Southern WV
ENT & Endocrinology

Welcome,

Thank you for choosing Southern WV ENT & Endocrinology. Enclosed you will find your new patient paper work that must be completed and mailed back to us as soon as possible. ***Please*** bring your ***medication bottles*** and your ***insurance cards*** to this visit.

Your appointment is scheduled for:

_____ at _____

We ask that you please arrive 30 minutes prior to your scheduled appointment to allow us time to get you registered.

If your paperwork is not ***completed*** and ***returned*** your appointment may be delayed or rescheduled.

Please give our office ***24 hours*** notice in the event that you need to cancel or reschedule your appointment.

Please read the attached Cancellation and No-Show Policy.

Thank you,

The Staff at Southern WV ENT & Endocrinology

Dr. Justin Douglas, MD, MS

Dr. Jillian Douglas, DO

Lewisburg Office:

206 Skylar Drive

Lewisburg, WV 24901

Phone: (681) 318-3540

Fax: (877) 712-1319

Southern WV
ENT & Endocrinology

Cancellation Policy and No Show Policy

We understand there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel, and we are unable to schedule you for a visit due to a seemingly "full" appointment book.

If you fail to show for your appointment, you will be charged a fifty dollar ($50) fee. This will not be covered by your insurance company.

- You must cancel your appointment 24 hours in advance.
- If you are 15 minutes past your scheduled appointment time, you will be rescheduled.

Cancellation/No Show Policy for Surgery

Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expenses for the office. If your surgery is not cancelled at least ten (10) days in advance, you will be charged a seventy-five ($75) dollar fee. This fee will not be covered by your insurance.

Account Balances

- Patients with self pay balances will be required to pay their account balances to zero (0) prior to receiving further services by our practice.
- Patients who have questions about their bills or who would like to discuss a payment plan may call our office at (681) 318-3540. A representative can review your account and concerns with you.
- Patients with balances over $100 must make payment arrangements prior to scheduling future appointments.

Patient's Printed Name Patient/Guardian Signature

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E-PRESCRIBING PBM CONSENT FORM

E-prescribing is a service that allows your physician to electronically send an accurate, error-free, and understandable prescription directly to your pharmacy.

Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These include:

- Formulary and Benefit Transactions. This gives your healthcare provider information about which drugs are covered by your drug benefit plan.
- Medication History Transactions. This gives your healthcare provider information about which medications you are already taking, prescribed by any of your providers, to minimize the number of adverse drug reactions/events.

By signing this consent form, you are agreeing that **Southern WV ENT and Endocrinology** can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

Patient Name (printed) **Date of Birth**

Signature of Patient (guardian or representative) **Date**

Relationship (if other than patient)

Southern WV
ENT & Endocrinology

Physician Initial _____

Today's Date:	Primary Care Physician:

PATIENT INFORMATION

Patient's Last Name:	First:	Middle Initial:	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	Former name (if applicable):	Birth date:	Age:	Sex: ☐ Male ☐ Female

Street address **OR** P.O. Box #:	Social Security #:	Home phone #:	Cell phone #:

City:	State:	Zip code:	Work phone #:

Occupation:	Employer:	Employer phone #:

Email address:	Other family members seen here:

Race/Ethnicity (**Optional** - please check one box): ☐ American Indian/Native American ☐ Asian ☐ Black or African American ☐ Hispanic ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Two or More

INSURANCE INFORMATION

Person responsible for bill (if different from patient):	Birth date:	Address (if different):	Home phone #:

Occupation:	Employer:	Employer address:	Employer phone #:

Name of Primary Insurance:	Is the responsible person a patient here? ☐ Yes ☐ No

Subscriber's name:	Social Security #:	Birth date:	Group Number:	Policy Number:	Copay amount:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Name of Secondary Insurance:	Subscriber's name:	Group Number:	Policy Number:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

IN CASE OF EMERGENCY

Name of local relative or friend (not living at same address):	Relationship to patient:	Home phone #:	Cell phone #:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Southern WV ENT & Endocrinology or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian Signature *Date*

Southern WV
ENT & Endocrinology

Physician Initial _____

NAME: _____ **DATE:** _____ **PATIENT #:** _____

Date of Birth: _____

Please fill out this form and return to our office. Please complete all pages.

