



**PATIENT INFORMATION**

First Name: \_\_\_\_\_ Middle: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Preferred Name: \_\_\_\_\_ Sex: \_\_\_\_\_  
Address: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_ [ ] Married [ ] Single [ ] Widowed  
Email Address: \_\_\_\_\_ [ ] Divorced [ ] Legally Separated  
Cell Phone: ( ) \_\_\_\_\_  
Home Phone: ( ) \_\_\_\_\_  
Pharmacy Name \_\_\_\_\_ Primary Physician: \_\_\_\_\_  
Pharmacy Address: \_\_\_\_\_ Primary Physician Phone: ( ) \_\_\_\_\_  
Pharmacy Phone: ( ) \_\_\_\_\_  
Emergency Contact Name: \_\_\_\_\_ Emergency Contact Phone: \_\_\_\_\_

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**Race:** [ ] American Indian/Alaska Native [ ] Asian [ ] White [ ] Black/African American [ ] Pacific Islander  
[ ] Other \_\_\_\_\_ [ ] Declined to state  
**Ethnicity:** [ ] Not Hispanic/Latino [ ] Hispanic/Latino [ ] Declined to state

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**INSURANCE INFORMATION (Please provide your insurance card to the receptionist)**

Insurance Company: \_\_\_\_\_ Insured DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Insurance/Card Holder's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
ID#: \_\_\_\_\_ Group#: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION**

Insurance Company: \_\_\_\_\_ Insured DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Insurance/Card Holder's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
ID: \_\_\_\_\_ Group #: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

**Patient or Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**PAST MEDICAL HISTORY**

Have you ever been hospitalized?  Yes  No If yes, for what reason? \_\_\_\_\_

Have you ever been vaccinated for Hepatitis A or B (circle one)?  Yes  No

Have you ever been tested for Hepatitis A, B, or C (circle one)?  Yes  No

**Please check all that apply:**

- |  |   |   |                                      |
|--|---|---|--------------------------------------|
| <input type="checkbox"/> AIDS, HIV                   | <input type="checkbox"/> Headache             | <input type="checkbox"/> Skin Rash        | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Allergies                   | <input type="checkbox"/> Heart Attack         | <input type="checkbox"/> Stroke           | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Anemia                      | <input type="checkbox"/> Hepatitis            | <input type="checkbox"/> Swelling of Feet |                                      |
| <input type="checkbox"/> Arthritis                   | <input type="checkbox"/> Herpes               | <input type="checkbox"/> Hyperthyroid     |                                      |
| <input type="checkbox"/> Asthma                      | <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Hypothyroid      |                                      |
| <input type="checkbox"/> Back Problem                | <input type="checkbox"/> Kidney Problems/UTI  | <input type="checkbox"/> Tonsillitis      |                                      |
| <input type="checkbox"/> Cancer. What type?<br>_____ | <input type="checkbox"/> Liver Disease        | <input type="checkbox"/> Ulcer, Colitis   |                                      |
| <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Nervous/Anxiety      | <input type="checkbox"/> Lupus            |                                      |
| <input type="checkbox"/> Emphysema, COPD             | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Rheumatoid       |                                      |
| <input type="checkbox"/> Epilepsy, seizures          | <input type="checkbox"/> Psychiatric Care     | <input type="checkbox"/> Fibromyalgia     |                                      |
| <input type="checkbox"/> Glaucoma, Eye               | <input type="checkbox"/> Reflux Disease, Acid | <input type="checkbox"/> Depression       |                                      |
|  | <input type="checkbox"/> Sinus Problems       |   |                                      |

**Social History**

Do you smoke?  Yes  No Packs per day? \_\_\_\_\_ Have you smoked in the past?  Yes  No

Do you chew tobacco?  Yes  No Have you in the past?  Yes  No

Do you drink alcohol, beer, wine, spirits?  Yes  No Drinks per week? \_\_\_\_\_ Drink in the past?  Yes  No

