ENTrusting LLC

Ear, Nose, & Throat Surgical Specialist

PATIENT INFORMATION

First Name: _____ Middle: _____ Last Name:_____

Preferred Name: _____ Sex: _____

Address: _____ Date of Birth: _____ / _____ / _____

City: _____ State: ____ Zip: _____ Email Addres: _____

Social Security: _____ Cell Phone: ( ) _____

[ ] Married [ ] Single [ ] Widowed [ ] Divorced Home Phone: ( ) _____

[ ] Legally Separated [ ] Domestic Partner Pharmacy Phone: ( ) _____

[ ] Employed [ ] Retired [ ] Full-Time Student Pharmacy Address: _____

Employer: _____ Primary Physician: _____

Address: _____ Primary Physician Phone: ( ) _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

To know more about our patients, we would appreciate the following information:

Preferred Language (if other than English): _____

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

---

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:** _____

ENTrusting LLC
Ear, Nose, & Throat Surgical Specialist

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:

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

ALLERGIES: Please list any medication allergies you have: _____

_____

_____

Please list any SURGERIES you have had in your past: _____

_____

ENTrusting LLC
Ear, Nose, & Throat Surgical Specialist

MEDICATIONS

Drug Name	Dosage

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

Do you drink coffee or caffeinated beverages? [ ] Yes [ ] No How many cups, cans, glasses per day? _____

Do you take any illicit drugs? [ ] Yes [ ] No If yes, what kind? _____

Are you currently taking any NSAID? [ ] Yes [ ] No If yes, what type? _____

Family History

Member	Living?	Age	Please list serious illnesses
Mother	[ ] Yes [ ] No		
Father	[ ] Yes [ ] No		
Sister(s)	[ ] Yes [ ] No		
Brother(s)	[ ] Yes [ ] No		

Has anyone in your family had any of the following:

Condition	Which Family Member?
Anemia or blood disorder/clotting disorders	
Cancer – What kind?	
Diabetes	
Genetic disorder of any kind	
Glaucoma, eye disorder	
Heart Disease	
High blood pressure	
HIV, Infectious disease	
Mental Issues, Depression, Anxiety, Bipolar	
Stroke	
Rheumatoid, lupus, rheumatological disease	

ENTrusting LLC
Ear, Nose, & Throat Surgical Specialist

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** Missed Appointment Fee: I understand that *Appointment Reminders are a courtesy*. Failure to show up for, or cancellation of an appointment with less than 24 hours’ notice may result in a no-show fee assessed to my account. The no show fee will be $25 and must be paid in full before a new appointment is scheduled. Patients with three missed appointments may be discharged from ENTrusting, LLC.

Guarantee of Payment

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 owned to ENTrusting, LLC for its services.

Returned Checks

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.

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I consent to the use or disclosure of my protected health information by ENTrusting, LLC for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of ENTrusting, LLC. I understand that diagnosis or treatment to me by ENTrusting, LLC may be conditioned upon my consent as evidenced by my signature on this document.

My “protected health information” means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the ENTrusting, LLC *Notice of Privacy Practices* prior to signing this document. ENTrusting, LLC’s *Notice of Privacy Practices* has been provided to me. The *Notice of Privacy Practices* describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of ENTrusting, LLC. The *Notice of Privacy Practices* also describes my right and the duties of ENTrusting, LLC with respect to my protected health information. ENTrusting, LLC reserves the right to change the privacy practices that are described in the *Notice of Privacy Practices*.

LIFETIME AUTHORIZATION

By signing below, I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to the billing agent or this physician or supplier, any information needed for this or related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to myself or to the party who accepts assignment. The original authorization will be kept on file by ENTrusting, LLC.

I may obtain a revised Notice of Privacy Practices by requesting in writing from ENTrusting, LLC.

Patient/Guarantor (Print): _____

Patient/Guarantor (Signature): _____ Date: _____

AUTHORIZATION TO COMMUNICATE PROTECTED HEALTH INFORMATION (PHI) via ELECTRONIC MEANS

PATIENT INFORMATION:

Last Name: _____ First Name: _____ Middle Initial: _____

DOB: _____ / _____ / _____ Phone #: ( ) _____

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

METHOD	CONTACT INFORMATION
[ ] TEXT	
[ ] EMAIL	
[ ] VIDEO CONFERENCE	
[ ] PHONE CALL	
[ ] VOICE MAIL	

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

This Authorization to Communicate PHI via electronic means expires:

[ ] Upon written revocation [ ] Other

1. I understand that by selecting the method of communication above and signing below, I authorize ENTrusting, LLC to share/communicate PHI information via electronic means to myself or my designated representative described above.

