West Houston ENT & Sleep Center, PA
12606 West Houston Center Blvd #220, Houston Tx 77082; Tel: 281.556.1102; Fax: 281.556.1340

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:_____ Name of Insured: ID #:
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:_____ Name of Insured: ID #:
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	**Legal Assignment Of Benefits And Designation Of Authorized Representative** 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. 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. _____ _____ Signature of Insured / Guardian Date

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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 deductable due to my benefit plan.

X_____ **X**_____

Patient/Guardian Signature **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:
- Hepatits ❑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 your 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	❑Mother	❑Father	❑Brother	❑Sister
Ears:				
Hearing loss before age 20	❑Mother	❑Father	❑Brother	❑Sister
Hearing loss after age 20	❑Mother	❑Father	❑Brother	❑Sister
Nose & Sinus:				
Nasal Allergies	❑Mother	❑Father	❑Brother	❑Sister
Nose Bleeds	❑Mother	❑Father	❑Brother	❑Sister
Nasal Polyps	❑Mother	❑Father	❑Brother	❑Sister
Cardiovascular				
Heart Attack	❑Mother	❑Father	❑Brother	❑Sister
High Cholesterol/Heart Disease	❑Mother	❑Father	❑Brother	❑Sister
High Blood Pressure	❑Mother	❑Father	❑Brother	❑Sister
Pulmonary:				
Asthma	❑Mother	❑Father	❑Brother	❑Sister
Lung Cancer	❑Mother	❑Father	❑Brother	❑Sister
Gastrointestinal				
Stomach/Esophageal Cancer	❑Mother	❑Father	❑Brother	❑Sister
Reflux	❑Mother	❑Father	❑Brother	❑Sister
Nervous System				
Stroke	❑Mother	❑Father	❑Brother	❑Sister
Brain Tumors	❑Mother	❑Father	❑Brother	❑Sister
Blood & Lymph Nodes				
Bleeding/Clotting Disorder	❑Mother	❑Father	❑Brother	❑Sister
Leukemia/Lymphoma	❑Mother	❑Father	❑Brother	❑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

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Pediatric Sleep Patient Evaluation Form

HEALTH STATUS:

Is your child gaining weight appropriately? ❑No ❑Yes
If no, please explain: _____
Is your child meeting his/her developmental milestones? ❑No ❑Yes
If no, please explain: _____

SCHOOL PERFORMANCE:

Your Child's Grade: _____
Has your child ever repeated a grade? ❑No ❑Yes
Has your child enrolled in any special education classes? ❑No ❑Yes
Is he/she having any difficulty in school? ❑No ❑Yes
If yes, please explain: _____

Child's grades this year:
❑Excellent ❑Good ❑Average ❑Poor ❑Failing

Child's grades last year:
❑Excellent ❑Good ❑Average ❑Poor ❑Failing

BEHAVIOR:

Is your child inattentive? ❑No ❑Yes
Is your child hyperactive? ❑No ❑Yes
Does he/she exhibit aggressive and/or defiant behavior? ❑No ❑Yes
Does your child have daytime sleepiness? ❑No ❑Yes
Does he/she have problems staying awake in school? ❑No ❑Yes
Please list any other behavioral concerns regarding your child.
_____
_____

SLEEP HEALTH HABITS:

Does your child drink caffeinated beverages (coffee, tea, cola)? ❑No ❑Yes Amount per day: _____

Generally, what time does your child go to bed? _____
Generally, what time does your child wake up in the morning? School days? _____ Weekends? _____

Does he/she sleep through the night? ❑No ❑Yes
If no, number of awakenings: _____ approximate time(s): _____

What is your child's typical bedtime routine? (i.e., bath, quiet time, story time, feeding?)
_____
_____

Where does you child sleep? Please check all that apply: ❑Co-sleep with parent(s) ❑Has his/her own bed
❑Has his/her own bedroom ❑Shares bedroom (with _____) ❑Other _____

Are there any factors in the home that would influence his or her ability to get a good night's sleep (i.e., noise, bright lights, household members who stay up late)? ❑No ❑Yes
If so, what are they? _____
_____

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Pediatric Sleep Patient Evaluation Form

SLEEP SYMPTOMS:

Does your child snore? ❑No ❑Yes If yes: ❑Mild ❑Moderate ❑Loud
Is it positional? ❑No ❑Yes If yes: ❑Back ❑Side

Does your child gasp/choke while sleeping? ❑No ❑Yes
Is your child a restless sleeper? ❑No ❑Yes
Do your child's lips turn bluish color while sleeping? ❑No ❑Yes
Does you child mouth breath? ❑No ❑Yes
If yes, when? ❑During the day ❑Only at night ❑Most of the time

Does your child: ❑Sleep walk ❑ Sleep talk ❑ Have nightmares ❑ Have sleep terrors ❑ Complain of nightly reflux

Does he/she currently wet the bed? ❑No ❑Yes If yes, for how long? _____
Has he/she wet the bed before this period? ❑No ❑Yes If yes, when? _____

INSOMNIA COMPLAINTS:

Does your child have difficulties falling asleep? ❑No ❑Yes staying asleep? ❑No ❑Yes