Island ENT Wellness Spa and Audiology

901 Venetia Bay Blvd Suite 350
Venice FL 34285

P 941-786-0386 F 941-761-6241 www.IslandENTvenice.com

Name: _____ Birthdate ____/____/____
FL Address_____
Email _____ Permission to text?_____
Cell phone _____ Landline_____
Snowbird? Second address_____

Reason for your visit today _____

Treatment tried _____
Did you have any scans? Did you bring them? Where performed? _____

Primary Doctor _____ Pharmacy (**location**?)_____

Who can see your medical records? (relation)_____

HT_____ Weight _____ T_____ P_____ BP_____ O2_____ % tinnitus _____

Allergies to drugs, food or environment reaction? Mild, mod, or severe. Type of reaction
Permission to use a national database of pharmacies to access medication list? **Y / N**
Medication, supplements, herbals dose (mg), how often taken,

How did you hear about Island ENT? _____

Social history: (Circle). Never smoker, Ex Smoker. Smoker ___ cigs. per day
Alcohol: do not drink, former drinker, 0-4 glasses/month, 1-2/wk 1-2/day, 3 or more/day

Significant **family history** or trauma that relates to your health?

Your Medical history: Please list any significant information Circle any that pertain:
Cardiologist _____Heart Disease, Afib, CAD, Stents,High Blood Pressure, Bleeding Disorders or thinners, CHF,
Pulmonologist _____COPD, Short of breath, Asthma, pulmonary hypertension, PE,
Neurologist _____ seizures, black outs, neuralgia, Headaches,
Gastroenterologist _____ Reflux or heartburn, gastric emptying issues, chronic constipation, Crohn's, food intolerances
Other stuff: Hepatitis, Thyroid issues, Kidney Disease, TB, HIV/AIDS, Diabetes, Stroke, recent change in weight, Joint Pain, problems with anesthesia Y or N Cancer (list details below), list any others

_____
_____
_____

Sinus Problems: Pain and pressure in cheeks or forehead? Have you had a CT scan of your head? Location of CT _____Have you used Flonase? Y or N Do you use a saline sinus rinse Y or N Other nasal sprays? Sinus Surgeries? Antibiotics in the last year for sinus infections?

Sleep Problems: use C-Pap? Do you tolerate it well? Y or N, why not _____
Last sleep study within 2 years? _____ Known sleep apnea? Y or N Do you disturb your partner?

Hearing/Ear Problems: Do you have hearing loss? Y or N Tinnitus? Y or N Ear pain? Which side?
Trouble equalizing pressure in ears? Wax buildup? Last hearing test? Where?
Hearing Aids? Brand? Do you wish they worked better?

Surgical History: please list anything done, approx. date, surgeon if known , knowing you had anesthesia helps us prepare for future needs

Check any other things you would be interested in talking about today or in a consultation.

____ Treatment for depression, anxiety, OCD, addiction, overall wellbeing, tinnitus, **ExoMind**
____ Body sculpting and fat loss, **Emsculpt Neo, Exion body**
____ Cellulite toning and skin tightening, **Emtone**
____ Pelvic floor health, work out in your clothing, free 5 minute session, ask staff, **Emsella**
____ Non invasive facelift, facial rejuvenation, **Emface and Exion face**

All of our treatments are non invasive in that there is no cutting, nor downtime. Most therapies are finished within 3-4 weeks, once to twice a week. See Wellness Self Assessment for details.

Please notify us if your insurance changes and complete a new form

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RELEASE OF MEDICAL RECORDS

I, (name) _____ request the following doctor's offices send my records to Island ENT, also that Island ENT send my records to them as needed.

DOB: ____ / ____ / _____ phone number: _____

List physicians and healthcare team you would like us to send and receive records

Name of physician or practice below	specialty	phone number	fax number
1.			
2			
3			
4			
5			
6			

To: Medical Records	From: Island ENT 941-761-6241 Dr. Michael Jonathan Clark MD Dr. Madeleine Berg Au.D
Date sent	Date received

Please sign _____date_____

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Consent to Treat and HIPAA Notice

