LIBERTY ENT ASSOCIATES, LLC

JOHN L. SAPORITO, MD, FACS

Patient Information

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

Address:_____ City:_____ State:_____ Zip:_____

Phone#:_____ Work#:_____ Cell#:_____

Email:_____ SS#:_____ DOB:_____

Patient Age:_____ Patient Height:_____ Patient Weight:_____ Marital Status: ❑S ❑M ❑D ❑W Sex: ❑M ❑F

Referring Doctor/Primary Doctor:_____ Phone:_____

Address:_____
(Street) (City) (State) (Zip)

Pharmacy:_____ Phone:_____

Address:_____
(Street) (City) (State)

Employer (or Parent/Guardian Employer):_____ Phone:_____

Address:_____
(Street) (City) (State)

Emergency Contact:_____ Relationship:_____ Phone:_____

Parent/Guardian of Child:_____ DOB:_____ Phone:_____

How did you hear about us? ❑Returning Patient ❑Friend/Family ❑Internet ❑Doctor Referral_____ ❑Other_____

Insurance Information

Name of Insured Subscriber:_____ SS#:_____ DOB:_____

Insurance Company:_____ Phone:_____

Address:_____
(Street) (City) (State)

Group#:_____ ID#_____

Secondary Insurance Company:_____ Phone:_____

Name of Insured Subscriber:_____ Employer:_____ Phone#:_____

Subscriber DOB:_____ Group#:_____ ID#_____

Workers Compensation:_____

PLEASE NOTE: INSURANCE CONTRACTS ARE MADE BETWEEN YOU AND THE INSURANCE COMPANY. WE DO NOT RENDER SERVICES ON THE ASSUMPTION THAT THE CHARGES WILL BE PAID BY YOUR INSURANCE COMPANY. PAYMENT OF ANY CHARGES ARE PRESUMED TO BE YOUR RESPONSIBILITY.

I HEREBY AUTHORIZE LIBERTY ENT ASSOCIATES, LLC and JOHN L. SAPORITO, MD TO FURNISH INFORMATION CONCERNING MY ILLNESS AND TREATMENT TO MY INSURANCE COMPANY, ATTORNEY, SCHOOL, OR OTHER TREATING PHYSICIAN.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. I UNDERSTAND THAT LIBERTY ENT ASSOICIATES, LLC AND JOHN L. SAPORITO, MD REQUIRES PAYMENT AT THE TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN AGREED UPON.

Signature of Responsible Party:_____ **Date**:_____

Name:_____
(Print Name)

… Thank you for completing the entire form.

Office Policy - Patient Responsibility

Patient Name_____ **DOB**:_____
(please print)

I understand that it is my responsibility to know my insurance policy regarding doctor participation, referrals, and what is covered by my insurance company.

I understand that additional charges will be incurred for procedures performed by the doctor at the time of my visit.

I understand that if I require surgery, it is my responsibility to get any necessary referrals, if needed, and to also call my insurance company to see what my responsibilities are.

I understand that if my insurance company requires a referral, and I do not have one, I am responsible for full payment at the time of my visit.

I understand that referrals will not be accepted after the time of my visit.

I understand that insurance contracts are made between me and the insurance company.

I understand that I am responsible for any amount not covered by insurance.

Liberty ENT Associates, LLC and John L. Saporito, MD do not render services on the assumption that the charges will be paid by my insurance company. Payment of any charges are presumed to be my responsibility.

I hereby authorize Liberty ENT Associates, LLC and John L. Saporito, MD to furnish information concerning my illness and treatment to my insurance company, attorney, school, or other treating physician.

I understand that Liberty ENT Associates, LLC and John L. Saporito, MD require payment at the time of treatment unless prior arrangements have been agreed upon.

I understand that there will be a $25.00 charge for all returned checks.

I understand I will be responsible for all collection and attorney fees should my account be referred to a collection agency.

Signature of Responsible Party:_____ **Date**:_____
Person who brings in patient, if patient is a minor, is responsible for payment.

ATTENTION:

IF YOU HAVE ANY CHANGES IN YOUR INSURANCE COVERAGE, PLEASE PROVIDE US WITH THIS INFORMATION SO WE MAY UPDATE OUR RECORDS.

