EAR NOSE THROAT HEAD & NECK SURGERY

MEHMET C. AGABIGUM M.D. P.C.

Patient's Name: _____
Last First Middle

Date of Birth: _____ **Age:** _____ **Today's Date:** _____

Social Security: _____ **E-mail:** _____

☐ Prefer not to disclose Soc. S. **Gender:** ☐ Male ☐ Female ☐ Transgender

Profession:
_____
_____
☐ RETIRED
☐Disabled
☐Student
☐N/A

Marital Status:
☐ Single
☐Married
☐Widowed
☐Divorced
☐Separated

Ethnicity:
☐ Hispanic/Latin
☐ Non-Hispanic/Latino
☐ Prefer not to disclose

Native Language:
☐ English
☐ Other_____

Race:
☐ American Indian / Alaska Native
☐ Asian
☐ Black/African-American
☐ Native Hawaiian/ Other Pacific Islander
☐ White/Caucasian
☐Other:_____
☐ Prefer not to disclose

Address: _____
Street City Zip Code

Home Phone: Cell: Other: _____

Primary Physician: Who referred you to this office? _____

Emergency Contact: Relationship: _____

Home Phone: Cell: Other: _____

For Patients Under Age 18:

Mother's Name Phone: _____

Father's Name Phone: _____

Primary Insurance:

_____
Insurance Name Subscriber Name/Relation to Patient

_____
Employer Subscriber Social Security Subscriber Date of Birth

Secondary Insurance:

_____
Insurance Name Subscriber Name/Relation to Patient

_____
Employer Subscriber Social Security Subscriber Date of Birth

Patient or Authorized Persons Signature

I hereby authorize Mehmet C. Agabigum M.D., P.C. to release/receive any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit. I hereby authorize direct payment of surgical/medical benefits to Mehmet C. Agabigum M.D., P.C. for services rendered by him in person or under his supervision. **I understand that I am financially responsible for any co-payment, deductible, and/or any balance not covered by my insurance**

_____
Signature/Relationship to Patient Date

MEDICATIONS

PLEASE LIST ALL PRESCRIPTIONS AND NON-PRESCRIPTION MEDICATIONS/SUPPLEMENTS, DOSAGE, AND FREQUENCY.

MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY

Drug Allergies: ☐None ☐Codeine ☐ Sulfa ☐Latex ☐CT Dye ☐Penicillin Other: _____

Pharmacy of Choice: _____ **Location:** _____

SURGERIES/HOSPITALIZATIONS

SURGERY/HOSPITALIZATION	DATE

Do you currently smoke or chew tobacco? ☐ Yes **Packs:** *Day/Week* _____ ☐ No **Former smoker***?* ☐ Yes ☐ No

Year started smoking _____ **Year stopped smoking** _____ **Secondhand smoke exposure:** ☐ Yes ☐ No

Are you on a *Smoking Cessation Plan*? ☐Yes ☐No **Do you plan to quit smoking?** *?* ☐Yes ☐No

Do You Snore? ☐Yes ☐No **Do you experience difficulty in sleeping?** ☐Yes ☐No

Average hours of sleep:_____ **How often do you wake up?**_____

Do you exercise? ☐Yes ☐ No **How Do you Exercise?**_____ ☐ Daily/Weekly

How often do you consume caffeine? (coffee, tea, energy drinks, etc.) ☐Frequently ☐ Rarely ☐ Never

Do you consume alcohol? ☐ No ☐ Yes, **Drinks:** *Day*___ *Week* ___ ☐ Occasionally, **Have you in the past?** ☐Yes ☐No

Use of Illicit Drugs: ☐ Yes ☐ No **Have you in the past?** ☐ Yes ☐ No **When was the last time?**_____

When was the last time you were prescribed with Opioids? _____**For How many Days**?_____

When did you last took them?_____

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FAMILY MEDICAL HISTORY:

Indicate which relative has had the following conditions (parents and siblings are most important).

☐ **NO SIGNIFICANT HISTORY KNOWN** ☐ **ADOPTED**

CONDITION	MOTHER	FATHER	SISTER(S)	BROTHER(S)	MOTHER'S MOM	MOTHER'S DAD	FATHER'S MOM	FATHER'S DAD	COMMENTS
Heart Disease									
Heart Attack									
Hearing Loss									
Hypertension									
Thyroid Conditions									
Sickle Cell Trait									
Blood Disorder									
Von Willebrand Disease									
Diabetes									
Neurological Disorders									
Cancer									
Stroke									
Asthma									
Lung Conditions									
Kidney Conditions									
Depression									

PERSONAL MEDICAL HISTORY

Do you have now (current) or have you had (past) any of the following conditions? ☐ **NONE**

