes When? _____
 - Cystic Fibrosis No Yes When? _____

Have we missed anything?

- SURGERIES:**
- Tonsillectomy No Yes Age? _____
 - Adenoidectomy No Yes Age? _____
 - Ear Tubes No Yes
 - If yes, # of sets? _____ Ages _____
 - Sinus Surgery No Yes Age? _____
 - Other _____

Have you ever been hospitalized? No Yes

Have you ever had a problem with anesthesia? No Yes
Reaction _____

CURRENT MEDICATIONS: (Please include all prescription & over-the-counter medications, herbal and vitamin supplements.)

NONE

Name of Medication	Dose	Times/day

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New Pediatric ENT Patient Health History

MEDICATION ALLERGIES: NONE

Name of Medication	Type of Reaction (ex: rash, hives, swelling)

SOCIAL HISTORY:

Who does your child live with? Both Parents Mom Dad Other _____
 Number of Siblings None One Two Three Four Other _____
 Does your child attend daycare? No Yes Days/Week: _____ # Children: <5 children 6-10 >10
 Are you concerned with your child's school performance? No Yes N/A Grade: _____
 Did your child have a new born hearing screen? No Yes Did your child pass the screen? No Yes

Pregnancy: Full Term Pre-Mature If premature, # of weeks: _____ Delivery: Vaginal C-Section
 Did your child go home with you from the hospital after birth? No Yes
 Has your child ever been hospitalized? No Yes
 If yes, which of these apply? ICU Care My child received IV antibiotics Required a ventilator
 Required UV lights for jaundice Prolonged hospitalization

Immunizations Up-to-Date? No Yes
 Are there any pets at home? No Yes
 Does anyone smoke at home? No Yes

FAMILY HISTORY:

Problems with anesthesia	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Ears:				
Hearing loss before age 20	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Hearing loss after age 20	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Nose & Sinus:				
Nasal Allergies	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Nose Bleeds	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Nasal Polyps	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Cardiovascular				
Heart Attack	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
High Cholesterol/Heart Disease	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
High Blood Pressure	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Pulmonary:				
Asthma	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Lung Cancer	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Gastrointestinal				
Stomach/Esophageal Cancer	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Reflux	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Nervous System				
Stroke	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Brain Tumors	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Blood & Lymph Nodes				
Bleeding/Clotting Disorder	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
Leukemia/Lymphoma	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister

Other: _____

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New Pediatric ENT Patient Health History

REVIEW OF SYSTEMS:

General Health Problems

- Fever/Chills Problems gaining weight
- Concern with speech/language delay Recent Illness
- Articulation Problems

Eye

- Blurry Vision Double Vision Itchy/Watery Eyes

Ear

- Ear Pain Hearing Loss Drainage
- Ringing Dizziness/Vertigo
- Recurrent Ear Infections? #/year? _____

Nose & Sinus

- Nasal Congestion Nasal Drainage Post-Nasal Drip
- Facial Pain Nose Bleeds Nasal Obstruction

Mouth & Throat

- Hoarseness Change in Voice Snoring
- Ulcers Sore Throat Witnessed Apnea
- Recurrent Throat Infections #/yr _____
- Difficulty Swallowing

Neck

- Pain Neck Mass Lymphadenopathy

Endocrine/Glands

- Change in thirst/appetite Feel cold all the time
- Neck has enlarged Feel hot all the time
- Weight Loss Weight Gain

Allergy

- Food intolerances Hives Itchy/watery eyes
- Mold Allergy Receive Allergy Shots
- Seasonal allergies Sneezing
- Allergy symptoms all year long

Pulmonary

- Non-productive cough Wheezing
- Productive cough Shortness of Breath
- Stridor Recurrent Pneumonia Noisy Breathing

Cardiovascular

- Blacking out/fainting Chest Pain
- Bluish discoloration of lips/fingernails
- Irregular heart beat

Stomach/Digestive

- Heartburn/Reflux
- Nausea Vomiting Stomach Problems

Genito/Urinary

- Kidney problems
- Describe: _____

MusculoSkeletal

- Pain Stiffness Muscle Cramps

Nervous System

- Seizures Numbness Weakness

Integument/Skin

- Birth Marks Hemangioma/Vascular lesions
- Get Big Scars

Blood/Lymph Nodes

- Bleed Excessively Bruise Easily
- Swollen Glands

Psychiatric

- Depression Anxiety Mood Disorder