IF COVERAGE HAS CHANGED AND WE ARE NOT AWARE OF THIS CHANGE, YOU ARE DIRECTLY RESPONSIBLE FOR ALL CHARGES.

Signature of Responsible Party:_____ **Date**:_____

NOTICE OF PRIVACY PRACTICES

I. 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.

II. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

We are legally required to protect the privacy of your health information. We call this information "protected health information", or "PHI" for short and it includes information that can be used to identify you that we've created or received about your past, present, or future health condition, the provision of health care to you, or the payment for this health care. We must provide you with this notice about our privacy practices that explains how, when, and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this notice.

However, we reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the PHI we already have. Before we make an important change to our policies, we will promptly change this notice and post a new notice in main reception area. You can also request a copy of this notice from the contact person listed in Section IV below at any time.

III. HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION.

We use and disclose health information for many different reasons. For some of these uses or disclosures, we need your specific authorization. Below, we describe the different categories of uses and disclosures.

A. Uses and Disclosures Which Do Not Require Your Authorization.

We may use and disclosure your PHI without your authorization for the following reasons:

1. **For treatment.** We may disclose your PHI to hospitals, physicians, nurses, and other health care personnel who provide you with health care services or are involved in your care. For example, if you're being treated for a knee injury, we may disclose your PHI to an x-ray technician in order to coordinate your care.

2. **To obtain payment for treatment.** We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. For example, we may provide portions of your PHI to our billing department and your health plan to get paid for the health care services we provided to you.

3. **For health care operations.** We may disclose your PHI in order to operate this practice. For example, we may use your PHI in order to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided health care services to you. We may also provide your PHI to our accountants, attorneys, consultants, and others in order to make sure we're complying with the laws that affect us.

4. **When a disclosure is required by federal, state or local law, judicial or administrative proceedings, or law enforcement.** For example, we make disclosures when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence; when dealing with gunshot or other wounds: or when ordered in a judicial or administrative proceeding.

5. **For public health activities.** For example, we report information about births, deaths, and various diseases, to government officials in charge of collecting that information, and we provide coroners, medical examiners, and funeral directors necessary information relating to an individual's death.

6. **For health oversight activities.** For example, we will provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.

7. **For purposes of organ donation.** We may notify organ procurement organizations to assist them in organ, eye, or tissue donation and transplants.

8. **For research purposes.** In certain circumstances, we may provide PHI in order to conduct medical research.

9. **To avoid harm.** In order to avoid a serious threat to the health or safety of a person or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.

10. **For specific government functions**. We may disclose PHI of military personnel and veterans in certain situations. And we may disclose PHI for national security purposes, such as protecting the President of the United States or conducting intelligence operations.

11. **For workers' compensation purposes.** We may provide PHI in order to comply with workers' compensation laws.

12. **Appointment reminders and health-related benefits or services.** We may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits we offer.

B. Use and Disclosure Where You Have the Opportunity to Object:

1. **Disclosures to family, friends, or others.** We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part.

C. **All Other Uses and Disclosures Require Your Prior Written Authorization.** In any other situation not described above, we will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke that authorization in writing to stop any future uses and disclosures (to the extent that we haven't taken any action relying on the authorization).

D. **Incidental Uses and Disclosures.** Incidental uses and disclosures of information may occur. An incidental use or disclosure is a secondary use or disclosure that cannot reasonably be prevented, is limited in nature, and that occurs as a by-product of an otherwise permitted use or disclosure.

However, such incidental uses or disclosure are permitted only to the extent that we have applied reasonable safeguards and do not disclose any more of your PHI than is necessary to accomplish the permitted use or disclosure. For example, disclosures about a patient at a nursing station that might be overheard by personnel not involved in the patient's care would be permitted.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI.

You have the following rights with respect to your PHI:

A. **The Right to Request Limits on Uses and Disclosures of Your PHI.** You have the right to ask that we limit how we use and disclose your PHI. We will consider your request but are not legally required to accept it. If we accept your requires, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.

