COLDEN SEYMOUR
EAR NOSE THROAT & ALLERGY
Adult & Pediatric Care / Hearing & Balance Center
Sinus & Sleep Specialists / Facial Plastic Surgery

Daryl Colden, MD FACS Peter Seymour, MD FACS

Patient: _____ **Date of Birth:** _____

Under Age (18) name of parent/guardian**:** _____ Relationship: _____

Marital Status: □ Married □ Single □ Widowed □ Divorced Email: _____

Race: _____ **Ethnicity:** _____ **Preferred Language:** _____

Address: _____ _____ _____ _____
Street City State Zip code

Home phone: _____ **Cell:** _____ **Work:** _____

Address/Phone of parent/guarantor if different from above: _____

Name of Emergency Contact: _____ **Phone:** _____ **Relationship:** _____

Primary Care Physician (PCP) Name: _____ **Phone:** _____

Address: _____

Referring Physician (If different from PCP): _____

Preferred Pharmacy: _____ _____ _____
Pharmcy Name City State

Patient employeer & address: _____

Occupation: _____

Name of Primary Insurance: _____ **Subscriber:** _____

Name of Secondary Insurance: _____ **Subscriber:** _____

Work related injury: □ Yes □ No If yes, please complete a workers compensation information form.

How did you hear about this practice/doctors? _____

I, the undersigned, have insurance coverage with _____ and assign directly to Colden & Seymour Ear Nose and Throat & Allergy medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefit. I authorize the use of this signature on all my insurance submissions. If my insurance requires a referral and I do not secure one, I will be responsible for payment.

Signature: _____ **Date:** _____
(patient signature or signature of parent/guardian if patient is a minor under 18y)

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New Patient Medical History

Patient Name: _____ DOB: _____ Sex: _____

Height: _____ Weight: _____ Marital Status: M S W

Pharmacy Info: _____ Occupation: _____

Physician who referred you to our office: _____

What brings you into the office today: _____

_____

Have you been recently hospitalized or had any imaging done? Please list: _____

Current Medication please include over the counter medications, vitamins and supplements:

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____
8) _____

Do you have a history of the following? Please check off if applicable.

- ☐ High Blood Pressure
- ☐ Heart Attack/Stroke
- ☐ Angina/Chest Pain
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Epilepsy/Seizures
- ☐ Asthma/COPD/Emphysema
- ☐ Bleeding Disorders/Anticoagulant Therapy
- ☐ Vertigo/Dizziness/Unsteady Gait
- ☐ Headaches/Migraines
- ☐ Depression/Anxiety
- ☐ Masses/Moles/Rash
- ☐ Cancer: _____
- ☐ Environmental Allergies: _____
- ☐ Food Allergies: _____
- ☐ Other: _____

Are you allergic to any medications: Please List: _____

Surgical History with Date:

1) _____ _____
2) _____ _____
3) _____ _____
4) _____ _____
5) _____ _____
6) _____ _____

Family History:

Father: Alive or Deceased Age Deceased:_____ Any Medical problems_____
Mother: Alive or Deceased Age Deceased: _____ Any Medical Problems_____
Children: Alive or Deceased Age Deceased:_____ Any Medical Problems_____
Siblings: Alive or Deceased Age Deceased:_____ Any Medical Problems_____
Patients # of Brothers_____ #of Sisters _____
Patients # of Sons_____ #of Daughters _____

Social History:

Do you participate in any of the following? Please check off if applicable

- ☐ Alcohol-# of drinks per day _____
- ☐ Caffeine-# of serv(s)per day_____
- ☐ Non-smoker
- ☐ Current Smoker-#PPD_____ # of years_____
- ☐ Former Smoker-#PPD_____ # of years_____ Year quit_____

Environmental History: Do you have any of these in/around your home?

- ☐ Old Home
- ☐ New Home
- ☐ Wooded Area
- ☐ Carpets/Throw Rugs
- ☐ Hardwood Floors
- ☐ Dusty Home/Work
- ☐ Forced Hot Air
- ☐ Wood Stove/Fireplace
- ☐ Mold Issues
- ☐ Pets

Patient Signature: _____ Date: _____

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1 Wallace Bashaw Jr. Way Suite 3002
Newburyport, MA 01950
Tel: 978-997-1550

Consent for Medical/Surgical Care/ Emergency Treatment And Child's Medical Information

In presenting my son/daughter for diagnosis and treatment

Name: _____for _____ (patient name)
□ Mother □ Father □ Legal Guardian □ Son □ Daughter

hereby voluntarily consent to the rendering of such care, including diagnosis procedures, surgical and medical treatment, by authorized members of the office staff or their designees, as may in their professional judgment be necessary.

