Cumberland Valley ENT

Comprehensive, compassionate care since 1978

Ear • Nose • Throat • Allergy

WELCOME TO OUR PRACTICE

Date: _____

Dear _____:

We welcome you to our practice and appreciate the opportunity to be of service to you. Our staff is a group of well-qualified professionals who work as a team to provide you with the highest level of treatment in a professional and caring environment.
Your appointment is scheduled with Doctor _____on _____.
We ask you to arrive at _____ to allow us time to update your information and copy your insurance card(s). One of our nursing staff will be taking a medical history at this time. ***Please bring a complete list of the medications you currently take, your allergies to medications, and your surgical history with year of surgery.***

Referrals: If your insurance is an HMO, a referral from your primary care physician (PCP) **is required** for you to be treated by our physicians. You are responsible for providing us with the referral before you are seen by our doctors. If you fail to provide us with a referral, you will be responsible for your charges.

Minors: All children under the age of 18 **must be accompanied by a parent or legal guardian**. If the parent or legal guardian is unable to accompany the minor child, we must have a note stating who will be accompanying the minor and permission from the parent/legal guardian authorizing this practice to treat the minor child.
Cancellations: We require at least a 24-hour notice should you need to change or cancel your appointment.

Telephone Calls: Should you have a problem, please do not hesitate to call. Our office staff has been trained to handle all situations. A message will be taken and then given to one of our physicians, who will review the chart and respond appropriately. Please remember to leave a phone number where you can be reached.
Should you need to contact us after hours, call 301-714-4375 and our answering service will forward your message to the physician on call. Please note that we share on-call coverage with Dr. Kirby Scott which means he may be returning your call.

In the event of an extreme emergency, go directly to the Emergency Room.

Green Entrance, Robinwood Professional Center
11110 Medical Campus Road, #126 Hagerstown, MD 21742 301-714-4375 (p) 301-714-4399 (f)

Medicare: We do participate with Medicare. We will file your claim for you and accept what Medicare **allows**. If you have a secondary carrier, we will submit any unpaid balance to it. All payments from Medicare and secondary carriers should be sent to our office. Please keep in mind that you may be responsible for any charges not covered by Medicare or the secondary insurance such as deductibles, co-payments, and co-insurances.

Commercial Insurance: We do participate with a number of insurance carriers. Please ask our staff if we participate with your particular insurance. If so, we will be glad to submit the charges for your visit and accept the insurance allowed amount for covered services. **Please keep in mind that you will be responsible for co-payments, deductibles and co-insurances.**

If you do not have insurance or have insurance with which we do not participate, we will expect your payment for services rendered at the time of your visit. You will receive two copies of the fee ticket to use when submitting your claim to your insurance company for reimbursement. If you are unable to pay at the time of service, you may make payment arrangements with our Billing Department prior to treatment. Please note that the charge for your visit depends on the level of service rendered to you. Prices may be higher if hearing tests or diagnostic/surgical procedures are required. Feel free to discuss charges with our physicians or staff prior to having these services. You may pay by cash, check, Visa, Mastercard or Discover.

Surgeries: If we participate with your insurance company, we will submit your surgery charges directly to your insurance company. Balances remaining after your insurance has paid are the responsibility of the patient.
Please be aware that we bill only for our physicians. You will receive bills from the anesthesiologist and the facility, which may include pathology fees.

Otolaryngologist-Head and Neck Surgeon- is a Specialist in diagnosing and treating diseases and disorders of the ear, nose and throat. The practice of Otolaryngology specializes in:

- Sinus infections
- Allergies
- Ear infections/ear surgery
- Snoring disorders
- Sleep Apnea
- Nasal problems
- Head and neck surgery for cancer of the mouth, throat and voice box
- Tonsils and adenoids
- Loss of hearing
- Thyroid disorders
- Plastic surgery for facial reconstruction

Additional Information:
Our office is designated as non-smoking and **we ask you not to bring food or drink into the office.**

In Conclusion: We thank you for choosing our practice and we hope that this letter will give you a better understanding of the services we provide to our community.

