Northwest Sinus & Allergy Clinic

Jason B. Sigmon MD, FAAOA | 10960 North May Ave. | Oklahoma City, OK 73120 | 405-595-3575

Patient Registration Form (Child)

Patient Information				
Last Name	First Name	MI	Acct #	
Mailing Address	City, State, Zip	Home Phone Cell Phone		
DOB	SS#	Marital Status	Sex (M/F)	Referring Physician
Employer Employer Phone	**Meaningful Use Verification** Preferred Language_____ Race White / American Indian/Alaskan Native Black/African American / Native Hawaiian/Pacific Islander Hispanic/Latino / Asian / Other Race			
Email Address				

Responsible Party ***NO MINORS can be listed as responsible party.*** Guardian present and signing paperwork and all adults over 18 years of age will be listed as SELF for responsible party		
Name	Employer	DOB
Mailing Address	City, State, Zip	Home Phone SS#

Primary Insurance	
Name and Phone # of Insurance	Insurance ID #
Insurance Address	Group #

Policy Holder Information

Name (Last, First, MI)	Relationship to Patient	Phone #	
Subscriber SS#	Sex (M/F)	DOB	Employer

Secondary Insurance	
Name and Phone # of Insurance	Insurance ID #
Insurance Address	Group #

Policy Holder Information

Name (Last, First, MI)	Relationship to Patient	Phone #	
Subscriber SS#	Sex (M/F)	DOB	Employer

Any Additional Insurance	
Name and Phone # of Insurance	Insurance ID #
Name of Policy Holder	Group #

Emergency Contact ***NOT AT THE SAME ADDRESS AS PATIENT***		
Name	Phone #	Relationship
Address	City, State, Zip	

Are you being seen today for a work or auto related accident?	**YES or NO**

All charges are due at the time of service. All services rendered are charged to the patient or their responsible party. I understand that I am responsible for any amount not covered by my insurance. Therefore I hereby authorize the doctors of Northwest Sinus & Allergy Clinic to furnish information to insurance carriers concerning my illness and treatment. The information authorized for release may include information which may be considered a communicable or venereal disease, including hepatitis, syphilis, gonorrhea, HIV and AIDS. I assign to the physician(s) all payments for medical services rendered to myself.

Signature _____ Date _____

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Medical History Questionnaire

Name _____ Date _____ Are you currently receiving home healthcare?

Account # _____ Date of Birth _____ ☐ Yes ☐ No

1. Personal Information

Age _____ Weight _____ Height _____

Your Other Physicians _____

2. Your Medical Illness *(check yes or no)*

Yes	No	
☐	☐	Allergy
☐	☐	Asthma
☐	☐	Emphysema / Lung Disease
☐	☐	Stroke
☐	☐	Heart Attack
☐	☐	Heart Rhythm Abnormalities
☐	☐	High Blood Pressure
☐	☐	Depression
☐	☐	Headache / Migraine
☐	☐	Skin Cancer
☐	☐	Cancer (Other) _____
☐	☐	Obstructive Sleep Apnea
☐	☐	Anemia / Blood Disorders
☐	☐	Thyroid Disease
☐	☐	Diabetes
☐	☐	Kidney Disease
☐	☐	HIV / AIDS
☐	☐	Hepatitis
☐	☐	Other Illnesses (Please List) _____

3. Previous Surgeries **Date**

_____ _____

_____ _____

4. Current Medication *(Please list names and dosing)*

Name **Dosage**

_____ _____

_____ _____

_____ _____

_____ _____

5. Medication Allergies *(List medication and reaction)*

_____

_____

6. Social History *(Do you use any of the following)*

Yes	No	
☐	☐	Alcohol | Drinks/week _____
☐	☐	Cigar/Cigarettes | Packs/day _____
☐	☐	Chewing Tobacco
☐	☐	Drugs
☐	☐	Herbal Medicine | Type _____

7. Pediatric Social History

Who lives in the home? _____

Does your child attend daycare? _____

Does anybody smoke in the home? _____

Are there pets in the home? _____

8. Family Health History

	Sibling	Parent	Grandparent
High Blood Pressure	☐	☐	☐
Stroke	☐	☐	☐
Heart Attack	☐	☐	☐
Migraine	☐	☐	☐
Diabetes	☐	☐	☐
Asthma	☐	☐	☐
Allergy	☐	☐	☐
Bleeding Disorder	☐	☐	☐
Cancer (What type?) _____	☐	☐	☐

