ARIZONA HEARING CENTER, PC
Mark J. Syms, M.D., F.A.C.S.

PATIENT PROFILE

Please PRINT with a black or blue ink pen. Provide a government issued ID and an insurance card with your completed paperwork. Any incomplete fields will delay your check-in process*

PATIENT INFORMATION:

Name: _____ **Email**: _____

Address: _____ Date of Birth: _____ Age: _____

_____ Social Security #: _____

City, State: _____ Zip: _____ Gender: [ ] Male [ ] Female

Phone #: _____ [ ] Home [ ] Cell [ ] Work Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Other

Phone #: _____ [ ] Home [ ] Cell [ ] Work **Referring Physician:**_____

Phone #: _____ [ ] Home [ ] Cell [ ] Work Ref MD Phone #: _____

May we leave messages to home/cell #: [ ] Yes [ ] No Ref MD Fax #: _____

Preferred contact: [ ] Email [ ] Home [ ] Cell [ ] Text **Primary Physician:** _____

Emergency Contact Name: _____ Primary MD Phone #: _____

Emergency Contact #: _____ Primary MD Fax #: _____

FINANCIAL RESPONSIBLE PARTY:

[ ] Same as Patient - Skip and continue to ***INSURANCE***

Name: _____ Date of Birth: _____

Address: _____ Social Security #: _____

_____ Home #: _____ Cell #: _____

City, State: _____ Zip: _____ Relationship to Patient: _____

PRIMARY INSURANCE:

Main Policy Holder: [ ] Same as Patient [ ] Same as Responsible Party [ ] Other - provide information below

Name: _____ Date of Birth: _____

Address: _____ Home #: _____ Cell #: _____

_____ Email: _____

City, State: _____ Zip: _____ Relationship to Patient: _____

Policy ID #: _____ Social Security #: _____

Group ID #: _____ Specialist Co-Pay: _____

Staff Audit: _____

ARIZONA HEARING CENTER, PC
Mark J. Syms, M.D., F.A.C.S.

PATIENT PROFILE

SECONDARY INSURANCE:
Main Policy Holder: [ ] Same as Patient [ ] Same as Responsible Party [ ] Other - provide information below

Name: _____ Date of Birth: _____

Address: _____ Home #: _____ Cell #: _____

_____ Email: _____

City, State: _____ Zip: _____ Relationship to Patient: _____

Policy ID #: _____ Social Security #: _____

Group ID #: _____ Specialist Co-Pay: _____

TERTIARY INSURANCE:
Main Policy Holder: [ ] Same as Patient [ ] Same as Responsible Party [ ] Other - provide information below

Name: _____ Date oF Birth: _____

Address: _____ Home #: _____ Cell #: _____

_____ Email: _____

City, State: _____ Zip: _____ Relationship to Patient: _____

Policy ID #: _____ Social Security #: _____

Group ID #: _____ Specialist Co-Pay: _____

By signing below, I acknowledge that the information I provided is correct to the best of my ability. I hereby authorize my insurance company to make direct payments to Arizona Hearing Center, P.C. on behalf of Mark J. Syms, M.D. If for any reason the information I provided is insufficient, I will be responsible for the full charges of the visit and/or any non - covered services as well as any outstanding balance.

Patient's Signature: _____ Date: _____

Guarantor's Signature: _____ Date: _____
(Not applicable if the patient and person responsible is the same

Staff Audit: _____

ARIZONA HEARING CENTER /Mark J. Syms MD

MEDICAL HISTORY

Name: ______________________________ Date of Birth: ________________________

A. **Reason for Visit**:____

B. **Medications**:

1. List all medications currently taking, including over the counter drugs.

Name: Strength: Frequency:

____

____

2. **Do you have any allergies to medications? [ ] No [ ] Yes [ ] Not Sure**

LŦ ʅyƻøyƩ ƚʎăű KŜŊŜ: ____

C. **Medical History**

List any medical conditions and indicate the year and reason you were admitted to the hospital.