Sincerely,

Drs. Saylor, Wathne, Manilla and Stonebraker

Green Entrance, Robinwood Professional Center
11110 Medical Campus Road, #126 Hagerstown, MD 21742 301-714-4375 (p) 301-714-4399 (f)

CUMBERLAND VALLEY ENT CONSULTANTS/ALLERGY DEPARTMENT
Phone 301-714-4388 Fax 301-714-4387

Dr. Michael J. Saylor
Dr. Jarl T. Wathne
Dr. A. Christopher Manilla
Dr. Angela Stonebraker

ALLERGY QUESTIONNAIRE

Date:_____ Patient's Name:_____

Do you have any of the following:

Nasal Congestion?	Y	N
Frequent sneezing?	Y	N
Watery Nasal Discharge?	Y	N
Discolored Nasal Drainage?	Y	N
Nasal Burning?	Y	N
Sinus/Facial Pain?	Y	N
Itchy Nose?	Y	N
Itchy Throat?	Y	N
Itchy, Burning Eyes?	Y	N
Watery Eyes?	Y	N
Red Eyes?	Y	N
Post Nasal Drip?	Y	N
Chronic Headaches?	Y	N
Asthma?	Y	N
Chronic cough?	Y	N
Shortness of breath?	Y	N
Wheezing?	Y	N
Cough with exercise?	Y	N

When did symptoms begin?_____
Do you have a family history of allergy?_____
Do you have any history of sinus problems?_____
Circle which seasons are most difficult for you. **Summer** **Fall** **Winter** **Spring**
Do you have eczema or get other rashes?_____
Do you get hives?_____
Are you allergic to specific foods? Which?_____
_____
Do you have any drug allergies?_____
Do you have excessive fatigue?_____
Excessive gas and indigestion?_____

Patient Name:_____ Account # _____

ENVIRONMENT:

Circle your type of home. **Apartment** **Trailer** **Single Family** **Duplex**
How old is your home?_____
Are you worse in a particular room?_____

Do you have a wood stove or burn wood in a fireplace?	Y	N
Do you have a basement?	Y	N
Is your basement damp or dry?	Y	N
Do you have standing water or leaks in or around your home?	Y	N
Do you have carpet in your bedroom?	Y	N
Do you have curtains in your bedroom?	Y	N
Do you have a feather pillow?	Y	N
Have allergy precautions been taken in the bedroom?	Y	N
Do you get stuffy shortly after you go to bed?	Y	N
Does house cleaning make your symptoms worse?	Y	N
Do you have a library with many old books?	Y	N
Do you have a lot of antique furniture?	Y	N
Do you have a lot of difficult to dust knick-knacks?	Y	N
Are your symptoms better when you go on vacation?	Y	N
Do your symptoms flare-up in: basement?	Y	N
around barns/farms?	Y	N
in the woods?	Y	N
around lakes/marsh?	Y	N
Are your symptoms worse when you go outside in the AM?	Y	N
in the P.M?	Y	N
Do your symptoms get worse when you do yard work?	Y	N
do gardening?	Y	N
Do you have many house plants?	Y	N

Please list indoor pets:_____
Please list outdoor pets:_____
Are there certain areas of the country where your symptoms are worse, or better?_____
What type of work do you do?_____
How many years have you been doing this type of work?_____
What type of hobbies do you enjoy?_____

PLEASE ANSWER THE FOLLOWING QUESTIONS IF PATIENT IS A CHILD:

Was the patient premature of full term?(circle one)

Was the patient a colicky baby?	Y	N
Breast fed?	Y	N
Bottle fed?	Y	N
Is the child in daycare?	Y	N
Does the child have ADD or ADHD?	Y	N

At what age did the patient start solid foods?_____
Does anyone smoke around the child?_____

The following questionnaire is intended to help define your symptoms and provide valuable information and insights for your doctor. Answer the questions, rating to the best of your ability the problems you have experienced over the past two weeks.