9. Review of Systems *(check yes or no)*

Yes	No	
☐	☐	Insomnia (General)
☐	☐	Fatigue
☐	☐	Fever
☐	☐	Weakness
☐	☐	Rash (Skin)
☐	☐	Dermatitis
☐	☐	Ear Pain (Ear)
☐	☐	Hearing Loss
☐	☐	Ringing in the Ear
☐	☐	Problems Hearing in Crowds
☐	☐	Television Turned Up Too Loud
☐	☐	Double Vision (Eye)
☐	☐	Dry Eyes (Eye)
☐	☐	Nasal Infections (Nose)
☐	☐	Nasal Congestion
☐	☐	Sneezing
☐	☐	Sore Throat (Mouth)
☐	☐	Snoring
☐	☐	Hoarseness
☐	☐	Cough
☐	☐	Shortness of Breath
☐	☐	Chest Pain (Cardiac)
☐	☐	Heart Rhythm Abnormalities
☐	☐	Chest Pain with Exertion
☐	☐	Headache or Migraine (Neuro)
☐	☐	Numbness in Extremities
☐	☐	Change in Mood (Psych)
☐	☐	Difficulty Swallowing (GI)
☐	☐	Heartburn / Reflux
☐	☐	Indigestion
☐	☐	Diarrhea / Constipation
☐	☐	Abnormal Bleeding (Heme)
☐	☐	History or Anemia
☐	☐	Weight Gain or Loss (Endo)
☐	☐	Thinning Hair
☐	☐	Frequent Urination (GU)
☐	☐	Difficulty Urinating
☐	☐	Pain on Urination
☐	☐	Swelling in the Neck (Neck)
☐	☐	Neck Pain
☐	☐	Node Enlargement (Lymph)
☐	☐	Joint Pain (MS)
☐	☐	Muscle Fatigue
☐	☐	Unsteadiness when Walking

10. Pharmacy Name and Location

_____

Reviewed by MD _____ Date _____

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Northwest Sinus & Allergy Clinic - Financial Policy

Thank you for choosing us as your health care provider. We ask that all patients read and sign our Financial Policy as well as complete our Patient Information Form prior to having your exam. The following is our Financial Policy.

Our main concern is that you receive the proper and optimal treatments needed to restore your health. Northwest Sinus & Allergy Clinic is committed to providing you with the best possible healthcare. In order to fully assess your medical condition during your thorough examination additional tests or procedures may be required (i.e. hearing test, allergy test or scope). These additional tests or procedures will result in an additional charge.

Insured Patients

If your insurance has a co-payment policy, the co-payment is due at the time of service. If you have a deductible, you are responsible for all charges until the deductible is met. You are responsible for any and all allowable charges which remain after your insurance has paid its portion. Balances are due within thirty (30) days of the billing statement date. The only exception will be if arrangements with the billing office have been made prior to your visit. Any balance unpaid after sixty (60) days will be turned over to a collection agency.

Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract. You should know the details of your particular insurance policy. Not all services are covered by all carriers. Services which are not covered by your insurance will be billed to you. Diagnoses and services are carefully documented to comply with federal law. Under no circumstances will these be changed, altered or falsified in order to obtain coverage by insurance; therefore you are ultimately financially responsible for payment of services rendered.

If your insurance carrier has a "network" of providers, it is your responsibility to make sure that we are an "in network" provider prior to obtaining services. If we are a provider on your plan we will bill your insurance carrier for you. If we are not "in network", we will still be happy to provide services, however, the percentage of charges for which you are responsible will be greater.

An authorization or referral may also be required. It is your responsibility to make sure we have this authorization prior to your appointment. It is also your responsibility to make us aware of any restrictions your policy has on ancillary services (such as requiring a specific lab).

Patient Responsibilities

- Obtain authorization/referral prior to appointment (if required)
- Make copayment at time of service
- Make sure we have accurate insurance carrier information and patient information. If a claim is denied because of flawed insurance or patient information, you will be responsible for the balance
- Be aware of your plan benefits and inform us of any restrictions for services or faculties that your plan might have
- Contact your insurance carrier if your claim has not been processed within 45 days
- Payment of statement in full at time of receipt
- Non-Insured patients make payment in full
- Payment of $35.00 return check fee if your check is not honored by your financial institute
- Insure that the "Person Responsible for Bill" section of the Patient Registration Form is completed with address that billing statements should be mailed to.

Your understanding of our financial policy is an essential element of your care and service. If you have any questions regarding any aspect of our policy, please feel free to contact our billing office at 405-595-3575.

