

KIM E. PERSHALL, M.D.

Certified by the
American Board of Otolaryngology
Fellow of the
American Academy of Otolaryngic Allergy

3811 24th Street
Lubbock, TX 79410
(806) 796-0202 • 1-800-658-6262
email: pertranscript@aol.com
www.kpershallmd.com

Ear, Nose and Throat
Head and Neck Surgery
Allergy
Sinus Disease
Hearing Testing
Hearing Aids

PATIENT INFORMATION

PLEASE ANSWER ALL QUESTIONS!

Office visit payments and co-payments are due at the time that services are rendered. We will be glad to assist you in filing your insurance, but can not accept insurance as payment.

Today's Date: _____ Pharmacy: _____ Location: _____
Referring Doctor: _____ Phone Number: _____ City: _____
Primary Care Physician: _____ Phone Number: _____ City: _____

PATIENT:

Name: _____ M.I. _____ Home Phone: _____
Street Address: _____ Cell Phone: _____
City: _____ State: _____ Work Phone: _____
Zip: _____ Sex (M/F): _____ Date of Birth: _____
Employer: _____ Social Security #: _____
Marital Status: S M D W Age: _____ Email: _____

In Case of Emergency: (someone not living with you)

Name: _____ Phone: _____
Address: _____

PARENT OR SPOUSE:

Name: _____ M.I. _____ Cell Phone: _____
Street Address: _____ Home Phone: _____
City: _____ State: _____ Work Phone: _____
Zip: _____ Sex (M/F): _____ Date of Birth: _____
Employer: _____ Social Security #: _____
Marital Status: S M D W Age: _____ Email: _____

INSURANCE POLICY:

Insurance Company: _____ Insured's Employer: _____
Policy Holder: _____ Date of Birth: _____
Address: _____ Phone: _____
Relationship to Patient: _____ Social Security #: _____

ACCOUNT #: _____

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CHILDHOOD HISTORY FOR _____ AGE _____

1) Race: _____ Ethnicity: _____ Language: _____

2) Infant History Height: _____ Weight: _____

Were there any problems with labor/delivery? NO YES
Was there any difficulty with the child upon returning home? NO YES
Did your child have jaundice? NO YES

3) Allergies: Does your child have any allergies to the following? If YES, please list:

Medications	NO	YES	_____
Foods	NO	YES	_____
Pollens, dust, animals, etc.	NO	YES	_____
Other (Tape, Iodine, etc.)	NO	YES	_____

4) Childhood Diseases: Has your child had or does your child now have any of the following diseases?

<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Mumps	<input type="checkbox"/> Measles	<input type="checkbox"/> Anesthetic complications
<input type="checkbox"/> Pneumonia/Bronchitis	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy/Convulsions
<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Ear infections	<input type="checkbox"/> Nasal infections	<input type="checkbox"/> Bleeding disorder, Bruising

5) Immunizations: Is your child up-to-date on the following immunizations?

DPT	NO	YES	Polio	NO	YES	Hepatitis	NO	YES
Tetanus	NO	YES	MMR	NO	YES			

6) Medications presently being taken: _____

7) Medications taken in the past: _____

8) Hospitalizations and Surgeries: (Please give details) _____

9) Family History

Other Children?	NO	YES	Names: _____	Age _____				
Allergies	NO	YES	Asthma	NO	YES	Hearing Loss	NO	YES
Hearing Loss	NO	YES	Sinusitis	NO	YES	Birth Defects	NO	YES

10) Does this child attend Day Care? NO YES Preschool? NO YES Grade _____

11) Does anyone in the home smoke? NO YES

12) If female, has the child started her menses? NO YES

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Patient Name: _____

Today's Date: _____

PATIENT REVIEW OF SYSTEMS

What is your reason for visiting us today? _____

Do you consider yourself generally: Healthy Not Healthy

Are you currently experiencing any of the following conditions:

EYES

Blurred vision Painful eyes Irritation from light Other: _____ None

EARS, NOSE, MOUTH, & THROAT

Itching Blocked nose Post nasal drip Rhinitis (runny nose) Sores in mouth
 Teeth hurt Bruxism (grinding teeth) Difficulty swallowing Painful swallowing Pressure in ears
 Hearing loss Other: _____ None