Patient Name: _____

Patient Phone: _____

Date: _____

Sino-Nasal Outcome Test (SNOT-20)

1. Consider how severe the problem is when you experience it and how frequently it happens, please rate each item below on how "bad" it is by circling the number that corresponds with how you feel. 2. Please mark the most important items affecting your health (maximum of 5 items).	No problem	Very mild problem	Mild or slight problem	Moderate problem	Severe problem	Problem as bad as it can be		5 most important items
1. Need to blow nose	0	1	2	3	4	5		○
2. Sneezing	0	1	2	3	4	5		○
3. Runny nose	0	1	2	3	4	5		○
4. Cough	0	1	2	3	4	5		○
5. Post-nasal discharge	0	1	2	3	4	5		○
6. Thick nasal discharge	0	1	2	3	4	5		○
7. Ear fullness	0	1	2	3	4	5		○
8. Dizziness	0	1	2	3	4	5		○
9. Ear pain	0	1	2	3	4	5		○
10. Facial pain / pressure	0	1	2	3	4	5		○
11. Difficulty falling asleep	0	1	2	3	4	5		○
12. Wake up at night	0	1	2	3	4	5		○
13. Lack of sleep	0	1	2	3	4	5		○
14. Wake up tired	0	1	2	3	4	5		○
15. Fatigue	0	1	2	3	4	5		○
16. Reduced productivity	0	1	2	3	4	5		○
17. Reduced concentration	0	1	2	3	4	5		○
18. Frustrated / restless / irritable	0	1	2	3	4	5		○
19. Sad	0	1	2	3	4	5		○
20. Embarrassed	0	1	2	3	4	5		○

SINUS RELIEF IS HERE.

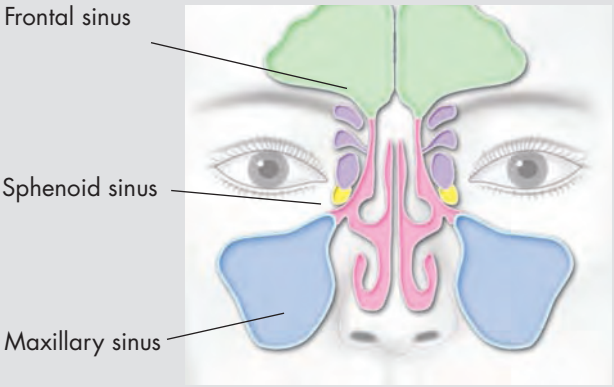
Balloon Sinuplasty™ is a breakthrough procedure that relieves the pain and pressure associated with chronic sinusitis.

WHAT IS SINUSITIS?

Sinusitis is an inflammation of the sinus lining often caused by infections and/or blockage of the sinus openings, altering normal mucus drainage.

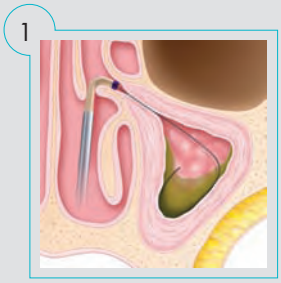
SYMPTOMS[1]:

- Facial pain, pressure
- Nasal congestion or fullness
- Difficulty breathing through the nose
- Discharge of yellow or green mucus from the nose
- Teeth pain
- Loss of the sense of smell or taste
- Headache
- Fatigue
- Sore throat
- Bad breath

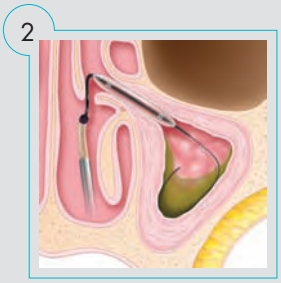


Sinus Area Close-up

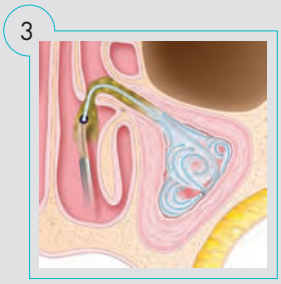
HOW DOES *BALLOON SINUPLASTY* WORK?



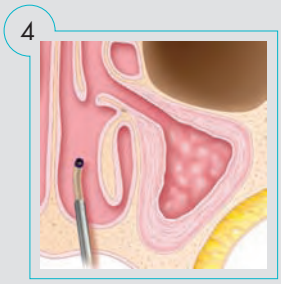
Step 1: A balloon catheter is inserted into the inflamed sinus.



Step 2: The balloon is inflated to expand the sinus opening.



Step 3: Saline is sprayed into the infected sinus to flush out pus and mucus.



Step 4: The system is removed, leaving the sinuses open.

SAFE - More than 160,000 patients have been treated safely with *Balloon Sinuplasty*.

FAST RECOVERY - While recovery time varies with each patient, many people quickly return to normal activities.[2]

PROVEN - Over 95% of patients who have the procedure say they would have it again.[3]

IN-OFFICE - Available to some patients as a procedure conducted in a doctor's office under local anesthesia.

