Rick Lockhart, M.D.

Patient Information

Name: _____ Date of Birth:_____

SS#: _____ Sex: M ( ) F ( ) Marital Status: ( )S ( )M ( )W ( )D

Address: _____ City, State and Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Email Address: _____ Employment Status: _____

Patient or Parent Employment if patient is a minor

Name: _____ DOB:_____

Phone: _____ Relationship: _____

Address: _____ SS #: _____

Employer: _____ Employer phone: _____

Guarantor of Account

( ) Same as patient
Name: _____ Relationship to Patient: _____

Address: _____ Phone: _____

Emergency Contact

Name: _____ Relationship: _____ Phone : _____

Primary Insurance

( ) Same as Patient ( )Same as Guarantor ( ) Other Insurance Company: _____

Insured Name: _____ SS#: _____

Phone:_____ Date of Birth: _____

Insured ID: _____ Group #: _____

Secondary Insurance

( ) Same as Patient ( )Same as Guarantor ( ) Other Insurance Company: _____

Insured Name: _____ SS#: _____

Phone:_____ Date of Birth: _____

Insured ID: _____ Group #: _____

At Middle Georgia Ear, Nose and Throat Surgery Center, P.C. our goal is to provide you or your family member with the highest quality of care. The first step is to learn all we can about your medical history. Please assist us by taking a few minutes to complete all the pages of the form below. Our staff will be more than happy to assist you if necessary. The care we give you can be no better than the information you provide.

Patient Name: _____ Age: _____ DOB: _____

Who sent you to us today? _____

Who is your primary care provider? _____

Please name the major problem or symptom that brings you to us today:_____

_____

Please describe the history of your present illness in detail: _____

_____

Rate the severity of *TODAY's* symptoms on a 1 – 10 score. (10 = worst): _____

How long have you symptoms been present?_____

What makes your symptoms worse or better? _____

What other providers have you seen for this illness? _____

What diagnostic tests have been performed so far? _____

What treatments have been tried so far (include operations done for this illness)?_____

Allergies: Please list any drug and food allergies:_____

Medications: Please list all medications you are currently taking, including dosages and the physician who prescribed them for you.

Name of Medication	Dosage and how many times a day	Prescribing Physician

Height: _____ Weight: _____ Race: _____ Language: _____

Have you received a flu shot? Yes ( ) No ( ) Have you had a pneumonia shot? Yes ( ) No ( )

Social History

Do you use of have you formerly used any of the following products:

Alcohol	Yes	No		Type:	Quantity:
Non Prescribed Drugs	Yes	No		Type:	Quantity:
Caffeine	Yes	No		Type:	Quantity:
Tobacco	Yes	No	Former Quit Date:	Type:	Quantity:

Past Medical History

Do you have or have had any of the following conditions? If yes, please put a check mark.

☑	Condition	Approximate Onset	Treating Physician
	Cancer (List Type)		
	Heart Disease (Include Heart Murmur, Bypass Surgery Pacemaker, Mitral Valve Prolapse, Stent or Heart Attack		
	High Blood Pressure		
	Asthma		
	Liver Disease/Hepatitis (List type)		
	Jaundice		
	Diabetes		
	Epilepsy/Seizures/Neurological Problems		
	Thyroid or Goiter		
	Bowel/Colon Problems		
	Bleeding/Clotting abnormalities		
	An abnormal Chest X – ray		
	An abnormal EKG		
	Stroke		

Surgical History

Please list all prior surgical procedures and dates:

Family History

Have any of your direct relatives or immediate family members been treated for the following conditions? If yes, please check off the condition and indicate their relationship to you.

☑	Condition	Mother	Father	Sister	Brother	Other Family Member
	Arthritis					
	Cancer **(specify type)**					
	Diabetes					
	Heart Failure					
	High Blood Pressure					
	Kidney Disease					
	Liver Disease					
	Migraine					
	Obesity					
	Psychiatric Problems					
	Rheumatoid Arthritis					
	Stroke					

Patient Name: _____ Date of Birth: _____

Are you currently experiencing any of the following symptoms? Please indicate Yes or No.

