LasColinas
Ear, Nose, Throat & Allergy

Name: _____ Age: _____ Today's Date: _____
Who referred you to our practice? _____
Reason for visit? _____
When did symptoms begin? _____

PAST MEDICAL HISTORY (Please Check Appropriate Boxes)

- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Cancer Type: _____
- ☐ Diabetes
- ☐ Emphysema
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Kidney Disorder
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Other: _____

PAST SURGICAL HISTORY (Please Check Appropriate Boxes)

- ☐ Appendectomy
- ☐ Back
- ☐ Cataracts
- ☐ C-Section
- ☐ Ear Tubes
- ☐ Gallbladder
- ☐ Heart Disease
- ☐ Hernia
- ☐ Hysterectomy
- ☐ Neck
- ☐ Orthopedic Type: _____
- ☐ Septoplasty
- ☐ Sinus Surgery
- ☐ Tonsillectomy
- ☐ Other: _____

MEDICATIONS YOU ARE CURRENTLY TAKING: _____

_____

DRUG ALLERGIES: _____

REVIEW OF SYSTEMS (Please Check Appropriate Boxes)

Yes	No		Yes	No		Yes	No	
☐	☐	Back Pain	☐	☐	Depression	☐	☐	Seizure
☐	☐	Bleeding Tendency	☐	☐	Fever	☐	☐	Shortness of breath
☐	☐	Change in Thirst or Appetite	☐	☐	Hives	☐	☐	Tiredness
☐	☐	Chest Pain	☐	☐	Irregular Heart	☐	☐	Tremors
☐	☐	Currently Breast Feeding	☐	☐	Memory Loss	☐	☐	Weakness
☐	☐	Currently Pregnant	☐	☐	Numbness	☐	☐	Weight Loss, Unintentional

FAMILY HISTORY (Please Check Appropriate Boxes)

- ☐ Asthma
- ☐ Cancer
- ☐ Deafness
- ☐ Diabetes
- ☐ Hayfever
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Strokes
- ☐ Thyroid Disorder
- ☐ Other:_____

Tobacco Use: ☐ Yes ☐ No ☐ Quit: _____ Alcohol Use: ☐ Yes ☐ No ☐ Quit: _____

OFFICE USE ONLY:

_____

_____

_____

_____

7449 Las Colinas Blvd, Suite 100• Irving, Texas, 75063 • Tel (972)432-8282 • Fax (972)432-0552
LasColinasENTallergy.com

LasColinas
Ear, Nose, Throat & Allergy

J. Byron Mullins M.D.

Patient Information/ Information De Paciente

Welcome to our practice! We strive to make each of your visits pleasant and comfortable. Due to the increased requirements of insurance companies and to help us better serve your needs; please take a few minutes to answer the following questions.

Bienvenidos ha nuestra practica! Nuestro esfuerzo es hacer sus visitas comodas. Ahora que mas requisitos de las companies de aseguranza y para poder servirles lo major posile, favor de tomar unos minutos para contester las siguientes.

Who may we thank for referring you?
Ha quien le damos gracias por su referencia? _____

Name/ Nombre **First/** Primer **Middle/** Medio **Last/** Apellido **Age/** Edad

Birthdate/ Fecha De Nacimento M F **Sex/** Sexo S M D W **Marital Status/** Estacion Matrimonial **SSN/** Numero Social

Mailing Address/ Direccion

City/ Cuidad **State/** Estado **Zip Code/** Codigo Postal

Home Phone/ Telefona De Casa **Work/** Trabajo **Cell/** Celular

Pharmacy **Location** **Phone Number and Fax**

Email Address/ Corespondencia Electronica: _____@_____ **Employer/** Patron: _____

Primary Care Physician/ Medico Primario **Address/** Direccion **Phone/** Telefono

INSURED PARTY INFORMATION/ INFORMATION DEL ASEGURADO

Insured's Name/ Nombre De Asegurado **Relationship to patient/** Relacion Al Paciente

Birthdate/ Fecha De Nacimento **Age/** Edad **SSN/** Numero Social **Sex/** Sexo

Mailing Address/ Direccion

Employer/ Patron **Address/** Direccion

Emergency Contact/ Contacto De Emergencia: _____

Relationship/ Relacion: _____ **Phone:** _____

May we have your permission to email or text you regarding upcoming practice information: **YES** **NO**
Nos da permiso para mandar corespondencia electronica o text telefonico sobre information de nuestra practica SI NO

7449 Las Colinas Blvd, Suite 100• Irving, Texas, 75063 • Tel (972)432-8282 • Fax (972)432-0552
LasColinasENTallergy.com

LasColinas
Ear, Nose, Throat & Allergy

J. Byron Mullins M.D.

HIPPA Access Form for Protected Health Information

I understand the policy of J. Byron Mullins, M.D. is to restrict access to my Protected Health Information. In addition to the caregiver(s) providing health services and my insurance company for payment of my claims, I would like for the following person(s) to have access to my Private Health Information.