For more information on sinusitis or *Balloon Sinuplasty*, please visit www.balloonsinuplasty.com.

1. http://www.entnet.org/healthInformation/Sinusitis.cfm

2. Wynn R, Vaughan, W. "Post-Operative Pain after FESS with Balloon Sinuplasty." AAO, 2006.

3. ORIOS I, office-based dilation, Data on File at Acclarent

Balloon Sinuplasty Technology is intended for use by or under the direction of a physician. It has associated risks, including tissue and mucosal trauma, infection, or possible optic injury. Consult your physician for a full discussion of risks and benefits to determine if this procedure is right for you.

MKT00699 Rev. E

Balloon Sinuplasty™
technology by Acclarent™

CUMBERLAND VALLEY EAR, NOSE, & THROAT CONSULTANTS

Michael J. Saylor, MD
A. Christopher Manilla, DO
Jarl T. Wathne, MD
Angela C. Stonebraker, MD

PATIENT SELF HISTORY SHEET

Date: _____

First Name: _____ MI: _____ Last Name: _____

SEX: MALE / FEMALE

Who told you to see us today? ☐ Family Doctor: (Dr Name):_____ ☐ ER/ Urgent Care (Dr. Name): _____ ☐ Self ☐ Other _____

Chief Complaint (**briefly** describe): _____

Location (Where is the problem?): _____

Date symptoms(s) began: _____

Frequency of Symptoms: ☐ _____x per day ☐ _____x per week ☐_____x per month ☐_____x per year

☐ Constant ☐Intermittent ☐ Occasional ☐ Rare ☐ Recurrent ☐ Other

Intensity of Symptoms: ☐ Mild ☐ Moderate ☐ Severe

How did symptoms start? ☐ Gradual ☐ Suddenly

How long do symptoms last? _____

What brings it on? _____

What makes it worse? _____

What relieves it? _____

Associated Symptom(s): _____

_____

If symptoms include pain, check the one(s) that best describe the kind of pain:

☐ Aching ☐ Continuous ☐ Gnawing ☐ Intermittent ☐ Periodic ☐ Shifting ☐ Sudden ☐ Mild

☐ Burning ☐ Cramping ☐ Moderate ☐Sharp ☐Stabbing ☐ Superficial ☐ Other : _____

Any prior treatment by another physician for this problems? ☐ No ☐ Yes, if so please explain:

_____

Any prior test(s) ordered by another physician for this problems? ☐ No ☐ Yes, if so what test(s).

_____

PAST/PRESENT MEDICAL HISTORY:

Please check any ongoing medical conditions that you have already been diagnosed by doctors, including serious illness of the past. DO NOT check any problems which have not yet been addressed by a doctor.

☐ No Past/Present Medical Hx
☐ Acid Reflux
☐ Alcoholism
☐ Alzheimer's Disease
☐ Anemia
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Atrial Fibrillation
☐ Bipolar Disorder
☐ Cancer
Type: _____
Year: _____
☐ Carpal Tunnel Syndrome
☐ Cataracts
☐ Chronic Constipation
☐ Coronary Artery Disease
☐ Degenerative Disc Disease
☐ Depression
☐ Diabetes Type I (Insulin Dep)
☐ Diabetes Type II (Non-Insulin)
☐ Drug Abuse
☐ Eczema
☐ Emphysema
☐ Erectile Dysfunction
☐ Fibromyalgia
☐ Glaucoma
☐ Hearing Loss
☐ Heart Failure (Congestive)
☐ Heart Attack
Year:_____
☐ Hemorrhoids
☐ Hepatitis
Circle: A B C
☐ High Blood Pressure
☐ High Cholesterol
☐ High Triglycerides
☐ HIV
☐ Irritable Bladder
☐ Irritable Bowel Syndrome
☐ Kidney Stones
☐ Macular Degeneration
☐ Migraine Headaches
☐ Obesity
☐ Overactive Thyroid
☐ Panic Disorder
☐ Prostate Enlargement
☐ Seasonal Allergies
☐ Seizure Disorder
☐ Sleep Apnea
☐ Stomach Ulcers
☐ Stroke
Year:_____
☐ Tension Headaches
☐ Transient Ischemic Attack
Year: _____
☐ Underactive Thyroid
☐ Other: _____
_____
_____
_____
_____
_____

