

INSURANCE AUTHORIZATION AND ASSSIGNMENT

I authorize Hyannis Ear, Nose & Throat Assoc., Inc. to furnish information to insurance carriers concerning my illness and treatments which may contain diagnostic and treatment information relative to alcohol/drug abuse, sexually transmitted diseases and psychiatric/mental health information. I hereby assign to the physician all payments for medical services rendered to myself or my dependent. I understand that I am responsible for any amount not covered by insurance.

NAME: _____

SIGNATURE: _____

DATE OF BIRTH: ____/____/____ DATE: _____

MEDICARE PATIENTS ONLY

I authorize this office to release any medical or other information to the Centers for Medicare and Medicaid Services (CMS) or its intermediaries or carriers, as needed, for a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to Hyannis Ear, Nose and Throat Associates, Inc., who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

NAME: _____

SIGNATURE: _____

DATE OF BIRTH: ____/____/____ DATE: _____



HYANNIS EAR, NOSE AND THROAT ASSOCIATES, INC.
THE COSMETIC SURGERY CENTER
 68 Camp Street • Hyannis, MA 02601
 (508) 775-7026 • Fax (508) 771-0499
 J. NICHOLAS VANDEMOER, M.D., F.A.C.S.

MEDICAL HISTORY QUESTIONNAIRE

NAME: _____ **BIRTHDATE:** _____ **DATE:** _____
HEIGHT: _____ **WEIGHT:** _____ **BP:** _____ **P:** _____ **R:** _____

PAST MEDICAL HISTORY

1. Please list your current medications and dosages (including non-prescription):

2. Please list your previous operations: _____
 Any reactions to anesthesia? _____
3. Please list any drug allergies you have and what type of reaction (i.e. hives, rash, stomach symptoms, etc.): _____
4. Have you suffered any serious injuries? _____
5. Have you had any blood transfusions? _____ Yes _____ No, if yes, any reaction? _____ Yes _____ No
6. Influenza vaccine this season? _____ Yes _____ No Month/Year _____
7. Pneumovax injection (age 65 and older)? _____ Yes _____ No
8. Screening or treatment for osteoporosis (females 65 or older)? _____ Yes _____ No

REVIEW OF SYSTEMS

1. Do you have asthma? _____ Yes _____ No
2. Do you have a chronic cough? _____ Yes _____ No
3. Have you had any problems with your heart? _____ Yes _____ No
 If so, what? _____
4. Do you have high blood pressure? _____ Yes _____ No
5. Do you get short of breath when climbing stairs or walking any distance? _____ Yes _____ No
6. Do you have chest pains or heaviness in the chest? _____ Yes _____ No
7. Do you have any bleeding problems? _____ Yes _____ No
8. Have you ever had phlebitis? _____ Yes _____ No
9. Have you ever had hepatitis, jaundice, or a liver condition? _____ Yes _____ No
10. Have you ever had kidney, bladder, or prostate problems? _____ Yes _____ No
11. Have you had any thyroid problems? _____ Yes _____ No
12. Are you, or might you be pregnant? _____ Yes _____ No Last menstrual period _____
13. Have you had convulsions, seizures, or been unconscious? _____ Yes _____ No
14. Do you have diabetes or other gland problems? _____ Yes _____ No
15. Have you had malignancy? _____ Yes _____ No
 (If yes, please explain) _____
16. Have you had trouble with numbness, tingling or loss of strength in your extremities? _____ Yes _____ No
17. Do you have glaucoma? _____ Yes _____ No
18. Do you _____ or your sleeping partner _____ snore? _____ Yes _____ No

FAMILY HISTORY, SOCIAL HISTORY

1. Are there bleeding tendencies in your family? _____ Yes _____ No
 2. How much alcohol do you drink? _____
 3. If you smoke, how many packs per week? _____ For how many years? _____
 Did you ever smoke? _____ How many packs per week? _____ When did you stop? _____
- FAMILY DOCTOR** _____

**HYANNIS EAR, NOSE & THROAT ASSOCIATES, INC.
CAPE COD MEDICAL AND SURGICAL CENTER**

68 Camp Street – Hyannis, MA 02601
(508) 775-7026 - FAX (508) 771-0499
J. Nicholas Vandemoer, M.D., F.A.C.S.

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you, as a patient of Hyannis Ear, Nose & Throat Associates, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. **Communications.** You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. **You can request a restriction in our use or disclosure of your health information** for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. **You have the right to inspect and obtain a copy of the health information** that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to: Hyannis Ear, Nose & Throat Associates, Attn: Kerry Igo (508) 775-7026, or Fax (508) 771-0499.
4. **You may ask us to amend your health information** if you believe it is incorrect or incomplete, as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to: Hyannis Ear, Nose & Throat Associates, Attn: Kerry Igo (508) 775-7026. You must provide us with a reason that supports your request for amendment.
5. **Right to a copy of this notice.** You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. **If you believe your privacy rights have been violated**, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Hyannis Ear, Nose & Throat Associates, Attn: Kerry Igo (508) 775-7026. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. **Right to provide an authorization for other uses and disclosures.** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact Hyannis Ear, Nose & Throat Associates, Attn: Kerry Igo (508) 775-7026.

I hereby acknowledge that I have been presented with a copy of Hyannis Ear, Nose & Throat Associates Notice of Privacy Practices.

Signature _____

Date _____

Name of Patient _____ DOB _____