Please print:

Name(s):	DOB:	Information Access Preferences:	
1. _____	_____	___All	___Restricted*
2. _____	_____	___All	___Restricted*
3. _____	_____	___All	___Restricted*
4. _____	_____	___All	___Restricted*
5. _____	_____	___All	___Restricted*

*Clinical Information Restricted – If you check any person(s) RESTRICTED, please specify what clinical information you **DO NOT** wish to share with the person(s) above. If checking ALL, you give the person(s) access to all your health information.

___ Sexually transmitted Disease(s) ___Pregnancy

___ Mental/ Behavioral Health ___ Terminal Illness

___ Other: _____

_____ _____
Patient/ Guardian (if minor) Signature Date

_____ _____
Witness Date

**State Law permits both parents to have access to PHI unless we are provided a court order restricting this right.

7449 Las Colinas Blvd, Suite 100• Irving, Texas, 75063 • Tel (972)432-8282 • Fax (972)432-0552
LasColinasENTallergy.com

Updated 05/2011

LasColinas
Ear, Nose, Throat & Allergy

J. Byron Mullins M.D.

Please read the following information regarding Insurance and Office Policies.

Financial Policy:

Payment is expected in full at time of service.

- If J. Byron Mullins, M.D. has a contract with your insurance Company or Provider Organization we will be happy to file a claim on your behalf. However, you will be required to pay any co-pay, deductible, and/or co-insurance required by your insurance company at the time of your visit.
- Our office NEVER guarantees your insurance will pay. We will make every attempt to verify your insurance benefits at the beginning of your healthcare. However, if for any reason your insurance company does not pay, or pay as expected, for whatever reason, or if they choose to delay payment, you will be responsible to pay the remaining balance within 30 days.
- We recommend you contact your insurance company to verify ENT and Allergy coverage on your policy. If injections, allergy testing, ear cleaning, or other in office procedures are recommended for your treatment; please be aware they may be considered surgical procedures and will be applied to your deductible. Most misunderstandings about insurance could be avoided if you understand in advance what your insurance policy provides. Therefore we encourage you to call you insurance company today.
- We will not file insurance if you live outside the state of Texas.
- Our office will not file with a secondary policy, unless Medicare is primary.
- There will be a $25.00 charge for any appointments missed or not cancelled within 24 hours.
- There will be a $25.00 charge for all returned checks.
- The patient must obtain all necessary referrals and authorizations prior to appointment or payment is expected at the time of visit.

Consent to Treatment:

I give permission to the physician and whomever he may designate as his assistant(s), associate(s) to administer such treatment as is necessary and to perform any medical care or procedures as are considered therapeutically necessary based on findings during examination or treatment.

Authorization to Release Information:

I authorize J. Byron Mullins, M.D. to release any medical information pertaining to the examination, treatment, history, prescription of medication and medical expenses of myself to any physician, hospital, clinic, insurance company and all other agencies deemed necessary in order to process insurance claims. This authorization also includes the release of any pertinent medical information to my specialist or other medical facility the physician may refer the patient to for treatment or evaluation.

Assignment of Benefits:

I authorize direct payment of medical benefits to J. Byron Mullins, M.D. for services rendered; a photo copy of my insurance card is valid and effective as if it were the original. I understand that I am financially responsible for any co-pays, co-insurance, and deductibles required by my insurance. I also understand that I am responsible for all charges that are not covered by my insurance.

By my signature, I agree to comply with the Financial Policy, Consent for Treatment Policy, Authorization to Release Information Policy, and Assignment of Benefits.

Medication History Consent:

I authorize Las Colinas Ear, Nose, Throat, and Allergy to retrieve Medication History from the national pharmacy database for me or my dependent, in order to reconcile prescriptions purchased through my current and/or previous insurance and therefore properly render treatment.