ALLERGIES:

Latex Allergy: _____ No _____ Yes (if yes, list reaction) _____
Drug Allergies: _____ No _____ Yes (if yes, list **drug** and type of **reaction** below)

_____ _____
_____ _____
_____ _____

IMMUNIZATIONS:

Have you received an Influenza Vaccine this year? ☐ No ☐ Yes (if yes, when did you receive it) Date: _____
Have you ever received a Pneumonia Vaccine? ☐ No ☐ Yes (if yes, when did you receive your last one) Date: _____

FAMILY HISTORY:

Please check any medical conditions/diseases in your IMMEDIATE family. These should be serious illnesses of mother, father, or siblings. Please indicate beside the illness, **F=Father**, **M= Mother**, **B= Brother, S= Sister**

☐ No Known Family History
☐ Abdominal Aortic Aneurysm _____
☐ Alcoholism _____
☐ Alzheimer's Disease _____
☐ Arthritis _____
☐ Asthma _____
☐ Cancer (Breast) _____
☐ Cancer (Colon) _____
☐ Cancer (Lung) _____
☐ Cancer (Ovarian) _____
☐ Cancer (Prostate) _____
☐ Cataracts _____
☐ Cirrhosis _____
☐ Congenital Heart Disease _____
☐ Congestive Heart Failure _____
☐ Depression _____
☐ Diabetes _____
☐ Emphysema _____
☐ Glaucoma _____
☐ Gout _____
☐ Heart Disease _____
☐ Hemophilia (Bleeding Disorder) _____
☐ High Cholesterol _____
☐ Hypertension _____
☐ Kidney Failure _____
☐ Kidney Stones _____
☐ Migraine Headaches _____
☐ Osteoporosis _____
☐ Overactive Thyroid _____
☐ Parkinson's Disease _____
☐ Underactive Thyroid _____
☐ Unknown
☐ Other _____
_____
_____
_____

SOCIAL HISTORY:

Do you smoke or use tobacco products?				Amount	Duration
Cigarettes	□ Never	□ Currently	□ Previously	_____	_____
Chews	□ Never	□ Currently	□ Previously	_____	_____
Cigar	□ Never	□ Currently	□ Previously	_____	_____
Pipe	□ Never	□ Currently	□ Previously	_____	_____
Dips Snuff	□ Never	□ Currently	□ Previously	_____	_____

Do family members smoke outside? □ No □ Yes
Do family members smoke inside? □ No □ Yes

Do you drink alcohol beverages? □ No □ Yes, if so, how many drinks per week: _____,

Have you ever used recreational drugs?

Marijuana	□ Never	□ Currently	□ Previously
Heroin	□ Never	□ Currently	□ Previously
Cocaine	□ Never	□ Currently	□ Previously

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

Employment:
□ Full Time □ Part Time □ Disabled □ Retired □ Student □ Unemployed
Occupation: _____

Do you have animals in your home? □ No □ Yes If yes, what type? _____
Is Daycare used? □ No □ Yes

SURGICAL HISTORY:

Please check ANY surgeries you have had in your lifetime.

□ No Previous Surgery	□ C-Section	□ Laparoscopy (incision into the abdomen)	□ Splenectomy
□ Adenoidectomy	□ D & C	□ Lithotripsy (crushing stone in urinary bladder)	□ Thyroidectomy
□ Appendectomy	□ Defibrillator (Placement)	□ Lobectomy (removal of lung/ all or part)	□Tonsillectomy
□ Back Surgery (Disc)	□ Delivery (Vaginal)	□ Lumpectomy	□Tonsils & Adenoids
□ Breast Augmentation	□ Ear Drum Repair	□ Mastectomy	□ Tubal Ligation
□ Breast Biopsy	□ Ear Tubes	□ Mastoidectomy	□ TURP
□ Breast Reduction	□ Fulguration of Endometriosis Surgery	□ Nephrectomy (kidney removal)	□ Vasectomy
□ Bunionectomy (foot)	□ Gallbladder	□ Oophorectomy	□ Other:
□ Cardiac Pacemaker	□ Hammer Toe	□ Oral Surgery	_____
□ Cardiac Stenting	□ Hemorrhoidectomy	□ Ovarian Cyst	_____
□ Carotid Endarterectomy	□ Herniorrhaphy (Hernia)	□ Plantar Wart	_____
□ Carpal Tunnel Release	□ Hip Replacement	□ Prostate – Biopsy	_____
□ Cataract	□ Hysterectomy	□ Prostatectomy	_____
□ Cervical Cone Biopsy	□ Laparoscopically Assisted Vaginal Hysterectomy	□ Salpingoophorectomy (Removal of tubes and ovaries)	_____
□ Colectomy (Partial/Complete Removal of Colon	□ Knee Arthroscopy	□ Septoplasty	_____
□ Colonoscopy	□ Knee Replacement	□ Sinus Surgery	_____
□ Coronary Artery Bypass Year: _____	□ Laminectomy	□ Skin Biopsy	