Patient Name: _____

At Island ENT , it may be required for me to undergo physical examination or other diagnostic procedures and treatment that is deemed necessary by the treating doctor. The nature/need for the procedure will be explained prior and I am able to refuse any treatment or procedures. I consent to procedures deemed necessary, diagnostic study, disposal of bodily fluids/ tissue obtained with routine hospital/governmental regulation, prescription and/or administration of medication. All explanations of treatments/procedures/ medication administration will include intended purpose, reasonable foreseeable risks, consequences, benefits, and alternatives which may be used or performed in the course of diagnosing/treating. I understand that treatments/procedures/medication administration will not be exhaustive and that other risks or complications may arise, but the likelihood is not reasonable or foreseeable. I have been advised that if I would like a more detailed explanation prior to consent, that one will be given to me. I acknowledge that I have received no warranties or assurances with respect to any benefits which are hoped to be realized, or consequences which may result from examination(s), procedure(s), or treatment(s), which may be performed or used. I understand that the practice of medicine is not an exact science and that diagnosis and treatment may involve risks of injury or even death. I consent to photographing and/or videotaping the appropriate portions of my body, which are pertinent to showing my physical condition for medical, scientific, or education purposes provided reasonable precautions are taken to conceal my identity. I acknowledge that I have read this document in its entirety and that I fully understand it prior to my signing. I understand that I am to make inquiries regarding any aspect of my diagnosis or treatment which I do not understand. By signing below, I represent to my doctor and this practice that I am eligible to give this consent.

Island ENT follows HIPAA guidelines in respect to Protected Health Information (PHI). Your PHI may be used or disclosed for the purpose of treatment, payment, or health care operations. Please see our Notice of Privacy Practices for an extensive overview of practices and patient's rights. Signing below also indicates that I received a notice of privacy practices and agree to allow this practice to use my health information as indicated above.

_____ _____

Patient or Representative Signature* Date
Parent if under 18 years of age

_____ _____

Relationship to Patient Signature of Witness

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It is your responsibility to understand your insurance, we gladly bill for you but we cannot know all the plans for every provider. We will on the best of our understanding bill you as directed. If your insurance does not pay , we will send a bill. All HMO plans must have an authorization before you can be seen. Some Advantage plans may have 2 copays, this is a change to what we expected from last year.

- ☐ I have Medicare part B. It pays 80% of the allowable rate after your deductible is met.
- ☐ I have a Medicare supplement plan _____ this should pay the remaining 20% unless you have a plan with a deductible and/or a copay. If your plan is an HMO supplement, we are out of network. Annual deductible $257
- ☐ I have VA CHAMP/ Community Care, referral needed # _____
- ☐ Tricare East we are a non-network participating provider, patients will owe 25% of allowable rate.
- ☐ Blue Cross Blue Shield all plans except the Select plan, HMOs require authorization _____
- ☐ Aetna all plans except CVS, specialist copay due at visit, _____
- ☐ Freedom/Optum HMO referral needed for service _____ copay _____

We are out of network with all other insurance plans. This worksheet will help you understand what your bill may be. Please check your plan. If incorrect information is given, the correct information will be on your bill. Please check your plan information in the book your insurance sent. We can bill electronically for out of network benefits as a courtesy and will reimburse if you have been overcharged. We are happy as well to email you superbills the next day.

- ☐ I have an **HMO** or **EPO** plan. There is no coverage or benefit with one of these plans. We will charge you the cash rate. If you get an authorization from your PCP for medical necessity to particularly see Dr. Michael Jonathan Clark because of his unique services and the inability to find another provider, you may be able to get reimbursed.
- ☐ I have a **PPO commercial** plan. I understand Island ENT is an out of network provider. My copay is _____. If you do not know your copay and we bill the insurance; they will tell us. My deductible is _____. I understand that my deductible must be met before my insurance will pay anything towards my bill.
- ☐ I have a **PPO medicare advantage** plan. I understand Island ENT is an out of network provider. My copay is _____. My deductible is _____. I understand that my deductible must be met before my insurance will pay anything towards my bill and OON doctors may have higher copays. These plans do have medicare limiting charges and this will be reflected in the bill.
- ☐ I prefer to pay **cash**. Workman's Compensation is handled by outside provider and fees are covered.

*****Please be aware that some insurance plans, even in network plans, have deductibles and co-pays on diagnostics as well as visit charges. You are responsible to pay what your insurance does not cover. You are responsible to understand the coverage of your individual plan. Our staff uses the tools we have to give you as much information as possible but not all information is easily accessible.***** **initial _____**

Medicaid and Dual Access Cards We are not in network, All clients are required to pay cash and in the case of Medicare Dual the 20% remaining of the allowable amount. Sign _____

Insurance company _____ ID_____

Secondary _____ ID_____

Print Name _____ Sign_____

Witness _____ Date _____

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