Do not include normal pregnancies

Year Illness/Operations

____

____

____

D. **Social**

1. Do you smoke? [ ]No [ ] Yes.______Packs per day
2. Do you drink alcohol? [ ]No [ ] Yes,______Glasses per day, week, month
3. Do you drink caffeine products? [ ] No [ ] Yes, ______Cups per day, week, month
4. Do you use recreational drugs? [ ] No [ ] Yes How Often? _________________________

E. **Family**

1. List all family members with a history of hearing loss or ear problems.

Relationship	Age	Types of hearing loss/problem
____________	______	____
____________	______	____

2. Please circle any of the following diseases which are common in your family. (This does not include Family members by marriage or adoption.)

Asthma Diabetes Migraine Auto Immune Disease Hay Fever Stroke High Blood Pressure

Bleeding disorder Heart Disease Cancer Tuberculosis Kidney Disease

3. Have you ever had Surgical Complications? [ ]No [ ] Yes, please explain __________________

Staff Audit ________

F. Symptom Review (indicate if you have had any of the following symptoms or diseases.)

Neurological

[ ] stroke

[ ] migraine

[ ] blackout spells

[ ] weakness/ paralysis

[ ] tremor/ handshaking

[ ] head injury

[ ] numbness/tingling

[ ] muscle pain

[ ] significant arthritis

Respiratory

[ ] pneumonia

[ ] tuberculosis

[ ] asthma

[ ] chronic cough

[ ] shortness of breath

Gynecological

[ ] pregnancy

[ ] currently breastfeeding

[ ] vaginitis

Endocrine

[ ] hormone therapy

[ ] thyroid

[ ] diabetes

Gastrointestinal

[ ] constipation

[ ] diarrhea

[ ] ulcer

[ ] heartburn

[ ] liver disease

Infections

[ ] AIDS

[ ] HIV positive

[ ] venereal disease

[ ] syphilis

[ ] gonorrhea

[ ] tuberculosis

[ ] chicken pox

[ ] German measles

[ ] mumps

Emotional

[ ] nervous breakdown

[ ] depression

[ ] anxiety

[ ] chronic fatigue

[ ] suicidal tendencies

Dermatologic

[ ] rashes

[ ] boils

[ ] eczema

[ ] psoriasis

Cardiovascular

[ ] heart attack

[ ] angina/chest pain

[ ] any heart trouble

[ ] arrhythmia

[ ] heart murmur

[ ] high blood pressure

[ ] rheumatic fever

General

[ ] cancer

[ ] poor vision

Blood/ Lymphatic

[ ] bleeding disorder

[ ] anemia

[ ] previous transfusion

[ ] easy bruising

Head and Neck

[ ] dry mouth

[ ] headaches

[ ] glaucoma

[ ] itching eyes or nose

[ ] hay fever

[ ] sneezing/runny nose

[ ] sinus trouble

[ ] dry eyes

[ ] eye disease

G. Ear Disease

Y **N**

[ ] [ ] Have you ever had your hearing tested?

[ ] [ ] Have you ever been to a doctor for ear trouble?

[ ] [ ] Have you ever had ear surgery?

[ ] [ ] Have you ever worn hearing aids?

[ ] [ ] Do you wear hearing aids now?

[ ] [ ] Today do you have any of the following?(please circle) Allergies, Cold, Ear infections, Dizziness, Ear Pain, Ear Pressure, Ear Drainage

[ ] [ ] Are you bothered by ringing or noises in your ears?

[ ] [ ] Are you now taking more than a few Aspirins a day?

[ ] [ ] Have you ever taken large doses of Aspirin, Anacin, Bufferin, Emperin or Quinine?

[ ] [ ] Have you ever taken medications known to be damaging to your ears?

[ ] [ ] Have you ever received injections of any antibiotics of the Mycin family? Erythromycin?

[ ] [ ] Were you in the military or National Guard? What was your job? _____

[ ] [ ] Do you wear hearing protection for work? How long? _____

[ ] [ ] Have you worn hearing protection prior to this test?