MEDICATIONS:
Please list all MEDICATIONS, their dosage, and other pills that you take including supplements and herbals:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

REVIEW OF SYSTEMS:

GENERAL	SKIN	HEENT	NECK
☐ Fever ☐ Chills ☐ Night Sweats ☐ Weight Gain ☐ Unexplained Weight Loss ☐ None	☐ Skin Rashes ☐ Itchy Skin ☐ Bruising ☐ None	☐ Headaches ☐ Voice Changes ☐ Blindness ☐ None	☐ Swollen Glands ☐ Neck Mass ☐ None
RESPIRATORY	**CARDIOVASCULAR**	**GASTRO-INTESTINAL**	**NEUROLOGICAL**
☐ Cough ☐ Shortness of Breath ☐ Wheezing ☐ None	☐ Irregular Heartbeats ☐ Chest Pains ☐ Blood Clots ☐ None	☐ Abdominal Pain ☐ Nausea ☐ Vomiting ☐ Reflux ☐ None	☐ Seizures ☐ Fainting ☐ Disorientation ☐ None
PSYCHIATRIC	**ENDOCRINE**		
☐ Anxiety ☐ Excessive Stress ☐ Panic Attacks ☐ Depression ☐ None	☐ Diabetes ☐ Thyroid Problems ☐ Excessive Urination ☐ None		

HEARING HEALTH CARE

Hearing Loss? YES or NO (If yes…) **Which Ear?** ☐ Right ☐ Left ☐ Both

Family History of Hearing Loss? ☐ Mother ☐ Father ☐ Siblings ☐ Grandparents ☐ None

Tinnitus ("Ringing Noise in Ears") ☐ **Which Ear?** ☐ Right ☐ Left ☐ Both
How long? _____ yrs. _____ mos.

Exposure to Noise Trauma ☐ Concerts ☐ Jet Engines ☐ Firearms ☐ Musical Instruments
☐ Other: _____

PHARMACIES:
Please list your preferred pharmacy.

	Pharmacy Name	**Street Name**	**City, State**
Local Pharmacy	_____	_____	_____
Mail Order Pharmacy	_____	_____	_____

NOTICE OF PRIVACY PRACTICES

Cumberland Valley ENT Consultants
and
The Hearing Care Center
A Division of Cumberland Valley ENT Consultants
11110 Medical Campus Road
Suite 126
Hagerstown, MD 21742
301-714-4375

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 Privacy Officer, Judith A. Kline.

This notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you. It relates to your past, present or future physical or mental health or condition and related health-care services.

We are required by law to maintain the privacy of protected health information and give you this notice of our legal duties and privacy practices regarding health information about you. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or by asking for one at the time of your next appointment.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your physician will use or disclose your protected health information as described in this section. Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice. Following are examples of the types of uses and disclosures of your protected health care information that the physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

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 has already obtained your permission to have access to 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 when we have the necessary permission from you to disclose your protected health information. 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 to your physician with your health care diagnosis or treatment.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: determination of eligibility or insurance coverage benefits, determination of medical necessity, and utilization review activities. Obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality-assessment activities, employee-review activities, training of medical assistant or nursing students, licensing, marketing activities, and conducting or arranging for other business activities.

