HELENA EAR, NOSE & THROAT CLINIC
3116 Saddle Drive, Suite 4, Helena, MT 59601 | HelenaENT.com | Phone: (406) 204-2409 | Fax: (406) 422-5611

Patient Registration – Please Print

Patient Name: _____ Date of Birth: _____ Age: _____
Last, First, Middle

Social Security #: _____ **Gender:** M / F **Marital Status:** Married Single Divorced Widowed

Mailing Address: _____ City, State, Zip: _____

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

May we leave a message at your home or cell number? Y / N Email: _____

Employer: _____ Occupation: _____ **Veteran:** Y / N

Referring Physician: _____ Primary Care Provider/General Physician: _____

Email (for use with Patient Portal only):
_____

Responsible Party Information (if different than above)

Responsible Party Name: _____ Date of Birth: _____ Age: _____
Last, First, Middle

Relationship to Patient: _____

Social Security #: _____ **Gender:** M / F **Marital Status:** Married Single Divorced Widowed

Mailing Address: _____ City, State, Zip: _____

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

May we leave a message at your home or cell number? Y / N Email: _____

Employer: _____ Occupation: _____ **Veteran:** Y / N

Emergency Contact Please provide name and phone number of a friend or relative that does not live at your current address.

Name: _____ Phone: _____ Relationship: _____

Federal Health Regulations now require that we record the following data as part of every health record.

Race: _____ Language: _____ Ethnicity: _____

OR check box to refuse to provide this information: [ ] Signature: _____

In order for us to bill your insurance we must have copies of all your insurance policies. Please bring copies of all insurance cards to your appointment. If you are not currently covered by health insurance plan, a $200.00 pre-payment is required prior to your appointment.

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Insurance Authorization and Assignment (Please Read)

I authorize Helena ENT Clinic to provide any applicable personal and medical healthcare information contained in my records for my treatment, account balance resolution and other healthcare operations to appropriate agencies, including collection agencies, insurance companies and third party payers. I CERTIFY THAT I AM THE PERSON NAMED ABOVE OR THE LEGAL GUARDIAN OF THE PATIENT and agree to pay for all fees and charges for my treatment and services provided. **I understand that should I default on payment of my account and collection agency services are required, all costs of collections up to 45% of the balance, including attorney/court costs will be added to the balance of my account. This agreement shall remain in effect for all services provided within the 90 days from the date of signing this agreement.**

Patient/Responsible Party Signature: _____ **Date**: _____

If you are interested in being preregistered for your appointment, please include any available insurance below before returning your new patient packet to the clinic prior to your appointment. Thank you.

PRIMARY INSURANCE		**SECONDARY INSURANCE**	
Insurance Name:	_____	Insurance Name:	_____
Subscriber ID #:	_____	Subscriber ID #:	_____
Subscriber Name:	_____	Subscriber Name:	_____
Date of Birth:	_____	Date of Birth:	_____
Group Number:	_____	Group Number:	_____

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Dr. Scott Pargot, DO
Dr. Nate Sanders, DO

Patient Name_____

Age _____ Date of Birth _____

Preferred Pharmacy_____

Referring Physician_____ Primary Care Provider_____

CURRENT MEDICAL CONDITION

What current problems are you experiencing? Describe your symptoms_____

_____

_____Date of Onset of Condition_____

LIST ALL PREVIOUS SURGERIES

_____

_____

PERSONAL MEDICAL HISTORY

☐High Blood Pressure	☐Tonsillectomy	☐ Anemia	☐Cancer,specify( )
☐Stroke	☐History of Ear Tubes	☐HIV or AIDS	☐Migraines/Headaches
☐Heart Problems/CHF	☐Asthma	☐Bleeding disorders	☐Vertigo/Dizziness
☐Cardiac Pacemaker	☐Allergies/Hay Fever	☐Blood Transfusion	☐Diabetes
☐Heart Attack/Heart Murmur	☐Difficulty breathing/wheezing	☐Chronic Cough	☐Snoring/Sleep Apnea/CPAP
☐Chronic Ear Infection	☐Emphysema/COPD	☐Difficulty Swallowing	☐Hearing Loss/Hearing Aides
☐Sinus Surgery	☐Arthritis	☐Acid Reflux/GERD	☐Liver or Kidney Disease
☐Septoplasty	☐Autoimmune Disorder	☐Thyroid Problems	☐Epilepsy
☐Chronic Sinusitis	☐Hepatitis	☐Psychiatric Disorders (Depression, Schizophrenia, etc)	

☐Other_____

ALLERGIES TO MEDICATIONS

Please list any medication allergies including the type of reaction:_____

_____

MEDICATIONS

Please list all of the medications that you are currently taking (**include over the counter and herbal medications)**

Medication	Dose	Medication	Dose
_____		_____	
_____		_____	
_____		_____	
_____		_____	
_____			