B. **The Right to Choose How We Send PHI to You.** You have the right to ask that we send information to you to an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). We must agree to your request so long as we can easily provide it in the format you requested.

C. **The Right to See and Get Copies of Your PHI.** In most cases, you have the right to look at or get copies of your PHI that we have, but you must make the request in writing. If we don't have your PHI but we know who does, we will tell you how to get it. We will respond to you within 30 days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed.

If you request copies of your PHI, we will charge you $1 for each page. Instead of providing the PHI you requested, we may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

D. **The Right to Get a List of the Disclosures We Have Made.** You have the right to get a list of instances in which we have disclosed your PHI. The list will not include uses or disclosures that you have already consented to, such as those made for treatment, payment, or health care Operations, directly to you, to your family, or in our facility directory. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or in compliance with National Instant Criminal Background Check System as of 1/7/14.

We will respond within 60 days of receiving your request. The list we will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide the list to you at no charge, but if you make more than one request in the same year, we will charge you $10 for each additional request.

E. **The Right to Correct or Update Your PHI.** If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. We will respond within 30 days of receiving your request in writing. You must provide the request and your reason for the request in writing. We may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed, (iv) not part of our records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and our denial be attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that need to know about the change to your PHI.

F. **The Right to Get This Notice by E-Mail.** You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of this notice.

V. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.

If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed in Section VI below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Ave., S.W.; Room 615F; Washington, DC 20201. We will take no retaliatory action against you if you file a complaint about our privacy practices.

VI. PERSON TO CONTACT FOR INFORMATIN ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.

If you have any questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact: Liberty ENT Associates, LLC, Attn: Carole Penzynski; 66 West Gilbert Street, Suite 100; Red Bank, New Jersey 07701-4918; (732) 212-0051 ext. 275; e-mail: cpenzynski@grouppbc.com.

VII. EFFECTIVE DATE OF THIS NOTICE.

This notice went into effect on January 1, 2015.

Acknowledgment of Receipt of Privacy Practices

By signing below I acknowledge that I have received a copy of the Notice of Privacy Practices.

Name of Patient: _____ **DOB**:_____

Please list anyone that you give your permission to have your Protected Health Information:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

The Privacy Rule that is contained in HIPPA establishes a federal requirement that health care providers obtain a patient's written consent before using or disclosing the patient's Protected Health Information to carry out treatment, payment, or health care operations (TPO). This must be obtained before information may be used or disclosed for TPO purposes, except in emergency situations.

The following information must be included in a medical record release form used by the Practice to be in compliance with HIPPA requirements.

I also authorize the release of "my results", such as laboratory results, X-ray results, clinical findings of consultations and the like, by phone or fax to following number_____

This information may also be left on the answering machine at the same phone number: ❑Yes ❑ No

Signature of Patient or Personal Representative:_____ **Date**:_____

If signed by personal representative, relationship to patient:_____

OFFICIAL USE ONLY

Our practice will make a good faith effort to obtain a written acknowledgment of receipt of the Notice provided to the individual. If written acknowledgment is not obtained, or practice must document its good faith efforts to obtain such acknowledgment and record the reason why the acknowledgment was not obtained.

❑Refused to sign ❑Physically unable to sign ❑(Other):_____

Employee Name:_____ Date:_____

Employee Signature:_____

Patient Name_____ **Date of Birth**_____ **Age**_____

General Medical History

1) Reason for visit_____

2) FEMALE PATIENTS

Are you currently pregnant?	❑ YES	❑ NO
Attempting to become pregnant?	❑ YES	❑ NO
Are you currently breast-feeding?	❑ YES	❑ NO

3) Patient Medical History
Do you or have you had?