Are you currently taking any NSAID?  Yes  No If yes, what type? \_\_\_\_\_

**MEDICATIONS** (please use the back for more space)

Drug Name	Dosage

**ALLERGIES**

Allergic to:	Reaction

**SURGERIES:**

Surgery	Date

**FAMILY HISTORY:**

Member	Living?	Age	Please list serious illnesses
Mother	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Father	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Sister(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Brother(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No		



**LIFETIME AUTHORIZATION**

By signing below, I authorize the release of my medical or related information as necessary to process insurance claims, determine benefits, and obtain payment for services provided. I authorize payment of applicable insurance benefits to me or the party accepting assignment. A copy of this authorization shall be considered as valid as the original. The original authorization will be maintained on file by ENTrusting, LLC.

I understand that I may request a revised Notice of Privacy Practices in writing from ENTrusting, LLC.

Patient/Guarantor (Print): \_\_\_\_\_

Patient/Guarantor (Signature): \_\_\_\_\_ Date: \_\_\_\_\_

**I AUTHORIZE ENTRUSTING, LLC TO COMMUNICATE WITH ME VIA THE FOLLOWING ELECTRONIC MEANS:**

METHOD	CONTACT INFORMATION
<input type="checkbox"/> TEXT	
<input type="checkbox"/> EMAIL	
<input type="checkbox"/> VIDEO CONFERENCE	
<input type="checkbox"/> PHONE CALL	
<input type="checkbox"/> VOICE MAIL	

I do not authorize ENTrusting, LLC to communicate with me via electronic means.

- 1) By selecting a communication method and signing below, I authorize ENTrusting, LLC to electronically communicate Protected Health Information (PHI) to me or my designated representative, including information related to appointments, procedures, treatment recommendations, prescriptions, test results, billing matters, services, and office updates.
- 2) I understand that ENTrusting, LLC may use or disclose my information only as authorized by me, permitted by law, or described in the Notice of Privacy Practices, and will not sell my information to third parties without authorization except as permitted by applicable law.
- 3) I acknowledge that email and text messaging are not secure forms of communication and accept the associated risks. I release ENTrusting, LLC and its employees from liability arising from communications sent as authorized by me.
- 4) I understand that this authorization is voluntary and may be revoked at any time by written notice to ENTrusting, LLC; however, revocation will not apply to information previously disclosed. Refusal to sign will not affect my treatment, payment, enrollment, or eligibility for benefits.

Patient/Guarantor (Print): \_\_\_\_\_

Patient/Guarantor (Signature): \_\_\_\_\_ Date: \_\_\_\_\_



**CONSENT TO TREAT**

- I, the undersigned, voluntarily consent to medical treatment and services provided by ENTrusting, LLC and its healthcare providers, including examinations, diagnostic procedures, testing, treatment, preventive care, and follow-up services as deemed necessary or advisable for my care.
- I understand that treatment may include physical examinations, review of medical history, laboratory testing, imaging, medical interventions, and other diagnostic or therapeutic services. I acknowledge that no guarantees or assurances have been made regarding the results or outcome of any treatment or procedure.
- I understand that I may refuse or discontinue treatment at any time and that I will be informed of the risks, benefits, and alternatives of recommended treatments or procedures. I acknowledge that I have had the opportunity to ask questions and that my questions have been answered to my satisfaction.
- I understand that my medical information will be kept confidential and disclosed only as permitted by law, described in the Notice of Privacy Practices, or authorized by me in writing, including disclosure to healthcare providers involved in my care.

Patient Name (printed): \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_

**CONSENT FOR MINOR PATIENTS (if applicable):**

If the patient is a minor, I, the undersigned, am the parent or legal guardian of the patient and give my consent to treat the minor as outlined above.

Parent     Legal Guardian

Patient Name (printed): \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Witness Name (printed): \_\_\_\_\_ Witness Signature: \_\_\_\_\_



**CONSENT FOR TRANSFER OF BIOLOGICAL SPECIMEN**

Pursuant to Florida Statute Section 817.5655, a patient is entitled to provide informed consent before the transfer of any biological specimen. Specifically, the statute requires that before any specimen, including but not limited to blood, tissue, or other biological materials, is transferred for any purpose other than the original medical treatment or testing, the patient must be fully informed of the purpose, scope, and potential uses of the specimen.