I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on my child's condition.

I have read this form and certify that I understand its contents.
We/I hereby give our/my consent to _____

who will be caring for our/my child _____DOB: _____?
(Name of Child)

for the period _____to _____ to arrange for routine or emergency medical care and treatment necessary to preserve the health of our/my child.

We/I acknowledge that we are/ I am responsible for all reasonable charges with the care and treatment rendered during this period.

Signature: _____ Date: _____
Mother, Father or Legal Guardian

Witness: _____ Date: _____

In case of emergency, I can be reached at: _____

Consent to Discuss Medical Care and Treatment

I hereby authorize the office of Colden & Seymour Ear Nose Throat & Allergy to discuss my medical care and treatment with

Name: _____
□ Mother □ Father □ Spouse □ Other (please specify)

Patient Signature_____Date_____ DOB: _____
(patient must be 18 years or older)

COLDEN & SEYMOUR EAR NOSE THROAT AND ALLERGY FINANCIAL POLICY

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

- All patients must complete our "patient information forms" prior to seeing the doctor
- Full payment is due at the time of service (unless we have contracted with your insurance carrier and all appropriate Referrals/authorizations have been issued). After full payment is made, you will receive an itemized receipt which you can submit for direct reimbursement.
- Your insurance carrier requires we collect designated copayment due at each and every visit. You are responsible for any deductible/coinsurance as indicated by your insurance plan. We reserve the right to collect these fees prior to rendering professional service (s), if applicable.
- During your evaluation, additional procedures may be done if medically necessary. These include hearing tests, allergy evaluation, wax removal, endoscopy of the nose or throat and cautery and/or packing for nasal bleeding.
- They are billed in addition to the office evaluation. If you prefer not to have any of these procedures done, please let us know in advance
- Non-emergency treatment may be denied if:
  - A minor under eighteen is unaccompanied by an adult
  - A patient does not have a valid insurance card
  - A referral is unobtainable (when required by the insurance)
  - A patient has been delinquent on balance and/or the account has been sent to our "collection agency"
  - A patient has missed more than three previous appointments and has been advised of being denied another appointment
- We accept CASH, CHECKS, MASTERCARD, VISA, DISCOVER and AMERICAN EXPRESS.
- Failure to show for an appointment will result in a $35.00 administration fee.
- Cancellations within 2 business days of the appointment will result in a $35.00 administration fee.

Thank you for taking the time to review our policies. Please feel free to ask any questions or share with us special concerns.

I, _____have read and understand the conditions for payment to Colden & Seymour Ear Nose Throat & Allergy as outlined above.

Signature_____ DATE _____
(patient signature or signature of parent/guardian if patient is a minor under 18)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices from the office of Colden & Seymour Ear Nose Throat & Allergy

Name of Patient (Please print) _____

Signature of Patient _____ DATE _____
(patient signature or signature of parent/guardian if patient is a minor under 18)

Notice of Health Information Privacy Practices

Our use of your health and demographic information

1. Basis for planning your medical treatment
2. Means of communication among health professions involved in your treatment
3. Legal document describing your treatment
4. Basis for obtaining payment including third party payer verification of services billed
5. Basis for regular health operations including risk or quality improvement
6. Tool in educating health professionals
7. Source of information for public health officials, law enforcement, correction institutions, workers compensation as required by law

Your health information rights

1. Obtain a copy of this notice of information practices upon request
2. Obtain a copy of your health information as provided for in (45CFR 164.524).
3. Amend your health information (45 CFR 164.528)
4. Obtain an accounting of disclosures of your health information (45 CFR 164.528)
5. Request disclosure of your health information by alternative means or at alternative locations
6. Request restriction on uses and disclosure of your health information (45 CFR 164.522)
7. Revoke your authorization to use or disclose your health information except to the extent that action has already been taken
8. Receive a copy of any revisions to this notice

Our responsibilities and rights

1. Maintain the privacy of your health information
2. Provide you with this notice
3. Abide by the terms of this notice
4. Notify you if we are unable to agree to a requested restriction
5. Accommodate reasonable requests regarding disclosure of health information by alternative means or at alternative locations
6. Discontinue use or disclosure of your health information with receipt of your written revocation of authorization
7. Reserve the right to revise this notice (CFR164.520)
8. Provide a copy of any revisions to this notice to the address provided by you

For more information or to report a problem

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer or With the Office for Civil Rights without retaliation:
Office of Civil Rights
US Department of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Bldg.
Washington, DC 20201