

Statesboro ENT & Hearing Clinic
Professional Hearing Clinic

PATIENT INFORMATION

DATE: _____ DATE OF BIRTH: _____ AGE _____ RACE _____ SEX _____

PLEASE PRINT
PATIENT'S LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____

MAILING ADDRESS _____

PHYSICAL ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ SS# _____

HOME PHONE _____ S M W D (IF MARRIED, NAME OF SPOUSE) _____

PERSON RESPONSIBLE FOR BILL _____ RELATIONSHIP _____

PATIENT'S/PARENT'S EMPLOYER _____ WORK PHONE _____

EMPLOYER ADDRESS _____

SPOUSE'S EMPLOYER _____ WORK PHONE _____

GUARDIAN'S SS# _____ FAMILY PHYSICIAN _____

SIGNIFICANT PAST MEDICAL HISTORY _____

MEDICATIONS TAKEN DAILY _____

ARE YOU ALLERGIC TO ANY MEDICATION? _____

REASON FOR TODAY'S VISIT? _____ REFERRED BY? _____

NOTIFY IN CASE OF EMERGENCY _____ PHONE _____

MEDICAL CONTRACT AND RELEASE OF INFORMATION FOR DR. THOMAS CREWS AND PROFESSIONAL HEARING CLINIC, I/We hereby grant you, Dr. Thomas M. Crews, M.D. and/ or Professional Hearing Clinic/ your agents the right to confirm and verify all information given you for the purpose of treatment/billing. I/ We are obligated to pay this account in accordance with all regular rate and terms of these offices. I authorize the release of any medical information necessary to process this claim. I authorize payment of insurance benefits directly to Dr. Thomas M. Crews and/or Professional Hearing Clinic for services rendered. If this account should be turned over to a collection agency/ attorney for nonpayment, I/ We assume responsibility for full cost of all collection/legal fees. I understand all delinquent accounts will be assessed at 1.5% interest monthly and 18% annually. I authorize the release of any credit record necessary to process and collect this claim. I certify all information given is correct.

I hereby authorize the release and sharing of medical information by and between Dr. Thomas Crews and Professional Hearing for the purpose of medical treatment or obtaining a hearing instrument.

**PATIENT OR GUARDIAN
SIGNATURE** _____

METHOD OF PAYMENT: CASH _____ CHECK _____ CREDIT CARD _____

MEDICAID _____ MEDICARE _____ INSURANCE _____

PLEASE GIVE INSURANCE CARD(S) TO THE RECEPTIONIST FOR COPY.

SMILE REMINDER

WE HAVE A NEW PROGRAM TO REMIND OUR PATIENTS OF THEIR APPOINTMENTS. TO ENSURE THAT YOU ARE INCLUDED IN THIS NEW PROGRAM PLEASE PROVIDE US WITH A CURRENT CELL PHONE NUMBER. THIS SERVICE WILL SEND YOU A TEXT MESSEGE ONE TIME LETTING YOU KNOW THE TIME AND DATE OF YOUR APPOINTMENT. AN EMAIL ADDRESS WILL ALSO BE APPRECIATED AS IT WILL ALLOW US TO NOT ONLY SEND EMAIL CONFIRMATIONS, BUT BIRTHDAY WISHES AND UPDATED NEWSLETTERS REGARDING OUR OFFICE.

CELL PHONE NUMBER: _____

EMAIL ADDRESS: _____

THIS WILL SAVE YOU FROM
ANNOYING PHONE CALLS 😊

STATESBORO ENT & HEARING CLINIC
STATESBORO ENT SURGICAL CENTER, P.C.
106 PROCTOR STREET
STATESBORO, GA 30458
(912) 764-8200
1-800-526-0998

PATIENT: _____

PERSON
INSURED: _____

I, _____, have released to you all the insurance information that the patient listed above has. I understand that insurance is filed as a courtesy to me and I have no other insurance coverage. I will be responsible for any balance insurance does not pay and will be willing to set up payment arrangements. I have read and fully understand all the information stated above.

PATIENT / INSURED SIGNATURE

DATE

WITNESS

DATE

STATESBORO ENT AND HEARING CLINIC
STATESBORO ENT SURGICAL CENTER
106 Proctor Street * Statesboro, Georgia 30458
Phone: (912) 764-8200 * fax: (912) 489-2954

Thomas M. Crews, M.D.

