JEFFREY ADELGLASS, M.D., F.A.C.S.
EAR, NOSE & THROAT • ALLERGY • FACIAL PLASTIC SURGERY

Welcome to our practice!
We strive to make each of your visits pleasant and comfortable. Due to the increased requirements of insurance companies, and to help us better serve your needs; please take a few minutes to answer the following questions.

PATIENT INFORMATION

Who may we thank for referring you? _____

Patients Name _____ _____ _____
First **Middle Initial** **Last**

Sex: M F Birthdate _____ **Age** _____ **S.S.N.** _____

Mailing Address: _____

_____ _____ _____
City **State** **Zip Code**

_____ _____ _____
Home Phone **Work Phone** **Cell Phone**

_____
E-mail address

_____
PCP (Primary Care Physician) **Address** **Phone**

Will we be filing any insurance on your behalf? _____

Please provide us with a copy of your insurance card.

*** If it is an HMO, provide the receptionist a copy of your referral from your PCP upon completion of the form.**

INSURED PARTY INFORMATION

Parent/Guardian/
Insured's Name: _____ _____ _____
First **Middle Initial** **Last**

Sex: M F Birthdate _____ **Age** _____ **S.S.N.** _____

Mailing Address: _____

_____ _____ _____
City **State** **Zip Code**

_____ _____ _____
Home Phone **Work Phone** **Cell Phone**

Emergency Contact: _____ **Relationship:** _____

Phone Number: _____

- ARE YOU INTERESTED IN LEARNING MORE ABOUT THE COSMETIC **PROCEDURES** WE PROVIDE? YES NO
- ARE YOU INTERESTED IN OUR SKIN CARE OR NUTRITIONAL PROGRAMS? YES NO
- WOULD YOU LIKE TO MEET WITH A PATIENT CARE COORDINATOR WHILE YOU ARE HERE TODAY AT NO CHARGE? YES NO

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EXPLANATION OF PAYMENT AND INSURANCE FILING PROCEDURES

Our office is pleased to assist you in filing claims with your insurance company for reimbursement of your expenses. We will wait ninety (90) days for your insurance company to pay your claim. If they deny your claim and/or do not pay your claim for any reason, any remaining balance must be paid by you within thirty (30) days. We will not fight your insurance company for payment. We file insurance for you as a courtesy.

- It is the patient's responsibility to pay any deductible, co-insurance, and/or co-payments at the time services are rendered.
- Our office NEVER guarantees that your insurance will pay. We will make every attempt at the beginning of your health care to receive verification of your policy benefits. However, if for some reason your insurance claim is denied, you are responsible for the amount due on your account immediately.
- We recommend that you also contact your insurance company to verify the ENT and Allergy coverage on your policy.
- We will not file insurance for patients that do not live in Texas. We will provide you with a receipt of all services rendered.
- If injections, allergy testing, ear cleaning, or other in-office procedures are recommended for your treatment; please be aware that they may be considered surgical procedures and will be applied to your deductible.
- Our office will not file with a secondary insurance policy unless Medicare is your primary.
- There will be a $25 fee on all returned checks. Checks will not be presented to the bank twice.
- You may receive a copy of your records at any time with a written request. There is a $25 fee for all records received by our office. A 72 hour notice is required to get copies completed.

I fully understand the above policies and agree to them. I understand that I am responsible for payment to Dr. Jeffrey Adelglass and/or Associates for all charges incurred by myself, regardless of my insurance coverage. For your convenience, we accept Cash, Visa, Master Card, American Express, Discover, and personal checks (with proper identification) as methods of payment.

CONSENT FOR TREATMENT
I give permission to the physician and whomever he may designate as his assistant(s)/associate(s) to administer such treatment as is necessary, and to perform any medical care or procedures as are considered therapeutically necessary based on findings during examination or treatment.

NOTICE TO PATIENTS OF FINANCIAL INTEREST
I understand that should Dr. Adelglass feel radiology services are necessary for diagnosing or treating my health, I may be referred to Presbyterian Plano Center for Diagnostics and Surgery. I am informed by this notice that Dr. Adelglass holds a financial interest in the Hospital and Radiology Services. I also understand that I have the option, at my discretion, to use an alternate health care facility.

AUTHORIZION TO RELEASE INFORMATION
I hereby authorize Dr. Jeffrey Adelglass, and/or Associates to release any medical information pertaining to the examination, treatment, history, prescription of medications, and medical expenses of myself to any physician, hospital, clinic, insurance company, and all other agencies deemed necessary in order to process insurance claims. This authorization also includes the release of any pertinent medical information to any specialist or other medical facility the physician may refer the patient to for medical treatment or evaluation.

ASSIGNMENT OF BENEFITS
I authorize payment of medical benefits to Dr. Jeffrey M. Adelglass, and/or Associates, for services rendered. I understand that I am financially responsible for any co pays, co-insurance, or deductibles required by my insurance company. I also understand that I am responsible for charges that are not covered by my insurance company.