RESPIRATORY (LUNGS)

Wheezing Cough Shortness of breath while sitting Other: _____ None

CARDIOVASCULAR (HEART)

Palpitations/Fluttering of heart Shortness of breath while exercising Chest pain
 Other: _____ None

MUSCULOSKELETAL

Soreness Weakness Cramping Other: _____ None

INTEGUMENTARY (SKIN)

Itchy skin Bleeding Lesions on skin Dry Skin Other: _____ None

GASTROINTESTINAL (STOMACH)

Constipation Diarrhea Pain Reflux Other: _____ None

GENITOURINARY

Pain with urination Urination at night Hesitation with urination
 Other: _____ None

HEMATOLOGIC / LYMPH NODES

Bleeding easily Night sweats Other: _____ None

PSYCHIATRIC

Mood swings Situational stress Depression Anxiety Other: _____
 None

ENDOCRINE

Hot flashes Hair loss/growth Heat/Cold intolerance Other: _____ None

ALLERGY / IMMUNOLOGY

Sneezing Eye irritation Reactions Other: _____ None

NEUROLOGICAL (NERVES)

Twitch Ringing in the ears Dizziness/Vertigo Abnormal movements
 Other: _____ None

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Patient Name: _____

INSURANCE DISCLOSURE

- By being a member of your insurance policy, the member agrees to pay any unmet deductibles and copays set by the insurance company. Failure by the responsible party to make such obligated payments, or failure to make payment arrangements with the collections/billing staff, will result in outside collection measures.
- In agreement with your insurance company, this office is legally obligated to bill you for any required copayment and unmet deductibles. If we failed to do this, we would be held responsible for breaking our contract agreement causing possible interruption in patient care and other legal ramifications.
- If at any time it is found that you were covered under more than one insurance plan and you did not provide this information to our office, we WILL NOT file to the unknown insurance and you will be responsible for the balance of all charges that were incurred.
- **Medicaid Recipients:** We do not accept Medicaid for services provided during the retroactive eligibility period. You will be responsible for payment of these services and Medicaid will not be filed.

PAYMENT AGREEMENT

This agreement is between Dr. Kim Pershall, M.D. and responsible party for patient:

_____.

- I understand I will be responsible for patient's:
 - referrals from primary care physician
 - deductibles
 - copays
 - non-Covered Services
 - verification that other facilities Dr. Pershall may refer me to are in my insurance network.
 - charges during the Medicaid retroactive eligibility period
- I understand that insurance verification and pre-certification are not a guarantee of payment. Any discrepancies with my insurance company and all claims not paid by insurance within 45 days of date of service become my responsibility to pay immediately.
- I/We understand that Dr. Pershall has a commitment of ownership in Covenant Surgicenter, Ltd. and SightLine Lubbock IMRT.

SIGNATURE: _____
Patient or Responsible Party

DATE: _____

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IN OFFICE PRODECURE WAIVER AND INFORMATION

Patient name: _____ Account Number : _____

Please be aware that certain procedures performed in our office are not included in the standard office visit. These prodedures will be billed separately and in addition to the physician office visit charge. We have become aware that some insurance carriers are classifying the procedures as a "surgical procedure". As such, your insurance company may apply a surgical deductible and or coinsurance responsibility to you. Be assured, we are following accepted billing and coding guidelines and that all procedures are performed in the best interest for your care.

Please understand that most procedures and certain diagnostic tests will be performed on a separate day.

Examples of in-office procedures / diagnostic test include:

- ** Flexible laryngoscopy or nasal endoscopy: This procedure involves passing a long thin fiber optic scope through the nasal cavity and into the throat. The fiber optic scope enables the physician to visualize areas of the nose and throat not readily seen using the laryngeal mirrors or nasal instruments.
- ** Comprehensive audiometric exam: Our audiologist till test your hearing thresholds in a sound proof booth by presenting a series of tones and recording the level at which you respond.
- ** Tympanogram: This test measures the movement of the eardrum by varying the pressure in your ear canal.
- ** Cerumen or ear wax removal: Removal of ear wax that involves using the microscope or is more involved than brief clearance with a curette.
- ** Ventilating ear tube placement: This includes microscope, surgery instruments and extra time.
- ** Excision of lesions: This includes surgery instruments, topical anesthesia and extra time.
- ** Dizziness testing: This includes specialized equipment and extra time with the audiologist.
- ** Allergy testing: This includes allergy testing supplies and approximately 2 hours of one on one with the allergy technician.