1. **What problem are you here for today?** _____

2. **Primary Care Provider:** _____
   If you want a report of this visit sent to another doctor, list doctor's name and office address: _____

3. **Allergies:** Do you have medicine or food allergies? (Circle) YES NO
   If yes, please list them below and tell us what type of reaction you have.
   Medications: _____
   Food: _____

4. **Medical History:** Please list all medical problems: (Please attach additional page if needed.)

Recent hospitalizations (within the last five years):

Date	Diagnosis	Hospital	Physician

Surgeries: List all operations:

Medications: List all medications you are currently taking and bring your medication bottles with you to your initial visit. Attach additional page if needed. Include both prescription and over-the-counter medications that you take regularly.
Please list dose and frequency.

Preferred Pharmacy Name: _____ Location: _____

Mail Order Pharmacy Name: _____

Physician Initial _____

NAME: _____ **DATE:** _____ **PATIENT #:** _____

5. **Social History:** Please fill in the following information.

Highest grade/level of education completed: _____

Current Job: _____

Were you in the military? (Circle one) Yes No

Marital Status: (Circle one) Married Divorced Single Widowed Separated Domestic Partner

Number of children: _____

Were you ever exposed to harmful chemicals, radiation, dust or asbestos? _____

Do you smoke cigarettes? (Circle one) Yes Never Used to but quit. How many packs a day? _____

If yes, how many years did you smoke? _____ Year stopped: _____

Do you use or have you used any other forms of tobacco? (snuff, chew, cigars or pipe): _____

Do you drink alcohol? (Circle one) Yes No If yes, how many drinks per week? _____

How much coffee/tea/pop with caffeine do you drink each day? (cups per day) _____

Diet: (Circle one) Regular Diabetic Cardiac Low-Carb Vegetarian Vegan Gluten-free Other _____

Did/do you use any "street" drugs? (Circle one) Yes No If yes, what kind? _____

6. **Family History:**

Do you or anyone else in your family have the following illnesses?

	Which Relative		Which Relative		Which Relative
Kidney Disease	_____	Diabetes	_____	Tuberculosis	_____
Thyroid Disease	_____	Glaucoma	_____	Stroke	_____
Bleeding Problems	_____	Osteoporosis	_____	Cancer	_____
High Blood Pressure	_____	Heart Disease	_____	Asthma	_____
Anesthesia Problems	_____	Born Deaf	_____	Other	_____

7. **System Review:**

If you have had any of the following problems **in the last 12 months** please circle **Yes**, if not, circle **No**.

GENERAL

Yes	No	Weight gain
Yes	No	Weight loss
Yes	No	Fever
Yes	No	Chills
Yes	No	Sweats
Yes	No	Excessive fatigue

RESPIRATORY

Yes	No	Cough
Yes	No	Coughing up blood
Yes	No	Shortness of breath
Yes	No	Wheezing/Asthma

EYE-EAR-NOSE-THROAT-NECK

Yes	No	Eye pain
Yes	No	Dry eyes
Yes	No	Vision changes
Yes	No	Double vision
Yes	No	Hearing loss
Yes	No	Noise in ears/Ringing
Yes	No	Ear pain/Drainage
Yes	No	Nosebleeds
Yes	No	Sinus infection
Yes	No	Neck mass/Pain
Yes	No	Frequent sore throats
Yes	No	Hoarseness

Physician Initial _____

NAME: _____ **DATE:** _____ **PATIENT #:** _____

7. **System Review (continued):**

If you have had any of the following problems **in the last 12 months** please circle **Yes**, if not, circle **No**.

ENDOCRINOLOGY

Yes No Goiter
Yes No Heat or cold intolerance
Yes No Excessive thirst
Yes No Excessive hunger

CARDIOVASCULAR

Yes No Heart murmur
Yes No Chest pain/discomfort
Yes No Can't breathe lying flat
Yes No Fluttering in chest
Yes No Irregular heart beat
Yes No Swollen legs

GASTROINTESTINAL

Yes No Loss of appetite
Yes No Difficulty swallowing
Yes No Nausea and vomiting
Yes No Vomiting blood/coffee grounds
Yes No Food intolerance
Yes No Heartburn
Yes No Abdominal pain
Yes No Constipation
Yes No Diarrhea
Yes No Jaundice

URINARY

Yes No Frequency
Yes No Get up from sleep to urinate
Yes No Kidney stones
Yes No Bladder or kidney infection
Yes No Blood in urine

