Appointment Date: ______________________________

Appointment Time: _______________________________

Welcome to Miami Family ENT

Attached are your new patient forms.

Please visit our website at www.miamifamilyent.com

For first-time appointments, please bring the following with you:

- Completed new patient forms
- Health insurance card(s)
- Picture Identification
- List of current medications you are taking
- Recent medical records pertaining to your visit today
- Referral/Authorization from Insurance/PCP
- As per your insurance benefits, any copay, coinsurance, or deductible/out-of-pocket amount the patient may be responsible for at the time of the visit.

OFFICE POLICIES

Welcome to Miami Family ENT, thank you for choosing us. We look forward to partnering with you to address your health concerns, and will do all we can to provide you the best medical care. In order to familiarize with you how our office works, we are providing this information which we hope you will find helpful.

OUR OFFICE

Our office and other providers are committed to delivering the highest level of care possible in a friendly, caring, and efficient environment. Our office stays up to date on the latest scientific research for the diagnosis and treatment of otolaryngology. We provide coverage to your medical needs within office hours.

APPOINTMENTS

In order to serve you most effectively, we see patients by appointment only. Please call 305-663-1552 to schedule your appointments. If you are unable to keep your appointment, we ask you to inform us at least 24 hours in advance so that we can make that time available for another patient in need of medical attention. We urge you to be on time for your appointment. We will charge a $10.00 administrative fee for patients who do not show up for their appointment or notify us in advance. We will charge a $20.00 fee for patients who do not show up for their procedure appointments or notify us in advance.

FORMS

There is a $25.00 administrative fee for completion of any disability, FLMA, or related paperwork.

TELEPHONE CALLS

Please call our office during our regular office hours between 9AM-2PM with questions regarding your care, prescription refills, or results of any sort. All calls will be addressed within 24 hours except on weekends and holidays. Medication refills will not be provided during weekends or holidays.

AFTER HOURS SERVICE

For urgent medical questions after hours, please call our regular office number 305-663-1552 and our answering service will take a message to contact the doctor or our office to return your call. For all non-urgent issues, we urge you to call the office during regular office hours Monday through Thursday 9AM to 2PM, Fridays 9AM to 12PM.

Feel free to ask any staff for questions or concerns regarding this information.

I have read and understand the above office policies.

Signature:____ Date:____________

Print Patient’s Name: ______________________________________ DOB:____________

Name: ____ D.O.B: ______________ Date:______

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING SYMPTOMS IN THE LAST 14 DAYS:

- ❏ Fever
- ❏ Cough
- ❏ Shortness of breath
- ❏ Difficulty breathing
- ❏ Chills
- ❏ Muscle Pain
- ❏ Recent onset of headaches
- ❏ Sore throat
- ❏ Loss of taste or smell

HAVE YOU TRAVELED ANYWHERE OUTSIDE OF FLORIDA OR THE U.S. IN THE LAST 14 DAYS? ____

COME INTO CONTACT WITH ANYONE WHO HAS COVID-19 OR MIGHT HAVE BEEN EXPOSED TO COVID-19? ____

HAVE YOU BEEN DIAGNOSED WITH COVID-19?IF YES, THEN WHEN? ________________

DO YOU HAVE ANY PRE-EXISTING CONDITIONS? _________________________________

MIAMI FAMILY ENT

Pablo Arango, MD

Name:________________________________ Age:________ Sex:____________

DOB:_____________ Marital Status: __Married __Divorced __Single __Widowed

Race: American Indian ___African American ___Asian __White __Other__________

Ethnicity: Hispanic or Latino ___ Non-Hispanic or Latino____

Address:____ Apt:_________________

City:___________________ State:______________ Zip Code:________________

Home Phone:_________________ Cell:__________________ Work:______________

Email:____ SSN:____-______-______

Emergency Contact:_________________________ Phone #:____________________

Relation:____

Primary Care Physician:____________________________ Phone #:______________

Reason for Visit:____

Pharmacy Name:____________________________ Phone #:____________________

Pharmacy Address:____

Insurance Name:____

Assignment of Benefits and Information Release

I authorize payment of medical benefits to the above named provider and I authorize the release of any medical information to process this claim. I also authorize my treating physicians/facilities and laboratories to release copies of my medical records to Pablo Arango, MD.