During your care with ENTrusting, LLC and its affiliates, it may be medically necessary to collect blood, urine, stool, tissue, or other biological specimens for analysis. This analysis will not include DNA testing to identify the presence or composition of genes in your body. After the analysis is completed and the specimen is no longer needed, it will be treated as medical waste and transferred to a third party for disposal in compliance with all applicable local, state, and federal laws.

In some cases, your biological specimen (such as blood, urine, hair, or bodily fluids) may be deposited on medical instruments, bedding, clothing, or other items. These items may also be transferred to a third party for cleaning or disposal.

By signing this document, you affirmatively state that you intentionally consent to the transfer of any biological specimens collected by or deposited with ENTrusting, LLC and its affiliates to a third party as described above. This consent does not authorize the sale or transfer of any biological specimen for DNA analysis.

**X** \_\_\_\_\_  
(Patient's Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Patient's Printed Name)

\_\_\_\_\_  
(Date of Birth)



## FINANCIAL RESPONSIBILITY

This is an agreement between ENTrusting, LLC, as a creditor, and the Patient/Debtor named on this form.

In this agreement, the words “I”, “you”, “your”, and “yours” mean the Patient/Debtor. The word “account” means any account that has been established in your name to which charges are made, and payments are credited. The words “we”, “us”, and “our” refer to ENTrusting, LLC.

\_\_\_\_\_ **Initials** Insurance: ENTrusting, LLC participates in many different types of health insurance plan that may vary in the amount and extent of coverage and medical services provided. It is your responsibility to check with your insurance to verify that Dr. H. Van Nguyen is within your network and your medical services will be covered. If you are unable to show proof of coverage or do not have health insurance, your appointment will be rescheduled, or you will be required to pay for services the day of your appointment. You are also responsible for knowing your insurance benefits and coverage. We will gladly file your insurance claim on your behalf with the insurance companies that we participate with and will allow 45 days for them to process the claim. If your insurance company does not process the claims within that period of time, you will be responsible for paying the entire bill. If there should be a dispute between you and your insurance company regarding coverage and/or policy benefit criteria such as co-pays, deductibles, co-insurance, non-covered services, and benefits coordination, we will not become involved. You are responsible for all co-payments at the time of your service.

\_\_\_\_\_ **Initials** For value received, including but not limited to the services rendered, I agree to guarantee and promise to pay ENTrusting, LLC all charges and expenses incurred in my treatment, unless otherwise agreed in writing that these charges will be discharged by ENTrusting, LLC. I understand and agree that if ENTrusting, LLC is required to bring a claim or file an action to enforce this agreement, ENTrusting, LLC shall be entitled to recover from me its reasonable attorney’s fees, expert fees, courts costs, and any other costs of collection, in addition to the amount owed to ENTrusting, LLC for its services.

### Returned Checks

\_\_\_\_\_ **Initials** A returned check will result in a service fee based on the face value of the check and may require all future payments to be made by cash or credit card. A collection agency may be used in the recovery of debt attributed to returned checks, in addition to the payment of the check plus any court cost, reasonable attorney fees, and any bank fees incurred by the payee in taking action as pursuant to *Florida Statute 68.065*.

### Divorce, Dependent and Child Custody Cases

Regarding divorce, the presenting guardian accompanying the person (minor or disabled adult) who receives care at ENTrusting, LLC is responsible for payments of copays, co-insurance and/or deductibles at the time of service.



**HIPAA CONTACT INFORMATION**

In the section below, please identify any person(s) authorized to receive information regarding your care. This authorization allows ENTrusting, LLC to communicate with those individuals about test results, office visits, and other protected health information (PHI). Spouses, parents, siblings, relatives, and friends must be specifically listed in order for us to communicate with them.