An example would be that we may disclose your protected health information to medical assistant or nursing students working with us. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e. g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Uses and Disclosures of Protected Health Information Based upon your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action based upon the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use of disclosure of all or part of your protected health information. If you are not present or able to agree or you object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: 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 person's involvement in your health care. 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 you best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your physician or another physician in the practice is required by law to treat you and the physician has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

Communication Barriers: We may use and disclose your protected health information if your physician or another physician in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the physician determines , using professional judgment, that you intend to consent to use or disclosure under the circumstances.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information to the governmental entity or agency authorized to receive such information, if we believe that you have been a victim of abuse, neglect or domestic violence. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, to track products, to enable product recalls, to make repairs or replacements, or to conduct post-marketing surveillance, as required.

Legal Proceedings: We may disclose your protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out his duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military service. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

2. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice use for making decisions about you. By law, we are permitted to charge for the preparation, the production and the mailing costs, if applicable, of your protected health information.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to a law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by obtaining a "Restriction of Protected Health Information Form" from the office staff and submitting the completed form to our Privacy Officer.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may qualify this accommodation by asking you for information as to how payment will be handled; for specification of an alternative address, or for other method of contact. We will not request an explanation from you regarding the reason for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after **April 14, 2003.** You may request a shorter time frame. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe we have violated your privacy rights. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer, Judith A. Kline, at 301-714-4375 for further information about the complaint process.

The original notice was published and became effective on **April 14, 2003.**

The revision of the original notice was published and became effective on **September 23, 2013.**

CUMBERLAND VALLEY ENT CONSULTANTS AND/OR HEARING CARE CENTER

HIPAA Compliant Information Form

Date_____ *(Please complete front & back, and sign form)*

For Office Use Only
Chart # _____
Doctor _____
Updated _____
Initials _____

Please PRINT clearly

PATIENT INFORMATION

Name (Last): _____ (First): _____ (MI): _____

Sex:___ M __ F Date of Birth:_____ Age: _____ SS #: _____

Marital Status: S____ M____ Other _____ P.O. Box: _____

Street Address: _____ City:_____ State:_____ Zip: _____

Billing Address: _____ City:_____ State:_____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone:_____

Please share your email address. Patient/Guardian email address is: _____

Employer: _____ Employer Address: _____

Family Doctor (Full Name): _____ Referring Doctor (Full Name): _____

Pharmacy: _____ Address: _____ Phone: _____

Please list an alternate person to whom we may release medical information if you are unable to be reached. (Example: spouse, parent, etc.)

Name: _____ Relationship:_____

Home Phone: _____ Work Phone: _____ Cell Phone:_____

INFORMATION REQUIRED BY THE FEDERAL GOVERNMENT

Preferred Language: _____ Place of Birth: _____

Race:

_____ American Indian or Alaska Native _____ Asian _____ Black or African American

_____ More than one race _____ Native Hawaiian _____ Other Pacific Islander

_____ White _____ Refuse to report

Ethnicity:

_____ Hispanic or Latino _____ Not Hispanic or Latino _____ Refuse to Report

PARENT / LEGAL GUARDIAN *(For children under age 18)*

Name (Last): _____ (First): _____ (MI): _____

P.O. Box: _____ Street Address: _____ City:_____ State:_____ Zip:_____

Home Phone: _____ Work Phone: _____ Cell Phone:_____

Social Security #: _____ Date of Birth: _____

Legal Custodian: _____ Relationship to Patient: _____

Please provide us with a copy of legal documentation

The person(s) listed above are authorized to receive medical information for this patient: YES or NO (Please Circle)

*****Note: The parent who brings a child to the office for medical treatment is responsible AT THE TIME OF SERVICE for co-payment, deductibles, and account balances. If our provider is not a participating provider with your insurance company, payment in full is required at the time of service.**

See Reverse Side →

CUMBERLAND VALLEY ENT CONSULTANTS AND/OR HEARING CARE CENTER

HIPAA Compliant Information Form

For Office Use Only
Chart # _____
Doctor _____
Updated _____
Initials _____

Patient Name _____ **Date** _____

POWER OF ATTORNEY *(For Adults) (If Applicable)*

Name (Last): _____ (First): _____ (MI):_____

P.O. Box: _____ Street Address: _____ City:_____ State:_____ Zip:_____ __

Home Phone: _____ Work Phone: _____ Cell Phone:_____

Relation to patient: _____ ***Please provide us with a copy of legal documentation***