Yes	No	Symptom		Yes	No	Symptom		Yes	No	Symptom
		Constitutional				**Gastrointestinal**				**Neuro/Psuchiatric**
		Chills/Rigors				Abdominal Pain				Focal weakness
		Fatigue				Blood in stool				Headache
		Fever				Constipation				Memory Impairment
		Night Sweats				Diarrhea				Seizures
		Weight Loss				Fecal Incontinence				Speech Changes
		Change in weight				Difficulty Swallowing				Tremors
						Nausea				Vertigo
		HEENT				Vomiting				Visual Changes
		Vertigo				Weight loss				Incoordination
		Ear Infections				Black, tarry bowel movements				Severe depression
		Nasal drainage				Jaundice				
		Sinus Problems				Heartburn				**Dermatologic**
		Throat pain/Hoarseness								Contact Allergy
		Eye Pain				**Genitourinary**				Change in mole
		Face Pain				Cloudy Urine				Skin lesion
						Foul urine odor				
		Respiratory				Painful Urination				**Musculoskeletal**
		Cough				Frequent Urination				Back Pain
		Wheezing				Bloody Urine				Bone and Joint symptoms
		Snoring				Urinary Incontinence				Myalgia
		Shortness of breath				Passage of stone				Neck stiffness/pain
		Frequent upper respiratory infections								Rheumatologic manifestations
						Reproductive				Muscle weakness
		Cardiovascular				Pain in the breasts				
		Chest Pain				History of infertility				**Hematologic**
		Irregular heartbeat/palpitations				Postmenopausal				Easy Bleeding
		Syncope/Fainting				Hormone replacement therapy				Easy Bruising
		Vascular				**Endocrine**				**Immunological**
		Leg pain with exercise				Chronically Overweight				Hay fever
		Edema/Swelling				Chronically Underweight				Hives
		Redness of legs				Cold Intolerance				Asthma
		Varicose veins				Generalized weakness				Food Allergies
		Paresthesias/pins and needles sensation				Goiter				Environmental Allergies

Privacy Policy Acknowledgement Statement and Patient Agreement for Communication
Consent for Use and Disclosure of Protected Health Information

I hereby acknowledge that I have been made aware that Middle Georgia Ear, Nose & Throat has a Privacy Policy in place in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that under HIPAA I have certain rights to privacy regarding my protected health information. I understand and consent that this information can and will be used to conduct, plan, and direct my treatment and follow up care among multiple providers who may be involved in that treatment directly or indirectly, obtain payment from third-party payers and conduct normal healthcare operations such as quality assessments and physician certifications.

As a patient of Middle Georgia, Ear, Nose and Throat, I understand and acknowledge the following:

1. Middle GA ENT has a privacy policy in effect in their office.
2. Middle GA ENT has made this policy available to me for review, by placing a complete version in a binder that resides in the waiting room and/or by placing a poster of this policy in the waiting room or similar common area with patient access.
3. Middle GA ENT has made me aware, that as a patient, I am entitled to a copy of this privacy policy if I desire a copy for my personal file.

Upon review of the above statements, please sign below acknowledging that you have been advised of the privacy policy implemented by Middle GA ENT and have read and understood the acknowledgement form. If you desire a copy of the Privacy Policy, please request one at this time.

____ No, I do not want a copy.
____ Yes, I do want a copy of the Privacy Policy.

I understand that as a part of my healthcare, Middle GA ENT will need to contact me in order to remind me of appointments, provide test results, give instructions, or provide other information,

I authorize Middle GA ENT to contact me in the following ways (check those which you authorize).

_____ Home phone	_____ Voicemail OK	Number _____
_____ Work Phone	_____ Voicemail OK	Number _____
_____ Cell Phone	_____ Voicemail OK	Number _____
_____ Email		

I understand that Middle GA ENT will use the minimum necessary information needed when communicating with me indirectly. I understand that I may revoke of modify this agreement at any time. Any revocation or change will not apply to past communications.