CONDITION	CURRENT	PAST	COMMENTS
Heart Disease			
Heart Murmur			
Shortness of Breath			
Blurry Vision			
Diabetes			
High Cholesterol			
Asthma			
Seizures/Epilepsy			
Hearing Loss			
High Blood Pressure			
Low Blood Pressure			
Lung Conditions			
Stroke			
Liver Conditions			
Sinus Conditions			
Seasonal Allergies			
Headache/ Migraines			
Arthritis			
Heartburn (Reflux)			
Blood Disorder			
Anemia			
Sickle Cell Trait			
Neurological Disorders			
Cancer			
Dizziness			
Depression			
Anxiety			
Ulcers			
Colitis			
Swollen Ankles			
Ear Conditions			
Thyroid Conditions			
Pacemaker			
Balance Disorder			
Kidney Conditions			
Bladder Conditions			

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PATIENT FINANCIAL POLICY

It is the goal of Dr. Agabigum's office to provide the best care on your behalf. It is also our desire to assist you in the financial arrangements related to your care. Therefore, it is important for you to fully understand our patient, insurance, credit, and collections policies. ***We ask that you initial next to each number and sign this statement once you have carefully read the following information.*** Thank you for your cooperation!

_____**1. Payment Responsibility:** The patient or legal guardian is responsible for all charges that are incurred. Payment is due prior to being seen.

_____**2. Surgery:** All patients that are scheduled for surgery must pay all co-payments, deductibles in full prior to surgery by at least 48 hours. After agreeing upon a chosen date, there will be a $30 fee assessed to your account should you cancel or reschedule your surgery, without a good reason.

_____**3. Insurance Contract:** Your insurance contract is an agreement between you and your insurance carrier. As a courtesy to you, our office will file your insurance claims for you. Your doctor's bill is an agreement between you and this office. You are ultimately responsible for payment of your bill regardless of the status of your insurance claim.

_____**4. Insurance Verification:** Your insurance is verified prior to your appointment. If the policy is inactive, the patient is responsible for all charges incurred. All information is subject to verification.

_____**5. Partial Insurance Coverage:** If your insurance only covers a portion of a service, you are responsible for the difference.

_____**6. Assignment of Benefits:** Our office will bill your insurance if you supply all necessary information such as proof of identification and insurance cards. It is the patient's responsibility to know what their insurance benefits cover. If you have an "HMO" insurance it is YOUR responsibility to get all referrals.

_____**7. Discounts:** By Federal Law and Managed Care Contract agreements, we are required to collect all co-payments and deductibles for each service. Therefore accounts cannot be reduced or discounted.

_____**8. Refunds:** Overpayments will be refunded once all active and past due accounts are paid in full. Refunds of less than $5.00 will not be processed unless specifically requested, and will be kept as a credit in your account.

_____**9. Processing Fees:** Accounts that are more than 30 days overdue are subject to a $5 monthly processing fee.

_____**10. Delinquent Accounts:** Patients with unpaid delinquent accounts, accounts that have been written off, and/or have been sent to a collection agency, may be denied treatment if not medically required

_____**11. Referral for Outside Collection:** If we do not receive payment in full by 90 days from the date of service, we reserve the right to refer your account to an outside collections agency where you will be responsible for all collection and attorney fees. Also a 30% rate will be applied to the delinquent amount, if your account is referred to a collection agency.

_____**12. Missed Appointments:** If you miss an appointment and fail to give 24 hours notice, your account will be charged $30 for each appointment.

_____**13. Returned Check:** A fee of $25 will be assessed to your account each time a check is returned.

_____**14. Payment Methods:** We accept cash, check, and money orders, and Care Credit. <u>We also accept credit cards but only for payments that are $10.^{00} and over.</u>

I have read and I understand the above financial policy.

Signature of Patient or Representative

Date

MEHMET C AGABIGUM, M.D., P.C. ACKNOWLEDGEMENT FORM

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I hereby acknowledge the receipt of Notice of Privacy Practices from Dr. Mehmet C. Agabigum, M.D., P.C. on

_____(Date)

_____
Signature of Patient

Or _____
Signature of (Guardian or Legal Representative)

_____
Relationship of Patient Representative to Patient

_____
Witness (office use only)

You may ask at anytime to receive a copy of the HIPAA Notice of Privacy Practices.

The individual or the individual's legal representative did not provide a written acknowledgment of receipt of this Notice of Privacy Practices. The following explains the good faith efforts to obtain the written acknowledgment and the reasons why the acknowledgment was not obtained:

_____

_____

_____

MEHMET C. AGABIGUM, M.D.,P.C. Authorization Form – Use or Disclosure of PHI

I hereby authorize the use and disclosure of my individually identifiable health information as described below. I understand that signing this authorization is voluntary and that if I refuse to sign this form it will not prevent receipt of health care or eligibility for benefits under a health plan. I understand that I am entitled to receive a copy of this for upon signing it. I understand that if the organization or individual authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. I understand that I have a right to revoke this authorization, but that I must send a written revocation to the address below, I also understand that the revocation applies to uses and disclosures made after the revocation is made.

Patient Name	ID Number

Person or organization authorized to release my health information:

Name	Phone Number

City	State	Zip

Person or organization authorized to release my health information:

Name	Phone Number

City	State	Zip

Specific description of information that is to be disclosed (include dates):

Purpose of the disclosure:

This disclosure will expire on (date or event): / /

Signature	Date

Patient Name (print):

If signed by a patient representative:

Representative Name (print)	Relationship to Patient and Authority Status