Northwest Sinus & Allergy Clinic

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

Patient Registration Form

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#
Relationship to Patient (circle one) PARENT STEP PARENT GRANDPARENT FOSTER PARENT OTHER: _____		

Primary Insurance

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

Insurance Subscriber Information

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

Secondary Insurance

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

Insurance Subscriber Information

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

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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Consent Signature

Patient Name		Date of Birth
Patient SS#		
Patient Address	City, State, Zip	Phone

Authorization to Consent: (Adult Patient)

I, _____ am giving consent for the below mentioned person/persons to obtain medical care for myself in my absence. I understand I am fully responsible for all medical expenses incurred with said medical treatments.

Authorization to Consent: (Pediatric Patient)

I, _____ am the parent of and/or legal guardian for the above mentioned patient and am giving consent for the below mentioned person/persons 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.

Access to All Medical Records	Financial Records Only	Designated Representative	Relationship to Patient

- All Medical Records would include making appointments, picking up prescriptions, release of records, etc.
- By signing, I acknowledge that I have read and received a copy of the Northwest Sinus & Allergy Clinic's Privacy Practice/Patient Rights and Responsibilities, as required by HIPAA.
- By signing, I acknowledge that I have read and received a copy of the Northwest Sinus & Allergy Clinic's Financial Policy.
- By signing, I acknowledge that I have read and received a copy of the Northwest Sinus & Allergy Clinic's Ownership Disclosure Policy.
- I understand that if I want to make any changes to the information listed above, I must contact Northwest Sinus & Allergy Clinic to revoke this form in its entirety or complete a new form.

Signature _____ Date _____

Signature of Parent / Legal Guardian _____ Date _____

Witnessed _____ Date _____

In Case of Emergency, I can be reached at: _____ (Emergency phone)

I, _____ do not wish to allow anyone other than myself to have access to my medical records and/or financial records for any reason.

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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 test or procedures may be required (i.e. hearing test, allergy test or scope). These additional tests or procedures will result in additional charges.

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 for 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 authorizations/referrals prior to your 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
- Contract 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 for return check fees 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 the 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.
- It is your responsibility to monitor discrepancies between payment for professional services and your EOB.
- Our office will review any payment discrepancies for services provided upon request.

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

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:

Alliance Health Deaconess, Alliance Health Ponca City, Community Hospital, Comprehensive Diagnostic Imaging, LLC, Diagnostic Radiology, DLO, Edmond Open MRI, Five Oaks Medical Group, Foundation Oklahoma Diagnostic Imaging, Gilbert Medical Clinic, Integris Hospitals, Lake Point Imaging, Mercy Hospitals, Norman Regional Hospital/Healthplex, Northwest Surgical Hospital, Oklahoma Heart Hospital, OU Edmond Medical Center, Oklahoma Surgicare, One Core Health, One Core Tower Day Surgery, Parkview Hospital, Physicians Surgery Center, Saint Anthony's Hospital, St. Anthony's Midtown Surgery Center, Sleep Solution Laboratory, Surgery Center of Oklahoma, Vantage Diagnostics and Weatherford Regional Hospital

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 best.

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

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Notice Of Privacy Practices *Effective Date: 09-23-2013*

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 practice administrator at 405-595-3575
10960 North May Ave. Oklahoma City, OK 73120

Who Will Follow This Notice

This notice describes the information privacy practices followed by our employees, staff and other personnel.

Your Health Information

This notice applies to the information and records we have about you, your health, health status and the healthcare services you receive from Northwest Sinus & Allergy Clinic. Your health information may include information created and received by Northwest Sinus & Allergy Clinic, may be in the form of written or electronic records or spoken words, and may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, related billing activity and similar types of health-related information. We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

How We May Use And Disclose Health Information

We may use and disclose health information for the following purposes:

Treatment. We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party that may need to access your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment. We may use and disclose your health information about you so that the treatment and services you receive at Northwest Sinus & Allergy Clinic may be billed to and payment may be collected from you, an insurance company or third party. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will pay for the treatment.

Healthcare Operations. We may use and disclose your health information about you in order to run Northwest Sinus & Allergy Clinic and make sure that you and our other patients receive quality care. For example, we may use your information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, newsletter about our practice, information on products that we believe may be beneficial to you or whether certain treatments are effective.