Patient Consent for Use and Disclosure
Of Protected Health Information

With my consent, Statesboro ENT Clinic and Statesboro ENT Surgical Center may use and disclose protected health information about me to carry out treatment, payment, and healthcare operations. Please refer to Statesboro ENT Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Statesboro ENT reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to JoAnne R. Furman, Privacy Officer at 106 Proctor Street, Statesboro, Georgia 30458. With my consent, Statesboro ENT clinic or Surgical Center may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment, and healthcare operations, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Statesboro ENT Clinic or Surgical Center may mail to my home or other designated location any item that assist the practice in carrying out treatment, payment, and healthcare operations, such as appointment reminder cards and patient statements as long as they are marked personal and confidential. I have the right to request that Statesboro ENT clinic or Surgical Center restrict how it uses or discloses my protected health information to carry out treatment, payment, or healthcare operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Statesboro ENT Clinic or Surgical Center's use and disclosure of my protected health information to carry out treatment, payment, or healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in relevance upon my prior consent. If I do not sign this consent, Statesboro ENT Clinic or Statesboro Surgical Center may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Patient's Name

Date

Print Name of Patient or Legal Guardian

CONSENT TO ROUTINE PROCEDURES & TREATMENTS

IMPORTANT: Do not sign this form without reading and understanding its contents. *Mark out and initial any Procedure and/or section of this form for which consent is not granted.*

During the course of my care and treatment, I understand that various types of tests, diagnostic or treatment procedures may be necessary. These Procedures may be performed by physicians, nurses, technicians, physician assistants or other healthcare professionals.

While routinely performed without incident, there may be material risks associated with each of the Procedures. I understand that it is not possible to list every risk for every Procedure and that this form only attempts to identify the most common material risks and the alternatives (if any) associated with the Procedures. I also understand that various Healthcare Professionals may have differing opinions as to what constitutes material risks and alternative Procedures.

If I have any questions or concerns regarding these Procedures, I will ask my physician to provide me with additional information. I also understand that my physician may ask me to sign additional Informed Consent documents.

The Procedures may include the following:

Initials

- _____ (1) **Needle Sticks** such as shots, injections, intravenous lines or intravenous injections (IVs). The material risks associated with these types of Procedures include, but are not limited to, nerve damage, infection, infiltration (which is fluid leakage into surrounding tissue), disfiguring scar, loss of limb function, paralysis or partial paralysis or death. Alternatives to Needle Sticks (if available) include oral, rectal, nasal, or topical medications (each of which may be less effective) or refusal of treatment.
- _____ (2) **Physical tests, assessments and treatments** such as vital signs, internal body examinations, wound cleansing, wound dressing, range of motion checks, and other similar procedures. The material risks associated with these typed of Procedures include, but are not limited to, allergic reactions, infection, severe loss of blood, muscular-skeletal or internal injuries, nerve damage, worsening of the condition and death. Apart from using modified Procedures and/or refusal of treatment, no practical alternatives exist.
- _____ (3) **Administration of Medications** whether orally, rectally, topically or through my eye, ear or nose. The material risks associated with these types of Procedures include, but are not limited to perforation, puncture, infection, allergic reaction, brain damage or death. Apart from varying the method of administration and/or refusal of treatment, no practical alternatives exist.
- _____ (4) **Drawing Blood, Bodily Fluids or Tissue Samples** such as that done for laboratory testing and analysis. The material risks associated with this type of Procedure include, but are not limited to, paralysis or Partial paralysis, nerve damage, infection, bleeding and loss of limb function. Apart from long-term Observation and/or refusal of treatment, no practical alternatives exist.
- _____ (5) **Insertion of Internal Tubes** such as bladder catheterizations, nasogastric tubes, rectal tubes, but are not limited to internal injuries, bleeding, infection, allergic reaction, loss of bladder control and/or difficulty urinating after catheter removal. Apart from external collection devices or refusal of treatment, no practical alternatives exist.

Understand that:

The practice of medicine is not exact science and that **NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME** concerning the outcome and/or result of any Procedure.

The Healthcare Professionals participating in my care will rely on my documented medical history, as well as other information obtained from me, my family or others having knowledge about me, in determining whether to perform or recommend the Procedures; therefore, I agree to provide accurate and complete information about my medical history and conditions; and

Physicians rendering services to me are independent professionals engaged in the private practice of Medicine (and are not employees or agents of the Hospital).

By signing this form:

I consent to Healthcare Professionals performing Procedures as they deem reasonably necessary or desirable in the exercise of their professional judgment, including those Procedures that may be unforeseen or not known to be needed at the time this consent is obtained; and I acknowledge that I have been informed in general terms of the nature and purpose of the Procedures; the material risks of the Procedures; and the practical alternatives to the Procedures.

Signature of Patient (or other person authorized to sign): _____

Printed Name of Patient: _____

Reason Patient Unable to Sign (if applicable): _____

Date Signed: _____

Explained by: _____