Signature:____ Date:______________

(Patient/Parent of Minor)

PAST MEDICAL HISTORY

Insurance companies are requiring fairly specific information regarding medical and social history. Please be as detailed as you can be with your answers. These answers are strictly confidential and are not shared with anyone without authorization by you.

Medical Conditions

____ High Blood Pressure
____ Diabetes
____ High Cholesterol
____ Thyroid Disease
List any additional
____
____
____

Social History

Tobacco

Pipe __ yes __ no amnt ____ per DAY/WEEK
Cigarette __ yes __ no amnt ____ per DAY/WEEK
Cigar __ yes __ no amnt ____ per DAY/WEEK
Dip __ yes __ no amnt ____ per DAY/WEEK

Alcohol

Beer __ yes __ no amnt ____ per DAY/WEEK
Wine __ yes __ no amnt ____ per DAY/WEEK
Liquor __ yes __ no amnt ____ per DAY/WEEK

Marijuana __ yes __ no amnt ____ per DAY/WEEK
Method of use: SMOKE/EDIBLE

Other Drugs

____
____
____

Previous Surgeries and Date (month/year)

____
____
____

Previous Hospitalizations & Date

____
____
____

Obstetrics

Number of Pregnancies ____ Births ____

Medications:

Please list name and dosage if possible

____
____
____
____
____
____
____
____

Allergies to Medications:

List medication and reaction

____
type of reaction: _________________________
____
type of reaction: _________________________
____
type of reaction: _________________________

Would you like information or help regarding quitting tobacco/alcohol/other substances? ___ yes

Name:

Date:

Patient name:____________________________ DOB:___________ Date:__________

REVIEW OF SYMPTOMS (mark only what applies)

CONSTITUTIONAL ❏ Chills ❏ Fever ❏ Weight Loss ❏ Fatigue	**THROAT/NECK** ❏ Frequent sore throat ❏ Enlarged Tonsils ❏ Lumps on neck ❏ Voice change / Hoarseness	**MUSCULOSKELETAL** ❏ Arthritis ❏ Gout ❏ Back Problems/ Disk Herniation
EYES ❏ Blurry Vision ❏ Double Vision ❏ Pain ❏ Cataracts ❏ Glaucoma ❏ Redness	**RESPIRATORY** ❏ Positive TB test ❏ Asthma ❏ Coughing Blood ❏ Sputum ❏ Cough ❏ Wheezing ❏ Shortness of breath ❏ Excessive snoring	**PSYCHIATRIC** ❏ Behavior Changes ❏ Memory loss ❏ Depression ❏ Anxiety ❏ Hallucinations/ Hear voices
NOSE ❏ Secretion ❏ Sinusitis ❏ Frequent Colds ❏ Nasal Obstructions ❏ Allergy/Hay Fever ❏ Nosebleeds	**CARDIOVASCULAR** ❏ Chest pain ❏ High blood pressure ❏ Palpitations ❏ Heart murmur ❏ Previous heart attack ❏ Heart stent placement ❏ Pacemaker	**NEUROLOGICAL** ❏ Fainting ❏ Tremor ❏ Dizziness ❏ Headache ❏ Numbness ❏ Stroke ❏ Unsteady Gait
MOUTH ❏ Bleeding gums ❏ Nasal drip ❏ Tongue pain	**GASTROINTESTINAL** ❏ Abdominal Pain ❏ Decreased appetite ❏ Nausea ❏ Problems Swallowing ❏ Diarrhea ❏ Vomiting ❏ Vomiting Blood ❏ Constipation ❏ Heartburn ❏ Liver Disease	**ENDOCRINE** ❏ Goiter ❏ Excessive Urination ❏ Heat Intolerance ❏ Weight gain ❏ Weight loss ❏ Diabetes
EARS ❏ Secretion ❏ Hearing impairment ❏ Ringing in ears ❏ Pain ❏ Dizziness/Vertigo ❏ Infections	**HEMATOLOGIC/LYMPH** ❏ Anemia ❏ Easy Bruising ❏ Swollen glands ❏ Frequent nose bleeds ❏ Trouble clotting	**ALLERGIC** ❏ Cough ❏ Itchy eyes ❏ Runny nose ❏ Watery eyes ❏ Itchy nose ❏ Sneezing