[ ] [ ] Do you have trouble understanding speech in crowds, church or meetings?

[ ] [ ] Do you understand speech less than you did 5 years ago?

[ ] [ ] Do you have difficulty listening to music?

How is your hearing?[ ] Good [ ] Fair [ ] Poor

H. Have you ever or are you currently involved in….

Y **N**

[ ] [ ] Motorcycling

[ ] [ ] Snowmobiling

[ ] [ ] Musical Instruments

[ ] [ ] Farm Equipment

[ ] [ ] Hunting

[ ] [ ] Target Shooting

[ ] [ ] Auto Racing

[ ] [ ] Private airplanes

[ ] [ ] Chainsaws

[ ] [ ] Any job that is noisy

Patient Signature _____ **Date:** _____

Physician Signature _____ **Date:** _____

Staff Audit _____

ARIZONA HEARING CENTER
Mark J. Syms, M.D.
2627 North 3rd Street, Suite 201
Phone: 602.307.9919 Fax: 602.307.5905

Payment Policy

Thank you for choosing Arizona Hearing Center for your medical needs. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. **Please read it, ask us any questions you may have, and initial in the space provided.** A copy will be provided to you upon request.

1. Insurance: We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing you insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. **Initials**____

2. Referrals from your Primary Care Physician. Arizona Hearing Center is a specialist medical office. We cannot obtain your referral for you: Please be aware that your insurance may require a referral from your primary care physician (PCP) to our office. Please check with your insurance carrier if you require a referral to be seen in our office. It is the patients' responsibility to contact their PCP and obtain a valid referral. It is also the patients' responsibility to make sure that a valid referral is presented to us on your appointment day. If you do not bring your referral with you to the appointment, your appointment may be rescheduled for a later time until one is obtained or you may be asked to pay for the visit in full. When scheduling your appointment, please keep in mind to allow your PCP ample time to obtain a referral from your insurance carrier. **Initials**____

3. Co-payments and deductibles: All co-payments and deductible must be paid at the time of service. The arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment and/or deductible at each visit. **Initials**____

4. Non-covered services: Please be aware that some -and perhaps all- of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. The balance will automatically be billed to you. **Initials**____

5. Proof of insurance: All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. **Initials**____

6. Claims Submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to the contract. **Initials**____

7. Coverage Changes: If your insurance changes, please notify us at least a week before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you. **Initials**____

8. Secondary Insurance: As a courtesy to our patients we bill secondary insurances after primary has paid. However if your secondary insurance does not pay the remaining claim balance in 30 days after receiving primary payment, the balance will automatically be billed to you. **Initials**____

9. Non-payment: If your account is over 60 days past due, you will receive a letter stating that you have 10 days to pay your account in full. Partial payments will not be accepted unless otherwise approved by our office and a written and signed payment plan is completed. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from this practice. If this is to occur, you will be notified by mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis. **Initials**____

10. Missed appointments/surgeries: Our policy is to charge a $25 fee for missed office visits and $100 fee for missed office procedures not canceled within 48 hours before scheduled appointment. Missed surgeries and surgeries not cancelled 7 days prior to surgery date will be charged $150 per occurrence. These charges will be your responsibility and billed directly to you. Please help us serve you better by keeping your regularly scheduled appointments. **Initial**____

Arizona Hearing Center is committed to proving the best treatment to our patients. Our prices are a representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines.

_____ _____

Signature of patient of responsible party **Date**

ARIZONA HEARING CENTER, P.C.
NOTICE OF PRIVACY PRACTICES:

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT **YOU** MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THE INFORMATION**. PLEASE READ IT CAREFULLY.**

Use and Disclosures:

Treatment: Your health information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions and providing treatment. For example, results of laboratory tests and procedures will be available in your medical records to all healthcare professionals who may provide treatment to you or who may be consulted by staff members.