I hereby authorize Dr Kim E Pershall to examine, treat and perform diagnostic tests and office procedures that the provider and the patient, and/or responsible party, may deem necessary.

Patient and/or responsible party signature

Relation to patient

Date: _____

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NOTICE OF PRIVACY PRACTICES

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. If you should have any questions about this Notice, please contact Business Administrator at 806/796-0202.

Dr. Pershall and all of his employees understand that medical information about you and your health is personal and are committed to protecting this information. Dr. Pershall will create a record of the care and services you receive. Dr. Pershall needs this record: As a basis for planning your care and treatment; as a means of communication among the many health care professionals who contribute to your care; as a means by which you and third-party payor can verify that services billed were actually provided; a tool for educating health professionals; a source of information for public health officials; and to provide you with quality care and to comply with certain legal requirements.

The methods in which Dr. Pershall may use and disclose medical information about you: For treatment, for payment, for health care operations, appointment reminders, research, and to avert a serious threat to health or safety. As required by law, Dr. Pershall will disclose medical information about you when required to do so by federal or Texas laws or regulations. Special situations may include: Organ and tissue donation, military and veterans, workers' compensation, qualified personnel and public health risks, lawsuits and disputes, law enforcement and coroners.

You have the following rights regarding medical information Dr. Pershall collects and maintains about you: Right to inspect and copy, right to amend, right to an accounting of disclosures, right to request restrictions, and the right to request confidential communications.

Dr. Pershall reserves the right to change the terms of the notice and to make new notice provisions effective for all PHI maintained. Should changes be made, the changes will be posted in a prominent area of the office, and available to patients up on request.

If you believe your privacy rights have been violated, you may file a complaint with Dr. Pershall or with the Office of Civil Rights, U.S. Department of Health and Human Services. To file a complaint with Dr. Pershall, contact the Business Administrator at 806/796-0202. The address of the Office of Civil Rights is:

Office of Civil Rights
U.S. Dept. of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

All complaints should be submitted in writing. ***You will NOT be penalized for filing a complaint.***

Printed Name of Patient

Signature of Patient or Representative

Date

Name of Representative (if applicable)

Relationship

If you would like a copy of this Privacy Notice, please ask the receptionist to make you a copy. Otherwise, it will become a part of your patient folder. Thank you.

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CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

I understand that as part of my health care, Dr. Pershall originates and maintains medical records describing my health history, symptoms, examination and test results, diagnoses, treatment, financial and demographic information, as well as any plans for future care or treatment. Dr. Pershall also originates and maintains billing records. I understand and consent to this information being used or disclosed for the following purposes:

- Planning my care and treatment;
- Communications between Dr. Pershall and health care professionals that act under the direction of Dr. Pershall and participate in my diagnosis, evaluation, or treatment;
- Collection of fees for medical services;
- Determining liability for payment and obtaining reimbursement;
- Conducting health care operations, including: the evaluation of health care services, appropriateness and quality of health care treatment, and the qualifications of health care practitioners.

I have been provided with a copy of Dr. Pershall's *Notice of Privacy Practices* that provides information about how Dr. Pershall uses and discloses Protected Health Information about me. I understand that I have the following rights and privileges:

- The right to review the *Notice* prior to signing this consent, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations. Dr. Pershall is not required to agree to requested restrictions, but is bound to any restrictions agreed to.

I understand that as provided in the *Notice of Privacy Practices*, the terms of the notice may change. If they do, I may obtain a revised copy from the Privacy Officer by calling (806) 796-0202.

I understand that I may revoke this consent in writing, except to the extent that Dr. Pershall has already taken action in reliance thereon. I also understand that by refusing to sign or revoking this consent, Dr. Pershall may refuse to treat me. I wish to restrict the use or disclosure of my health information as follows: _____

I understand that my confidential information may be released to the following individuals: Hospitals, referring physicians, transcriptionist and insurance companies, collection agencies, and legal entities.

Signature of Patient or Representative

Relationship of Representative

Date

Printed Patient Name

Signature of Employee

Title

Date

Account #