MUSCULOSKELETAL

Yes No Joint pain
Yes No Joint swelling
Yes No Muscle weakness
Yes No Neck pain
Yes No Leg pain
Yes No Muscle spasms/cramps

NEUROLOGIC

Yes No Seizures
Yes No Dizziness
Yes No Passing out
Yes No Numbness
Yes No Tingling
Yes No Difficulty walking
Yes No Balance problems
Yes No Severe headaches
Yes No memory loss

PSYCHIATRIC

Yes No Extreme sadness
Yes No Nervousness
Yes No Sleep problems
Yes No Hopelessness

HEMATOLOGIC

Yes No Easy bruising
Yes No Anemia
Yes No Bleeding problems
Yes No Transfusions

DERMATOLOGY

Yes No Rash
Yes No Itching
Yes No Hair loss
Yes No Excessive hair growth

MEN

Yes No Testicular pain or swelling
Yes No Difficulty with sexual function
__ / __ / ____ Date of last prostate exam

WOMEN

_____ Age menstrual periods started
_____ Date of last normal period
_____ Age of menopause
_____ Birth control method
_____ Number times pregnant
Yes No Bleeding between periods
Yes No Abnormal menstrual period
Yes No Nipple discharge

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NAME: _____ **DATE:** _____ **DATE OF BIRTH:** _____

Protected Health Information Release Form

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communication or that a communication of the PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (you may check more than one choice):

◯ ***Home Phone:*** _____
- ◯ OK to leave message with detailed information
- ◯ Leave message with call-back number only

◯ ***Written Communication***
- ◯ OK to mail to my home address
- ◯ OK to mail to my work/office address
- ◯ OK to fax to this number

◯ ***Cell Phone:*** _____
- ◯ OK to leave message with detailed information
- ◯ Leave message with call-back number only

◯ ***Work Phone:*** _____
- ◯ OK to leave message with detailed information
- ◯ Leave message with call-back number only

I authorize the doctors and staff (Southern WV ENT & Endocrinology) to speak to or release my health care information to the following person(s):

1. Name: _____ Relationship: _____
   Phone: _____ Birth date: _____
2. Name: _____ Relationship: _____
   Phone: _____ Birth date: _____
3. Name: _____ Relationship: _____
   Phone: _____ Birth date: _____

Your Protected Health Information (PHI) will be kept for adults: 7 years after your last office visit, and for a child—until age 21. It will then be disposed of following Health Insurance Portability and Accountability Act (HIPAA) guidelines.

_____ _____ _____

Signature of Patient (or parent/guardian if minor) ***Date of Birth*** ***Date***

The Privacy Rules generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Acknowledgement of Receipt of Notice of Privacy Practices

Southern WV ENT & Endocrinology: **206 Skylar Drive**
Lewisburg, WV 24901
P: (681) 318-3540

Contact Person: Office Manager

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information.

Our office policies contain important information regarding payment, insurance, collections, cancellations, and other important information.

By signing this form, you acknowledge that you have received a copy of this office's Notice of Privacy Practices, and office policies. You may refuse to sign this acknowledgment, if you wish.

Patient Name / Relationship: _____

Print your name: _____

Signature: _____

Date: _____

For Office Use Only

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy Practices and Office Policies from this patient but it could not be obtained because:

_____ The Patient refused to sign _____ We were not able to communicate with the Patient

_____ Due to an emergency situation it was not possible to obtain a signature

Other (please provide details): _____

_____

Employee Signature: _____ **Date:** _____

Southern WV
ENT & Endocrinology

Patient Portal Access

Please help us make your experience better! Our ***Patient Portal*** is a secure online home for your health information. From any device with internet access, you can view your hospital records on this special, password-protected website.

- Request an appointment and ask questions of our physician, educator and staff.
- View and share your personal health record (PHR) from your office visits.
- Have electronic access to an updated list of medications, diagnoses, allergies, lab test results, and other information.

It's easy to use. You don't have to download or install any programs. You can access My Health Home from any desktop computer, tablet or mobile device with internet connection. It's free. The service is provided by **Southern WV ENT and Endocrinology** to help you become a healthier, more informed patient. Our patient portal is a convenient way to communicate with your doctor.

All we need to get you started is your email address:

_____