SINUS QUESTIONNAIRE

Name: ___________________________________ Date: ___________________

How long have you had sinus/allergy symptoms: _______________

What symptoms do you experience (Check all that apply)

___Nasal Congestion	___Sneezing	___Post Nasal Drainagel
___Cough	___Irritaed throat	___Fever
___Pressure in ears	___Pressure in face	___Facial Pain
___Headaches	____Hoarseness	___Changes in smell/taste

Others____

What have you taken OVER THE COUNTER in the past for your symptoms?(check all that apply)

___clairitn/loratadine	___allegra/fexofenadine	___zyrtec/cetirizine
___benadryl	___afrin spray nasal	___flonase
___xyzal/levocetirizine	___solucion salina	___zicam
___neti pot	___ayr	___advil cold and flu
___tylenol	___sudafed	___dayquil/nyquil

What PRESCRIPTIONS have you taken in the past for your symptoms? (Check all that apply)

___Dymista	___Nasonex	___Patanese
___Qnasal	___Astepro	___Astelin
___Levaquin	___Cipro	___Augmentin
___Amoxicilin	___Z-Pack	___Predinose
___Medrol dose pack	___Avelox	___Doxycicline
___Cephalexin	___Keflex	___Atrovent
___Ceftin	___Omnicef/Cefdinir	Other:________________

Antibiotic History

How many times were you treated with antibiotic therapy in the past 12 months?___________________

What pharmacy do you fill your prescriptions at? ____________________________________

Surgery/Testing

Have you had any of the following tests or surgeries?

Allergy Testing (Please give copy to office) Date of Test:_____________________

Test Result:________________________________

Sinus CT: (Please give copy to office) Date of Test:________________________

Test Result:___________________________________

NOTICE TO PATIENTS

"Under Florida law, physicians are generally required to carry medical insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice.

YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law.

We are required by law to give you a copy of this notice to sign, acknowledge its receipt, and keep in your patient file."

NOTIFICACION A LOS PACIENTES

"Bajo la ley de la Florida, se requiere que los médicos tengan un seguro médico o de otra manera demostrar responsabilidad financiera para cubrir reclamos de negligencia médica.

SU MÉDICO HA DECIDIDO NO TENER EL SEGURO DE NEGLIGENCIA MÉDICA. Esto es permitido bajo la ley de la Florida sujeto a ciertas condiciones. La ley de la Florida impone penalidades en contra de los médicos que no están asegurados y que no pueden satisfacer los reclamos de negligencia médica.

La ley requiere que le demos esta notificación a los pacientes para que firmen, después de que la lean y la comprendan. Una copia de esta notificación firmada por el paciente será guardada en su expediente."

Signature/Firma: ______________________________ Date/Fecha:___________

CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY

I, ______________________________, authorize the provider and staff of Miami Family ENT to view my external prescription history via the RxHub Service.
I understand that prescription history from multiple unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by the providers and staff, and it may include a detailed list of past prescription information.

MY SIGNATURE CERTIFIES THAT I HAVE READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE ACCESS.

____ ___________

Patient Signature Date

BOTTOM PORTION IS FOR OFFICE USE ONLY.

____ ___________

Witness Date

PATIENT CONSENT TO RELEASE INFORMATION

The Department of Human Services has established a “Privacy Rule” to help insure that personal health care information is protected for privacy and is only to be used or shared in the minimum necessary fashion in order to provide a standard for certain health care providers to obtain their patients’ consent for uses and disclosures of health information about you to carry out treatment, payment, or healthcare operations. By signing this consent, you understand that your physician may need to provide necessary medical information to other appropriate physicians, pharmacies, hospitals, insurance companies, laboratories, and billing agencies.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information about treatment, payment or health care operations in order to provide health care that is in your best interest.

