



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):

Race: _____ Ethnicity: _____ Language: _____

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

Release of information for purposes of care coordination or in the case of an emergency:

I authorize the release of information including the diagnosis, records, examinations rendered, treatment plan, pre-op and post-op care as well as claims information to the following individual(s). In the case that I am scheduled for surgery, I authorize The Helena ENT Clinic to provide this contact information to the appropriate surgery center. The information may be released to/discussed with:

Name	Relationship	Home phone	Cell Phone	Work Phone
1. _____				
2. _____				

CONTINUED ON BACK



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.

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: _____
 Subscriber ID #: _____
 Subscriber Name: _____
 Date of Birth: _____
 Group Number: _____

Insurance Name: _____
 Subscriber ID #: _____
 Subscriber Name: _____
 Date of Birth: _____
 Group Number: _____



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

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)

Table with 4 columns: Medication, Dose, Medication, Dose. Includes horizontal lines for data entry.

CONTINUED ON BACK



FAMILY MEDICAL HISTORY

Please check all the diseases that run in your family

Disease	Mother	Father	Grandparent	Sibling	Children
Heart Disease	<input type="checkbox"/>				
High Blood Pressure	<input type="checkbox"/>				
Cancer	<input type="checkbox"/>				
Respiratory or Lung Problems	<input type="checkbox"/>				
Hearing Loss	<input type="checkbox"/>				
Diabetes	<input type="checkbox"/>				
Bleeding Disorder	<input type="checkbox"/>				
Thyroid Disease	<input type="checkbox"/>				
Anesthesia Reaction	<input type="checkbox"/>				
Neuromuscular Disease	<input type="checkbox"/>				
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? _____



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.



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: _____



Scott R Pargot DO Inc.
Nathan A Sanders DO PC

FINANCIAL POLICY

Patient Name _____
(Please print)

Date _____

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

Relationship _____

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)