Patient/Guardian Signature _____ Date _____

Ownership Disclosure

The physicians at Northwest Sinus & Allergy Clinic strongly believe that the interests and care of our patients should be handled with great importance. An important component in providing medical care involves the referral of our patients to various diagnostic and surgical facilities. The following list provides the facilities that we typically refer our patients Summit Surgery Center, Summit Medical Center, Integris/Baptist Hospital, Surgical Center of Oklahoma, Diagnostic Laboratory of Oklahoma, Vantage Diagnostics, and others. Northwest Sinus & Allergy Clinic physicians do hold a vested interest in the following facilities; Summit Surgery Center, Healthcare Partners Investments, LLC, Sleep Solutions Laboratory and Surgery Center of Oklahoma.

Our physicians believe that patients have a choice in the selection of healthcare facilities. When a referral is made from our office your insurance preference is always taken into consideration first. Most importantly, we respect your preferences when deciding which healthcare facilities may suit your needs the best.

Patient/Guardian Signature _____ Date _____

This notice is required by Section 6055(B)(g) of Title 36 of the Oklahoma Statutes

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Consent for Medical / Surgical Treatment

I, _____ am the parent of and/or legal guardian for the below mentioned patient and am giving consent for the below mentioned person(s) to obtain medical care for this patient in my absence. I understand that I am fully responsible for all medical expenses incurred with said medical treatments.

Patient's Full Legal Name _____ Date of Birth _____

Designated guardian _____ Relation to patient _____

Designated guardian _____ Relation to patient _____

Designated guardian _____ Relation to patient _____

Designated guardian _____ Relation to patient _____

List any one who would bring the child to an appointment besides yourself

Patient's Address _____ City, State, Zip _____

Legal Guardian _____

Mother Father Guardian

Signature of Parent/Legal Guardian _____ Date _____

Witness _____ Date _____

IN CASE OF EMERGENCY I CAN BE REACHED AT _____ (emergency phone)

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Right to Request Restrictions you have the right to request a restriction or limitation on the disclosure of protected medical Information we use or disclose about you for treatment, care, and payment or health care operations. We must receive your restrictions in writing before we have made such disclosures. Also, if you restrict our right to use your protected medical Information for treatment, care, payment or healthcare operations, we reserve the right to immediately withdraw our services from you and terminate the physician-patient relationship. You have the right to request a limit on the Protected Medical Information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For Example, you could ask that we not use or disclose protected medical Information about a surgery to your family. We are not required to agree to your request. If we do not agree, we will comply with your request unless the Protected Medical Information is needed to provide you emergency treatment. To Request restrictions, you must make your request in writing to the receptionist in our office. In your request, you must tell us what information you want to limit, whether you want to limit our use and /or disclosure and to whom you want the limits to apply.

Right to request Confidential Communications You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work, or at home, or by mail, or by phone or by e-mail. To request confidential communications, you must make your request in writing to the receptionist in our office. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a copy of this notice You have the right to a copy of this Notice. You may ask us to give you a copy of this notice at any time.

CHANGES TO THIS NOTICE

We reserve the right to change the content of this notice. We reserve the right to make the revised or changed notice effective for protected medical Information we already have about you as well as any protected medical Information we receive in the future. We will post a copy of the current Notice in our office. The Notice will contain on the first page, in the top right hand corner, the effective date.

COMPLAINT

If you believe your privacy right have been violated, you may File a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, please contact the Privacy Officer at 405-755-1930. All Complaints must be submitted in writing. You not be penalized for filing a complaint.

OTHER USES OF PROTECTED MEDICAL INFORMATION

Other uses and disclosures of Protected Medical Information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose protected medical Information about you, you may revoke that permission, in writing at any time. If you revoke your permission, we will no longer use of disclose Protected Medical Information about your for the reasons covered by your written authorizations. You understand and acknowledge that we are unable to take or retrieve any disclosures we have already made with your permission and that we are required to retain our records of the care that we provided to you.

A PROFESSIONAL CORPORATION

Northwest Sinus & Allergy Clinic Medical record # _____

I hereby acknowledge a receipt of a copy of the Northwest Sinus & Allergy Clinics Notice of Privacy Practices containing a full description of my rights under the Health Insurance Portability and Accountability Act ("HIPAA").

Printed name and address _____

_____

Signature _____

Date _____

Northwest Sinus & Allergy Clinic may periodically send promotional offers to you at your home address. If you wish to decline the receipt of this information, you must check this box and we will remove you from the mailing list.