2. I understand ENTrusting, LLC may communicate to me information such as, but not limited to, when I have an upcoming appointment, upcoming procedure, services recommended by my doctor, medication refills, test results, new services offered, financial information or statements and new locations at ENTrusting, LLC.

3. I understand that according to HIPAA Privacy Rule §164.501, ENTrusting, LLC cannot sell or distribute my communication method or information with any third-party without my prior consent.

4. I understand that, by federal law, ENTrusting, LLC may not use or disclose my health without my authorization, except as provided in ENTrusting LLC's Notice of Privacy Practices.

5. I hereby release ENTrusting, LLC and its employees from any and all liability that may arise from the release of information as I have directed.

6. I understand emailing and texting are not secure forms of communication and I release ENTrusting, LLC from any liability.

7. I understand that I have the right to revoke this Authorization at any time, if I do so, it must be in writing and address to ENTrusting, LLC. The revocation will not apply to any information already released as a result of this authorization.

8. I understand that I may refuse to sign this Authorization to communicate PHI via electronic means and that I cannot be denied or refused treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign it.

Notice of Billing Efforts Conducted via Electronic Means

I understand that in its regular course of billing and collection efforts, ENTrusting, LLC may communicate with me via electronic means and that any phone number (including cellular phone numbers) and/or email address provided to ENTrusting, LLC may be used for these purposes. I consent to the use of email, text or automated voicemail communication by ENTrusting, LLC if I have any balances due on my account, regardless of my preferred Contact selection(s) for communication of protected health information (PHI) via electronic means. I understand that contacts may be made as a direct dial call or through the use of email, text messages, pre-recorded or artificial voice messages, and/or the use or an “automated telephone dialing system” or “autodialer”. I understand that message or data rates may be assessed by my mobile provider.

By signing this form, you represent that you are the cellular subscriber or customary user with respect to the cellular number(s) provided and that you have the authority to provide consent.

Print Name: _____ Date: _____

Signature: _____

Signature by: [ ] Patient [ ] Legal Guardian [ ] Proxy [ ] Legal Representative

ENTrusting LLC
Ear, Nose, & Throat Surgical Specialist

HIPAA CONTACT INFORMATION

In the following section, please let us know of any person or persons that we can communicate with in regards to your care. This will enable us to let these individuals know about our test results, office visit information, and other sensitive and protected health information. You must list spouses, parents, siblings, friends, and relatives on this document for us to be able to communicate with them. We will not release copies of your medical records to these individuals without your written request to do so. You can revoke this request at any time by a written or a verbal request.

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

Ear, Nose, & Throat Surgical Specialist

CONSENT TO TREAT

I, the undersigned, hereby voluntarily give my consent to ENTrusting, LLC and its healthcare providers to provide medical treatment, including but not limited to, diagnostic procedures, treatment, and medical services that are necessary or advisable for my health care.

Purpose of Treatment:

The purpose of this consent is to allow the healthcare profession at ENTrusting, LLC to provide medical care, including examination, diagnosis, treatment, and follow-up care. I understand that medical care includes, but not limited to, routine medical evaluations, diagnostic tests, and preventive care.

Nature of Treatment:

I understand that the procedure and treatments may include physical examinations, medical history reviews, laboratory testing, imaging studies, medical interventions, and other diagnostic or therapeutic services. I acknowledge that no guarantees or assurances have been made to me regarding the outcome of any procedures or treatment.

Voluntary Participation:

I understand that I am voluntarily seeking medical treatment and that I have the right to refuse or discontinue any medical treatment at any time. I understand that I will be informed of the risks and benefits of any recommended treatments and procedures.

Confidentiality of Information:

I understand that my medical records will be kept confidential, and that my information will only be disclosed as required by law, or with my written consent. I am aware that my medical records may be shared with other healthcare providers involved in my care for purposes related to my treatment.

Right to Ask Questions:

I acknowledge that I have been provided with an opportunity to ask questions about the proposed treatment and that all questions have been answered to my satisfaction.

Acknowledgement of Risks and Benefits:

I acknowledge that I have been informed of the potential risks and benefits of the proposed treatment or procedures. I have had the opportunity to discuss my concerns and have received adequate answers.

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: _____