By my signature I agree to comply with the Financial Policy, Consent for Treatment Policy, Notice of Financial Interest, Authorization to Release Information Policy, and Assignment of Benefits.

_____ _____
Insured's or Authorized Person's Signature Date

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REQUEST FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ D.O.B. _____

I hereby request medical records be released:

To / From
(please circle one)

☐ **Jeffrey Adelglass, M.D., F.A.C.S.**

6020 W. Parker Road, Suite 400
Plano, TX 75093
972-492-6990 (ph)
972-394-4405 (fax)

To / From
(please circle one)

_____
Physician's Name

_____
Address

_____

_____ _____
Phone Fax

Reason: _____

_____

_____

_____ _____
Patient's Signature (*or patient's parent or legal guardian*) Date

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.

Dr. Jeffrey Adelglass & Associates has adopted the following privacy policies:

Uses and Disclosures

Treatment - Your health information may be used by staff members or disclosed to other health care 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 record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment - Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations - Your health information may be used as necessary to support the day-to-day activities and management of Dr. Jeffrey Adelglass & Associates. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement - Your health information may be disclosed to law enforcement agencies, without your permission, 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 example, we are required to report certain communicable diseases to the state's public health department.

Disputes - Your health information and/or photos may be disclosed to the appropriate institutions involved in any financial, medical, or legal dispute. For example, should you initiate a financial dispute for any reason, we reserve the right to release your medical information to the involved financial institution(s).

Other uses and disclosures require your authorization - Disclosure of your health information or its 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 the 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.

Dr. Jeffrey Adelglass & Associate's Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the 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. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

PRIVACY PRACTICES CONT…

Authorization for Phone Calls

I authorize the staff of Dr. Jeffrey Adelglass to call my home, work, or cell phone number regarding office appointments and/or surgery information.

I authorize the staff of Dr. Jeffrey Adelglass to leave a message on my voice mail, telephone recorder, or email regarding office appointments and/or surgery information.

Complaints/Contact Person

If you would like to submit a comment or complaint about our privacy practices, or if you believe that your privacy rights have been violated; you should call the matter to our attention by sending a letter outlining your concerns to:

Julie Latta, Office Manager
Dr. Jeffrey Adelglass & Associates
6020 West Parker Road, Suite 400
Plano, TX 75093

You will not be penalized or otherwise retaliated against for filing a complaint.

Expiration Date of Authorization

This authorization is valid for five (5) years from date of signature.

Acknowledgment Form

I acknowledge receipt of and have reviewed the Notice of Privacy Practices for Dr. Jeffrey Adelglass & Associates, and have been given a copy at my request.

Signature of Patient	Signature of Patient's Representative
Name of Patient (Print or Type)	Relationship of Representative to Patient
Date	Date

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HEALTH HISTORY

NAME: _____ AGE: _____ DATE: _____

WHO REFERRED YOU TO OUR PRACTICE? _____

REASON FOR VISIT? _____

WHAT DATE DID SYMPTOMS BEGIN? _____

PROBLEMS (Please Check Appropriate Boxes)

☐ Hearing Loss	☐ Vision Problems	☐ Sore Throat
☐ Vertigo	☐ Nose Congestion	☐ Snoring
☐ Ear Ringing	☐ Nose Discharge	☐ Heartburn
☐ Ear Pain	☐ Post Nasal Drip	☐ Hoarseness
☐ Ear Fullness	☐ Nose Bleeds	☐ Allergies
☐ Dizziness	☐ Headaches	☐ Swallowing Problems
☐ Neck Pain	☐ Neck Mass	

☐ Other _____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: _____

_____

_____

LIST ANY DRUG ALLERGIES: _____

PAST MEDICAL HISTORY (Please Check Appropriate Boxes)

☐ Heart Attack	☐ Thyroid Disorder	☐ Glaucoma
☐ Asthma	☐ Coronary Disorder	☐ Hypertension
☐ Diabetes	☐ Bleeding Disorder	☐ Heart Failure
☐ Emphysema	☐ Kidney Disorder	☐ Arthritis
☐ Hepatitis	☐ Stroke	☐ Cancer

☐ Other _____

PAST SURGICAL HISTORY (Please Check Appropriate Boxes)

☐ Ear Tubes	☐ Hernia	☐ Back/Neck
☐ Septoplasty	☐ Heart Bypass	☐ Appendix
☐ Sinus Surgery	☐ Cataracts	☐ Gall Bladder
☐ Tonsillectomy	☐ Other _____	

FAMILY HISTORY (Please Check Appropriate Boxes)

☐ Strokes	☐ Thyroid Disorders	☐ Hypertension
☐ Diabetes	☐ Allergies	☐ Hearing Loss
☐ Heart Disease	☐ Asthma	☐ Lung Cancer
☐ Breast Cancer	☐ Other _____	