For use by Northwest Sinus & Allergy Clinic Personnel Only

I, the undersigned employee of Northwest Sinus & Allergy Clinic provided the above-named individual with a copy of the Northwest Sinus & Allergy Clinic Notice of Privacy Practices and requested that the individual sign and date this Acknowledgment in the manner requested above. I was unable to obtain a completed Acknowledgment because

- ☐ The individual refused to sign this acknowledgment
- ☐ The individual was unable to understand the request to sign this acknowledgment or was unable to sign this acknowledgment
- ☐ An emergency condition prevented me from obtaining a signed acknowledgment prior to required treatment
- ☐ The individual exercised his/her option to restrict or prohibit some or all of the uses or disclosures provided by HIPAA.
- ☐ Other (specify)

Signature of Northwest Sinus & Allergy Clinic Employee

_____ Date _____

PATIENT PRIVACY NOTICE

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 have any questions about this notice, please contact our receptionist immediately

WHO WILL FOLLOW THIS NOTICE

This notice describes our office's practices and that of

- All employees, staff and personnel
- Any health care professional authorized to enter information into your file or record.
- All entities, sites and locations covered within or operated by Northwest Sinus & Allergy Clinic (Collectively, "health care providers" or "health care locations"). All Northwest Sinus & Allergy Clinic health care providers follow the terms of the notice. In Addition, these health care providers and health care locations may share medical information with each other for all treatment, payment or healthcare operations' purposes described in this notice

Effective April 14, 2003

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is person. We are committed to protecting medical information about you. We create a record of the treatment, car and services you receive in our practice. We need this record to provide you with quality care and to comply with certain legal requirements. We refer to this record of care and services as "protected medical Information". This Notice will tell you about the ways in which we may use and disclose protected medical Information about you. We are required to "

- Make sure that Protected medical Information that identifies you is kept private and is only disclosed in a manner permitted by the health Insurance Portability and Accountability Act ("HIPAA").
- Follow the terms of the Notice that is currently in effect
- Give you this Notice of our legal duties and privacy practices with respect to Protected Medical Information about you.

HOW WE MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION

The following categories describe different ways that we use and disclose protected medical Information. For each category of uses or disclosures we will explain what we mean. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose protected medical Information will fall within one of the categories.

For treatment we may use protected medical Information about you to provide you with medical treatment, care or services. We may disclose protected medical information about you to doctors, nurses, technicians, medical students, pharmacists or other personnel who are involved in your care. Different departments or areas of our practice also may share protected medical Information about you in order to coordinate the different things you may need.

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Skin Testing

If you are scheduled for skin testing please wear a tank top, camisole or a button down shirt. The test is performed on your upper arms. The list of medications below may interfere with allergy skin testing.

Medications to **STOP** taking **4 DAYS** prior to testing:

- Alavert
- Allergra/Allergra D
- AllerX
- Antivert
- Astelin
- Axid
- Benadryl
- Bonine
- Bromfed
- Chlorpheniramine
- Chlor-Trimenton
- Clarinex
- Claritin/D/Reditab
- Clemastine
- Comtrex
- Contac
- Coridiidin
- Deconamine
- Dimetane
- Dimetapp
- Dramamine
- Drixoral
- Extendryl
- Formula 44
- Hyroxyzine/Atarax
- Multisymp. Nyquil
- Pepcid
- Phenergan
- Periactin
- Rhinosyn
- Rynatan
- Sudafed Plus
- Tagament
- Tavist/Tavist D
- Triaminic
- Vicks
- Vistraril
- Xyzal
- Zantac
- Zyrtec

Medications to **STOP** taking **24 HOURS** prior to testing:

- Alprazolam/Xanax
- Amtriptyline/Elavil/ Vanatrip
- Amoxaine/Ascedin
- Buspar
- Chlomipramine/ Anafranil
- Clonazepam/ Klonopin
- Celexa
- Cymbalta
- Desipiramine/ Norprami
- Doxepin/Sinequan/ Zonalon
- Effexor/Effexor XR
- Elavil
- Imipramine/Tofranil
- Lexapro
- Lorazepam/Ativan
- Librax
- Mapotiline/Ludiomil
- Mirtazapine/ Remeron
- Nefazodone/Serzone
- Nortiptyline/Aventyl/ Pamelor
- Paxil
- Pepcid/Nizatidine/ Axid
- Protiptyline/Triptil/ Vivactil
- Prozac
- Ranitidine/Zantac
- Restoril
- Serzone
- Tagamet/Cimetidine
- Trazodone/Desyrel
- Trimipramine/ Surmontil
- Welbutrin/ Buproprion
- Zoloft

NOTE: If you are concerned about your health and any related conditions that would be complicated by stopping any of the above medicines, please contact our office at **405-595-3575**.