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FAMILY MEDICAL HISTORY

Please check all the diseases that run in your family

Disease	Mother	Father	Grandparent	Sibling	Children
Heart Disease	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Respiratory or Lung Problems	☐	☐	☐	☐	☐
Hearing Loss	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐
Anesthesia Reaction	☐	☐	☐	☐	☐
Neuromuscular Disease	☐	☐	☐	☐	☐
Other Significant Disease					

SOCIAL HISTORY

Weight_____Height_____

Do you currently smoke or did you ever smoke? ☐**Yes** ☐**No** If yes, Packs/Day_____ Years_____

Do you chew tobacco or smoke a pipe or cigar? ☐**Yes** ☐**No** If yes, how much per day? Years_____

If you no longer smoke or chew, when did you quit?_____

How many drinks of alcohol do you have in a typical week?_____

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HIPAA Notice of Privacy Policies

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.

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

Uses and Disclosures of Protected Health Information (PHI): Your PHI 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, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your PHI 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. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. For example, your PHI 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.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your PHI 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 students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients at our office. 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 PHI, as necessary, to contact you to remind you of your appointment.

We may use or disclose your PHI in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: 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.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. At no time will patient information be used for marketing purposes.

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 in reliance of the use or disclosure indicated by the authorization.

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GINA Act: Prohibits discrimination based on your genetic information.

Your Rights: The following is a statement of your rights with respect to your PHI.

You have the right to inspect and copy your PHI. 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 PHI that is subject to law that prohibits access to PHI.

You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI 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 physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. 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 alternatively i.e. electronically.

You have the right to have your physician amend your PHI. 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.

You have the right to receive an accounting of certain disclosure we have made, if any, of your PHI. We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. A copy will be available at each appointment.

Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

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

This notice was published and becomes effective on/before September 23, 2013.

Signature below is only acknowledgement that you have received this notice of our privacy practices:

Print Name: _____ Signature: _____

Date: _____

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Scott R Pargot DO Inc.
Nathan A Sanders DO PC

FINANCIAL POLICY

Patient Name _____ Date _____
(Please print)

Responsible Party _____ Relationship _____
(If different from patient. Please print)

Helena ENT Clinic is committed to meeting your healthcare needs. Our professional and courteous staff will make every effort to facilitate a positive experience for your while in our care. An integral part of those efforts is to keep your insurance or other financial arrangements as simple as possible. In order to accomplish this we ask that you review the following and indicate your understanding by initialing each.

****PLEASE INITIAL EACH LINE****

____ All co-payments are due at the time of service, before your appointment.

____ Unless otherwise requested, charges for your services will be submitted to your insurance company on your behalf. Any amounts not covered by insurance are due and payable within 30 days unless special payment arrangements have been made with our billing department.

____ It is your responsibility to provide us with current address, telephone number and insurance information at each visit. If you do not have proof of your current insurance information, you will be considered a self-pay patient for that visit and payment in full will be due that day.

____ It is your responsibility to contact your insurance carrier to confirm that your physician participates with your plan and you understand your insurance benefits and requirements.

____ Diagnostic testing, including sinus endoscopy, is frequently necessary to fully assess your condition and enable your physician to recommend an appropriate treatment plan. There is a separate charge for diagnostic testing. This charge is in addition to your office visit fee. A complete list of all fees is available upon request.

Please feel free to discuss your questions or concerns regarding any financial policies with Dr. Pargot and Dr. Sanders. They welcome open communication with their patients on this and any matter concerning your health and wellbeing.

Thank you for allowing Helena ENT Clinic to be a part of your health and wellness.

_____

(Responsible Party Signature)

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Patient Notice and Acknowledgment of Potential COVID-19 Exposure

Here at Helena ENT Clinic, our utmost priority is ensuring the health and safety of our patients and staff. Please know that, as always, we are taking every precaution to protect you and prevent the transmission of potential infectious diseases during your visit to our clinic. This has always been a priority of ours.

Due to the recent COVID-19 pandemic, you may experience increased precautions while attending your appointment. These are to help reduce the risk of potential exposure for you, our other patients, and staff.

It is important to acknowledge, however, that despite increased precautionary measures, there is always a risk of potential exposure to COVID-19 while visiting any public building, office, store, etc.

Please initial next to each statement.

____ I acknowledge that I have been made aware of the risk of potential exposure to COVID-19 by seeking elective care in this office despite cautionary measures being taken by the Helena ENT Clinic.

____ I understand that it is my right to reschedule my appointment if desired.

____ I understand that the Helena ENT Clinic has the right to reschedule/postpone my appointment if I fail to pass pre-appointment screening or there is reason to believe that I am a potential carrier of COVID-19.

By signing my name below, I acknowledge that I am consenting to elective care with the Helena ENT Clinic despite potential COVID-19 exposure.

_____ _____
(Signature of Patient/Legal Guardian) (Date)

_____ _____
(Print Patient Name) (Relationship to Patient)