Medical records will not be released to these individuals without your separate written authorization. You may revoke this authorization at any time by written or verbal notice.

I, \_\_\_\_\_, hereby request confidential communication of my protected health information to the following individual or individuals:

Contact Person: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Relationship: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Relationship: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Relationship: \_\_\_\_\_

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

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



ENTrusting, LLC is committed to protecting the privacy of your protected health information (“PHI”). This Notice explains how we may use and disclose your health information, your privacy rights, and our legal responsibilities under federal and Florida law. Please review it carefully.

### **How We Use and Share Your Health Information**

During your care, we create and maintain a medical record that may include your health history, symptoms, diagnoses, treatment, test results, billing information, and care plans. We may use or disclose your PHI for:

#### **Treatment**

To provide, coordinate, and manage your healthcare services with doctors, nurses, pharmacies, laboratories, and other healthcare providers involved in your care.

#### **Payment**

To bill and collect payment from you, your insurance company, or other third parties. This may include sharing information needed for claims, prior authorizations, or benefit verification.

#### **Healthcare Operations**

For business and operational activities such as quality improvement, staff training, scheduling, record management, licensing, accreditation, and compliance activities.

#### **Other Permitted Uses and Disclosures**

We may also disclose your PHI when permitted or required by law, including:

- To family members or others involved in your care when appropriate;
- For public health and safety activities;
- For workers' compensation claims;
- To law enforcement or government agencies as required by law;
- In response to court orders, subpoenas, or legal proceedings;
- For disaster relief efforts; and
- To health oversight agencies for audits, investigations, or compliance reviews.

We will not use or disclose your PHI for purposes other than those described in this Notice without your written authorization, except as permitted or required by law.

#### **Your Rights Regarding Your Health Information**

You have the right to:

- Request restrictions on certain uses or disclosures of your PHI;
- Request confidential communications by alternative means or locations;
- Inspect and obtain a copy of your medical and billing records;
- Request corrections or amendments to your records;
- Receive an accounting of certain disclosures of your PHI;
- Revoke a previously signed authorization in writing; and
- Request that information not be disclosed to your health plan if you paid in full out-of-pocket for the related service.

Some requests may be denied as permitted by law.



**Our Responsibilities**

ENTrusting, LLC is required by law to:

- Maintain the privacy and security of your PHI;
- Provide you with this Notice of Privacy Practices;
- Follow the terms of this Notice currently in effect;
- Notify you of any breach involving unsecured PHI; and
- Accommodate reasonable requests regarding confidential communications.

We reserve the right to update this Notice at any time. Updated versions will be available upon request.

If you have questions about this Notice or your privacy rights, please contact ENTrusting, LLC.

Patient Name (Printed): \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_

**OFFICE USE ONLY**

I attempted to obtain the patient’s signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so for the reason documented below:

Date	Initials	Reason



**Florida Patient's Bill of Right and Responsibilities**  
**Florida Statute Chapter 381(028)**

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

1. A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
2. A patient has the right to a prompt and reasonable response to questions and requests.
3. A patient has the right to know who is providing medical services and who is responsible for his or her care.
4. A patient has the right to know what patient support services and available, including whether an interpreter is available if he or she does not speak English.
5. A patient has the right to know what rules and regulations apply to his or her conduct.
6. A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
7. A patient has the right to refuse any treatment, except as otherwise provided by law.
8. A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
9. A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment; whether the health care provider or health care facility accepts for Medicare assignment rate.
10. A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for the medical care.
11. A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill, and upon request, to have the charges explained.
12. A patient has the right to impartial access to medical treatment or accommodation, regardless of race, national origin, religion, handicap, or source of payment.
13. A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
14. A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
15. A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievances procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.



**Ear, Nose, & Throat Surgical Specialist**

16. A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
17. A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.
18. A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
19. A patient is responsible for following the treatment plan recommended by the health care provider.
20. A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.
21. A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
22. A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as a promptly as possible.
23. A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.