I further authorize Middle GA ENT to discuss matters related to my condition/care with the following:

_____ _____
Patient's Name Relationship to Patient

_____ _____
Signature of Patient or Legal Guardian Date

Consent For Treatment

I hereby consent to and authorize the performance of examination and treatment for the below named patient that in the judgment of Dr. Rick Lockhart may be considered necessary and advisable.

_____ _____
Patient's Name Relationship to Patient

_____ _____
Signature of Patient or Legal Guardian Date

Administrative Fees – These are fees that will be charged ONLY IF you request these forms to be filled out.
Billable items on a requested basis-list include but are limited to:

1. $50.00 for completion of forms: A. Disability, B. FMLA, C. Life Insurance, D. Other miscellaneous administrative forms required by third parties other than your insurance company.
2. $15.00 for patient requested computer generated reports, additional claims, statements, payment histories, etc.
3. $38.00 for copying medical records.
4. Other administrative services that are not a covered service/benefit under your certificate of insurance. Fee to be determined at the time of request.

Co-payments
All office visits require a co-payment from your insurance company. Exceptions may include post operative visits for a determined period of time for some surgical procedures. Some insurance plans require a co-pay for post operative visits.

Deductible
A deductible is a portion of the bill that is the responsibility of the patient to pay before an insurance company will cover the service. An office visit with our physician will include a face to face encounter and evaluation. Generally, a co payment is required for this visit. In addition, some services and ALL procedures performed in the office require the patient to meet their deductible before insurance pays benefits. If you have not met your deductible, you will be responsible for full or partial payment, depending on your insurance contract. Procedures performed in the office are considered the same as surgery to the insurance company, and are billed as surgery.

Diagnostic Procedure Consent
Your office visit today may include a scope being placed in your nose or throat. This is considered a diagnostic procedure, which will be coded to your insurance carrier as an INVASIVE OR SURGICAL PROCEDURE. Depending on the specifics of your particular policy, your insurance carrier will pay all, part or none of the cost of this procedure. **It is the responsibility of you, the insured, to be aware of the limits of coverage of your policy prior to this procedure.** Any charges not covered by the insurance carrier will be the responsibility of the patient. By initialing this section you are acknowledging these terms. **You have the right to refuse this diagnostic procedure.**

Guarantee of Payment for Services & Assignment of Benefits
It is the policy of the office that you must pay for services when rendered except in the cases of surgery. If this applies to you, we will file your claim and you will be expected to pay only the portion that is not covered by your insurance. If you have any questions, please ask before leaving the office.
In the event that any of the above named companies or individuals fail to make prompt payment, I hereby give my personal guarantee of payment for all charges herein occurred. This includes all charges related to office visits, procedure performed, co-payments and deductibles. If this account is placed in collections, the undersigned agrees to pay the balance. I hereby authorize insurance benefits to be paid directly to the physician, and I am financially responsible for non-covered services. I also authorize the physician to release my medical information in the processing of this claim.

Insurance Coverage
I understand that my eligibility for coverage has not been verified at the time of my appointment, but I want to receive medical services from Dr. Rick Lockhart. I am aware that when the insurance is finally verified, there is a disclaimer which states my insurance does not guarantee payment, even though I may be eligible for benefits at the time of service. If it is determined that I am not eligible for coverage or the medical services are not covered, I understand that I will be responsible for payment for all services provided.

Referral Waiver
I understand that if my insurance requires a referral for my visit, I am responsible for making sure that the referral is obtained from my primary care physician. I also understand that if the referral from the PCP's office is not received before/on the day of my appointment, I agree to pay for all services rendered on the day of the visit.

I have read and understand the Administrative Fee policy of Middle GA ENT.

_____ _____

Patient Signature (Guardian if patient is a minor) Date