Fund Raising. We may contact you to ask for your help with different fund raising campaigns. Please notify us if you do not wish to be contracted during fund raising campaigns. Please advise us in writing (at the physical address listed at the top of this Notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

Special Situations

We may use or disclose your health information for the following purposes, subject to all applicable legal requirements and limitations:

TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY, when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

REQUIRED BY LAW, when required to do so by federal, state or local law. RESEARCH, for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

ORGAN AND TISSUE DONATION, if you are an organ donor, we may release your health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplant.

MILITARY, VETERANS, NATIONAL SECURITY AND INTELLIGENCE, if you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about foreign military personnel to the appropriate foreign military authority.

WORKERS' COMPENSATION, for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness. PUBLIC HEALTH RISKS, for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

HEALTH OVERSIGHT ACTIVITIES, for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

LAWSUITS AND DISPUTES, if you are involved in a lawsuit or dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

LAW ENFORCEMENT, if asked to do so by law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

CORONERS, MEDICAL EXAMINERS, AND FUNERAL DIRECTORS, this may be necessary, for example, to identify a deceased person or determine the cause of death.

INFORMATION NOT PERSONALLY IDENTIFIABLE, we may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

FAMILY AND FRIENDS, we may disclose health information about you to your family members or friends if we obtain CONSENT to do so. WE may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room or the hospital during treatment or while treatment is discussed.

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or reports such as CT Scans, MRIs, and X-Rays.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written AUTHORIZATION. Examples of disclosures requiring your authorization include disclosures to your partner, your spouse, your children and your legal counsel. Also, the following will not be disclosed without written Authorization:

- **Marketing purposes.** Does not include products or services of benefit to you about prescriptions you have already been prescribed.
- **Selling your health information.** We may receive payment for sharing your information for public health purposes, research, and releases to you or others you authorize a release to as long as payment is reasonable and related to the cost of providing your health information.
- **Any disclosure of your psychotherapy notes.** These are the notes that your behavioral health provider maintains that record your appointments with your provider and are not stored within your medical records.

If you give us AUTHORIZATION to use or disclose health information about you, you may revoke that AUTHORIZATION IN WRITING, AT ANYTIME. If you revoke your Authorization, we will no longer use or disclosure information about you for the reasons covered by your written Authorization, however we cannot take back any uses or disclosures already made with your permission.

In some instances, we may need specific, written authorization form you in order to disclose certain types of specially-protected information such as psychotherapy notes, HIV, substance abuse, mental health, and genetic testing information for purposes such as treatment, payment and healthcare operations.

Uses And Disclosures That Require Us To Give You An Opportunity To Object

Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that persons' involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU You have the following rights regarding health information we maintain about you: Right to Inspect and Copy: you have the right to inspect and copy your health information that may be used to make decisions about your care. This includes medical and billing records but does not include psychotherapy notes. To inspect and/or coy your health information you must submit your request to release information in our office. If you request a copy of the information, we may charge a fee for the cost of copying, mailing or other supplies associated with your request. By Oklahoma Statute, we may charge you $0.50 per page for copies, plus our postage cost. If your record contains any item that requires a photographic process to copy, such as an x-ray or photograph, we may charge you $5.00 per image.

Right to Amend: if you feel that the health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the health information is kept by Northwest Sinus & Allergy Clinic. To request an amendment, your request must be made in writing and submitted to our Practice Administrator (listed at the top of this Notice). In addition, you must provide a reason that supports your amendment request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Is not part of the health information that we keep
- You would not be permitted to inspect and copy
- In our judgment is accurate and complete as it appears
- Was not created by us, unless the person or entity that created the health information is no longer available to make the amendment

Right to an Accounting of Disclosures: You have the right to request an

"accounting of disclosures." This is a list of the disclosures we have made of your health information. You must submit the request of this list of disclosures, in writing to our office. Your request must state a period of time, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want to list. The first list you request within each 12 month period will be free. For additional lists, we may charge you for the cost of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time, before any costs are incurred.

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 Paper Copy of this Notice: you have the right to a paper copy of this notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. You may also find a copy of this Notice on our website, sigmonmd.com

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 your health information we already have about you as well as any health 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 at the top the Effective Date.

Breach Of Health Information

We will inform you if there is a breach of your unsecured health information.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services.

Office for Civil Rights Region-Southwest Region

U.S. Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, TX 75202

To file a complaint with Northwest Sinus & Allergy Clinic.
You will not be penalized for filing a complaint.

Practice Administrator
10960 North May Ave.
Oklahoma City, OK 73120