Payment: We may use and disclose health information so that we or others may bill and receive payment from you, an insurance company and/or a third party for the treatment and services you received. For example, your health plan may request and receive information on the dates of service(s) provided and the medical condition being treated.

Out of Pocket Payments: If you paid out of pocket (or in other words, you have requested that we not bill your health insurance plan) in full for specific items or service, you have the right to ask in writing that your protected health information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations. We will honor that request.

Healthcare Operations: Your health information may be used as necessary to support the day to day activities and management of Arizona Ear Center. For example, information on the services you received may be used to support budgeting and financial reporting as well as activities to promote compliance and promote quality care within the practice.

Law Enforcement: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For instance, we are required to report certain communicable diseases to the State's Public Health Department.

Other Uses and Disclosures require your authorization: Disclosure of your health information or use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information: Appointment reminders. Your health information may be used by our staff to contact your primary residence regarding future appointments or surgical procedures.

Marketing and Fundraising: The practice does not and will not sell or provide any patient information for the use or promotion of any healthcare company or fundraising agency.

Individual Rights: You have certain rights under the Federal Privacy Practice Policy. **These Include:**

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition.
- The right to inspect and obtain a copy of your medical records.
- The right to request an amendment(s) to your medical record.
- The right to be notified of a breach of any of your unsecured protected health information.
- The right to receive a printed copy of this notice.

Arizona Ear Center Duties: We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in Federal and State laws and regulations. Upon request, we will provide you with the most recently revised notice at any time. The revised policies and practices will be applied to all protected health information we maintain.

Request to Inspect Protected Health Information: You may generally inspect or receive a copy of the protected information we maintain. As permitted by Federal regulation, we require that requests to inspect or copy protected health information be submitted in writing and the proper form signed by the patient or legal representative. You may obtain a form to request access to your records by contacting Rosie Villegas, Privacy Officer, and Practice Administrator. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request. We further maintain the right to charge a copying fee for your records.

Complaints and Contact Person: If you would like to submit a comment or complaint about our privacy practices, you may do so by sending a letter outlining your concerns to:

Rosie Villegas, Privacy Officer
Arizona Hearing Center
2627 N 3rd St Ste 201
Phoenix AZ 85004

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the address above. You will not be penalized or otherwise retaliated against for filing a complaint

Effective Date: The notice is effective on or after June 12, 2018

ARIZONA HEARING CENTER, PC

Mark J. Syms, M.D., F.A.C.S.

ACKNOWLEDGMENT OF RECEIPT: NOTICE OF PRIVACY PRACTICES (HIPAA)

Arizona Hearing Center, P.C. reserves the right to modify the privacy practices outlined in the above notice. By signing below, I am certifying that I have received a copy of the Notice of Privacy Practices for Arizona Hearing Center, P.C.

_____ _____

Name of Patient (Please print) Date of Birth

_____ _____

Signature of Patient Date

_____ _____

Name of Patient Representative (Please print) Relationship to Patient
(Patient is a minor or unable to sign)

_____ _____

Signature of Patient Representative Date

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize the following person(s) to receive information on the status of my personal health information verbally and/or written. The following people may also speak on my behalf to Arizona Hearing Center, P.C.

_____ _____ _____

Name (Please print) Relationship Phone #

_____ _____ _____

Name (Please print) Relationship Phone #

_____ _____ _____

Name (Please print) Relationship Phone #

I give Arizona Hearing Center, P.C. permission to obtain/release medical records from/to other physicians, hospitals or facilities for continuity of care. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidential rules.

_____ _____

Signature of Patient or Representative Date

_____ _____

Signature of Witness (Office Staff Only) Date

I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services including treatment of alcohol and drug abuse. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Arizona Hearing Center, P.C. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that authorizing the disclosure of this health information is voluntary. I understand that I may inspect or copy the information to be sued or disclosed as provided in CFR 164.524. If I have questions about discloures of my health information, I can contact Arizona Hearing Center, P.C.

Staff Audit: _____