We also want you to know that we support full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients) and may have to disclose personal health information for purposes of treatment, payment, or healthcare operations. These entities are most often not required to obtain patient consent.

Refusing to consent to the use of disclosure of your personal health information prohibits the doctor from billing for services, scheduling your care at a hospital, calling in a prescription to a pharmacy, or other medical needs. Under this law we have the right to refuse to treat you should you refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may also revoke this consent in writing. No further information would be shared as of the date you present to revocation to the doctor.

If you have any questions about this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions, and revoke consent in writing after you have reviewed our privacy notice.

Print Name:____ DOB:__________________

Signature:____ Date:__________________

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To our patients,the misuse of personal health information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all of our employees, managers, and doctors continually undergo training so that they understand and comply with government regulations regarding Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the “Privacy Rule”. We strive to achieve the highest standards of ethics and integrity in performing services for our patients.
I have the Notice of Privacy Practices and have been provided an opportunity to review it.
Please indicate below if one or more of the following is an acceptable method to inform you of results, contact you, or if you would like to have your health information shared with anyone else besides yourself.

( ) OK to leave voicemail

( ) OK to email information

( ) OK to release information to:

Name:______________________________________ Phone:______________________________

Name:______________________________________ Phone:______________________________

Name:______________________________________ Phone:______________________________

Primary Physician: ________________________ Referring Physician: ___________________

( ) Other: ____

( ) NONE OF THESE METHODS ARE ACCEPTABLE ALTERNATIVES.

Patient name:____ DOB: ____________________

Signature:____ **Date**: ___________________

FINANCIAL POLICY

Thank you for choosing Miami Family ENT as your healthcare provider. We are committed to providing you with the best possible care. **The following is a statement of our financial policy which we require you to read and sign prior to any treatment** . All patients must complete out information and insurance forms before seeing the doctor.

- **PAYMENT IS DUE AT THE TIME OF YOUR APPOINTMENT.**
- We accept cash, checks, Visa, MasterCard, American Express, and Discover.
- There is a **$30.00 fee for any returned check**. We will no longer accept checks if yours is returned.

FINANCIAL AGREEMENT

As a courtesy to our patients, we accept assignment of insurance benefits, in most cases. However, we do require you to pay your co-payment, co-insurance, deductibles or other patient responsibility at the time services are rendered. Any deductibles, copayments, co-insurances and services not covered by your insurance company are your responsibility at the time of your visit. This includes charges for office visits, diagnostic studies, usage of scopes as part of diagnosis procedure, controlling of nasal bleeding, surgical, and outpatient procedures. **Further, if your insurance requires a referral and/or authorization and you have not obtained it by the time of your visit, you will be responsible for the balance of the entire bill.**

The medical bills incurred in this office are the sole responsibility of the patient or legal guardian thereof regardless of insurance of insurance status. I understand that unpaid accounts will be considered defaults after 90 days of the date of treatment. Signing below indicates that I understand and agree to these terms.
The Undersigned agrees that in consideration of the services to be rendered to the patient, he/she hereby individually obligates themselves to pay the account. Should the account be referred to an attorney for collection, I authorize an attorney to obtain my credit report; and the undersigned shall pay reasonable attorney’s fees and collection expenses.

Interest shall be charged beginning 45 days after date of service until paid, and will accrue at the rate of 18% per annum.

ASSIGNMENT OF BENEFITS

I hereby authorize payment to be made directly to “Miami Family ENT”, Pablo Arango MD, of benefits due to me from my insurance company. I understand that I am financially responsible for charges not covered by my insurance company. I further understand that if payment is sent to me by my insurance company, I will immediately pay “Miami Family ENT”, Pablo Arango, MD.

By signing below, I authorize the release of any and all medical information to the proper insurance company, and hereby consent to treatment.

→____ Date:______________

(Signature of Patient/Responsible Party/Guardian)