PRIMARY INSURANCE INFORMATION

Insurance Company: _____ Effective Date: _____

Policy Number: _____ Group Number: _____

Subscriber's Name: _____ Sex: ___M ___F Subscriber's Date of Birth:_____
(First) (MI) (Last)

Subscriber's SS #: _____ Patient's Relationship to Subscriber: _____

Subscriber's Employer: _____ Employer's Phone #: _____

Employer's Address: _____

SECONDARY INSURANCE INFORMATION

Insurance Company: _____ Effective Date: _____

Policy Number: _____ Group Number: _____

Subscriber's Name: _____ Sex: ___M ___F Subscriber's Date of Birth:_____
(First) (MI) (Last)

Subscriber's SS #: _____ Patient's Relationship to Subscriber: _____

Subscriber's Employer: _____ Employer's Phone #: _____

Employer's Address: _____

***Please inform us if you have a third insurance.**

If this is Workers' Comp. or accident related, please inform us and provide us with the proper paperwork.

Date of Injury: _____ Insurance Company: _____

Contact Person: _____ Phone Number:_____

Claim Number: _____

I certify that the information on this form is current and accurate to the best of my knowledge.

(SEAL)_____ _____ _____

Signature of Patient/Parent/Guardian | Relationship | Date

For Office Use Only
Chart # _____
Doctor _____
Updated _____
Initials _____

CUMBERLAND VALLEY ENT CONSULTANTS AND/OR HEARING CARE CENTER

11110 Medical Campus Road, Suite 126
Hagerstown, MD 21742
301-714-4375

FINANCIAL AGREEMENT, AUTHORIZATION FOR TREATMENT AND NOTICE OF PRIVACY PRACTICES' RECEIPT

- Patient is responsible for payment at the time of service when: **1)** patient is a self-pay; **2)** patient has a nonparticipating insurance company; or **3)** patient has an HMO and comes without the referral specified by the insurance company.
- We file all claims to insurance companies in which we participate. You may use the fee ticket to file your insurance claims when we do not participate with your insurance company.
- There is a $5.00 charge for replacement of a lost receipt
- Patient is responsible for any service that is not covered by his/her insurance as well as any co-pays, deductibles, and co-insurance.
- As part of your routine ENT exam, we may perform some common procedures on you. These may include hearing tests and an examination of the nose, sinuses or throat with various telescopes. An important part of your entire ENT exam, these tests and procedures aid your doctor in determining the proper treatment for your condition. Based on the contract you have with your insurance company, the endoscopic procedures may be categorized as surgical procedures even though they are part of your exam. Patient is responsible to contact insurance company with questions regarding benefits and co-payment obligations for office surgical procedures.
- **Copays are due at the time of service.**
- It is the patient's responsibility to provide our office with a written referral when required by his/her insurance plan.
- Patient is responsible to make sure laboratory studies, x-rays, scans, pre and post-operative testing are performed at a facility participating with patient's insurance.
- I agree to pay all charges promptly.
- A $35 returned-check fee will be assessed to the patient's account for each check returned to our office for non-sufficient funds
- If my account is assigned to a collection agency, I agree to pay the collection agency fee, court costs and attorney fees.

I hereby authorize Cumberland Valley ENT Consultants and Hearing Care Center to furnish information, including records from other health care providers, to my insurance company, authorized agency, or health care provider specified concerning my medical care. I agree to pay all charges promptly upon presentation thereof. I hereby assign and transfer any medical benefits due me to Cumberland Valley ENT Consultants for the services provided to me by this medical practice. I permit a copy of this authorization to be used in place of the original. Regulations pertaining to Medicare Assignment of Benefits apply, as applicable. I acknowledge the information I have supplied is correct.

I hereby authorize Cumberland Valley ENT Consultants and Hearing Care Center to treat me as needed. Also, I acknowledge receipt of the Notice of Privacy Practices.

_____ (SEAL) _____
Date Signature

I, parent or legal guardian, do hereby authorize Cumberland Valley ENT Consultants to treat _____ _____, being _____years of age and a minor. I understand that I am fully responsible for this minor's medical charges and agree to pay all charges for services rendered by the above-named medical practice. Also, I acknowledge receipt of the Notice of Privacy Practices.

_____ (SEAL) _____
Date Signature
(Parent or Legal Guardian)

_____ _____
Printed Name of Parent or Guardian Relationship to Patient