	YES	NO		YES	NO
Diabetes	❑	❑	Lung Problems	❑	❑
High Blood Pressure	❑	❑	Kidney Disease	❑	❑
Heart Problems	❑	❑	Gout	❑	❑
Stroke	❑	❑	Stomach Problems	❑	❑
Rheumatic Fever	❑	❑	Gallbladder Problems	❑	❑
Anemia	❑	❑	Colitis	❑	❑
Regional Enteritis	❑	❑	Crohn's Disease	❑	❑
Jaundice	❑	❑	Thyroid Disease	❑	❑
Hormone Therapy	❑	❑	Cancer	❑	❑
Diverticulosis	❑	❑	Chemotherapy	❑	❑
Hepatitis	❑	❑	Radiation Therapy	❑	❑

When was your last tetanus vaccine?
❑ Less than 10 years ago
❑ More than 10 years ago

If you are over 65, have you received the pneumonia vaccine?
❑ YES ❑ NO

Do you receive yearly flu shots?
❑ YES ❑ NO

4) List all drug allergies_____

5) Do you have a latex allergy? ❑ YES ❑ NO

6) List all current medications _____
_____

Past Surgical History:

_____
_____

Family History: *Please list disease or illness prevalent in family*

_____
_____

Social History

Use of Alcohol	❑ Never	❑ Rarely	❑ Moderate	❑ Daily
Use of Tobacco	❑ Never	❑ Previously, but quit	❑ Current packs/per day_____	

Patient Name_____ **Date of Birth**_____

Please answer the following questions:

Date of last physical examination: _____

CONSTITUTIONAL	**YES**	**NO**
Good health generally	❑	❑
Weight loss	❑	❑
Weight gain	❑	❑
Night Sweats	❑	❑
Excessive sleepiness	❑	❑

CARDIOVASCULAR	**YES**	**NO**
Chest Pain	❑	❑
Palpitations	❑	❑

GENITOURINARY	**YES**	**NO**
Painful or frequent urination	❑	❑
Venereal disease (VD)	❑	❑
Venereal warts	❑	❑
Kidney Stones	❑	❑

NEUROLOGICAL	**YES**	**NO**
Weakness in arms or legs	❑	❑
Changes in coordination	❑	❑
Changes in balance	❑	❑
Shaking or tremors	❑	❑
Loss of consciousness	❑	❑
Passing out	❑	❑
Seizures or fits	❑	❑
Headaches	❑	❑
Numbness	❑	❑

GASTROINTESTINAL	**YES**	**NO**
Nausea or vomiting	❑	❑
Constipation	❑	❑
Diarrhea	❑	❑
Vomiting blood	❑	❑

MUSCULOSKELETAL	**YES**	**NO**
Bone or joint pain	❑	❑
Muscle pain	❑	❑
Muscle weakness	❑	❑

EARS	**YES**	**NO**
Hearing loss	❑	❑
Left ear	❑	❑
Right ear	❑	❑
Dizziness	❑	❑
Spinning	❑	❑
Imbalance	❑	❑
Lightheadedness	❑	❑
Pain	❑	❑
Left	❑	❑
Right	❑	❑

EYES	**YES**	**NO**
Blurred or double vision	❑	❑
Excess tearing	❑	❑

THROAT	**YES**	**NO**
Difficulty swallowing	❑	❑
Hoarseness	❑	❑
Sore Throat	❑	❑
Pharyngitis	❑	❑

NECK	**YES**	**NO**
Swelling	❑	❑
Masses/lumps	❑	❑
Tenderness/pain	❑	❑

SKIN	**YES**	**NO**
Itching or burning	❑	❑
Sores or rashes	❑	❑

EARS	**YES**	**NO**
Ringing in ears	❑	❑
Left ear	❑	❑
Right ear	❑	❑
Drainage	❑	❑
Left ear	❑	❑
Right ear	❑	❑

NOSE/SINUSES	**YES**	**NO**
Drainage	❑	❑
Congestion	❑	❑
Facial pain	❑	❑
Bleeding	❑	❑
Diminished smell	❑	❑
Diminished taste	❑	❑
Sinusitis	❑	❑
Allergy symptoms	❑	❑

RESPIRATORY	**YES**	**NO**
Shortness of breath	❑	❑
Cough	❑	❑
Coughing blood	❑	❑
Coughing blood	❑	❑

OFFICE USE ONLY

PATIENT UNABLE TO COMPLETE FORM _____

THIS FORM HAS BEEN REVIEWED WITH PATIENT

_____ M.D. _____ Date
_____ M.D. _____ Date