Island ENT Wellness and Audiology
Medical and Surgical Expertise with a Holist Approach
420 Nokomis Avenue S, Venice FL 34285 call 941-786-0386 fax 941-761-6241
www.IslandENTVenice.com

Audiology Only Intake, if you are referred to Dr. Clark, you will be asked to complete our regular intake forms, please bring audiogram with you, in house audiograms available.

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

Primary Doctor _____ Pharmacy (where?)_____

Who can see your medical records? (relation)_____

HT_____ Weight _____ T_____ P_____ BP _____ O2_____%

Allergies to medications:
Medication, supplements, herbals dose (mg), how often taken
Permission to use a national database of pharmacies to access medication list? **Y / N**

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 medical conditions and surgeries:

Are you having Dizziness? describe

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

Signature: _____

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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

*please notify us if your insurance changes and complete a new form.

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RELEASE OF MEDICAL AND AUDIOLOGY 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 (if you did not see Dr. Clark or Dr. Burke under the old practice, you may cross #1 out.

Name of physician or practice below	specialty	phone number	fax number
1. ENT and Allergy Specialist of SWFL (previous office)	ENT	941-355-2767	941-355-0617
2			
3			
4			
5			
6			

Please fax all records, esp. any audiograms and radiology reports to 941-761-6241

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

Please sign _____

*please notify us if your insurance changes and complete a new form.

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Island ENT accepts Medicare part B and its supplements, VA CHAMP and Blue Cross

- ☐ 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 you plan is an HMO supplement, we are out of network.
- ☐ I have VA CHAMP/ Community Care, referral needed # _____
- ☐ Tricare East we are non network participating providers, patients owe 25% of allowable rate.
- ☐ Blue Cross Blue Shield (not Blue Select plans) copay in network specialist $_____

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 are happy to fax anything for you. 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**.

Insurance company _____ ID_____

Insurance fax # _____ Service phone _____

Secondary _____ ID_____

Print Name _____ Sign_____

Witness _____ Date _____

*please notify us if your insurance changes and complete a new form.