Patient/ Guardian (if minor) Signature _____ Date _____

7449 Las Colinas Blvd, Suite 100• Irving, Texas, 75063 • Tel (972)432-8282 • Fax (972)432-0552
LasColinasENTallergy.com

LasColinas
Ear, Nose, Throat & Allergy

J. Byron Mullins M.D.

Notice of Privacy Practice

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.

We are required by law to provide you with this notice that explains our policy practices with regards to your medical information and how we may use and disclose you protected health information for treatment, payment, and for your health care operations, as well as for other purposes that are permitted or required by law.

Ways in which we may use your Protected Health Information:

The following paragraphs describe different ways that we can use and disclose your protected health information. We have provided an example for each category, but these examples are not meant to be exhaustive.

• **Treatment-** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. We will also disclose your health information to other physicians who may be treating you. Additionally, we may from time to time disclose your health information to another physician whom we have requested to be involved in your case. For example- we would disclose your health information to a specialist to whom we have referred you for diagnosis to help in your treatment.

• **Payment-** We will use and disclose your health information to obtain payment for the health care services we provide you. For example- we may use medical information with a bill to a third-party payer that identifies you, your diagnosis, procedures performed, and supplies used in rendering the services. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services.

• **Health Care Operations:** We will use and disclose your protected health information to support the business activities of our practice. For example- we may use medical information about you to review and evaluate out treatment and services or to evaluate our staff's performance while caring for you. In addition, we may disclose your health information to third party business associates who perform billing, consulting, or transcription services for our practice.

Other ways we may use and disclose your protected health information:

• **Appointment Reminders:** We will contact you by phone to confirm scheduled appointments and/or relay information regarding surgery or treatment information. If you are not available we may leave a detailed message on your answering machine or voicemail.

• **Treatment Alternatives:** We will use and disclose your protected health information to tell you about or to recommend possible alternative treatments or options that may be of interest to you.

• **Others Involved In Your Care:** We will use and disclose your protected health information to a family member, a relative, a close friend, or any other person you identify that is involved in your medical care or payment for care.

• **Research:** We will use and disclose your protected health information to researchers provided the research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

• **As Required by Law:** We will use and disclose your protected health information when required by federal, state, or local law. You will be notified of any such disclosures.

• **To Avert a Serious Threat to Public Health or Safety:** We will use and disclose your protected health information to a public health authority that is permitted to collect or receive the information for the purpose of controlling disease, injury, or disability. If directed by that health authority, we will disclose your health information to a foreign government agency that is collaborating with the public health authority.

• **Worker's Compensation:** We will use and disclose your protected health information for workers compensation or similar programs that provide benefits for work- related injuries or illness.

LasColinas
Ear, Nose, Throat & Allergy

J. Byron Mullins M.D.

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that complied it, the information belongs to you. You have the right to:

A Paper Copy of This Notice: You have the right to receive a paper copy of this notice upon your request. You may obtain a copy by asking our receptionist at your next visit or by calling and asking us to mail you a copy.

Inspect and Copy: You have the rights to inspect and copy the protected health information that we maintain about you in our designated records set for as long as we maintain that information. This designated record set include your medical and billing records, as well as any other records we use for making decisions about you. Any psychotherapy notes that may have been included in records we received about you are not available for your inspection or copying by law. We may charge you a fee for the copying, mailing, or other supplies used in fulfilling your request.

If you wish to inspect or copy your medical information, you must submit your request in writing to our practice manager. You may mail in your request, or bring it to our office. We will have 30 days to respond to your request for information that we maintain at our practice. If the information is stored off-site, we are allowed up to 60 days to respond but must inform you of this delay.

Request Amendment: You have the right to request that we amend your medical information if you feel that it is incomplete or inaccurate. You must make this request in writing to our practice manager, stating exactly what information is incomplete or inaccurate and the reasoning that supports your request.

We are permitted to deny your request if it is not in writing or does not include a reason to support the request. We may also deny your request if:

- the information was not created by us, or the person who created it is no longer available to make the amendment;
- the information is not a part of the records which are permitted to inspect and copy;
- the information is not part of the designated records set kept by this practice; if it is the opinion of the health care provider that the information is accurate and complete.

Request Restrictions: You have the right to request restriction or limitation of how we use or disclose your medical information for treatment, payment, or health care operations. For example- you could request that we do not disclose information about prior treatment to a family member or friend who may be involved in your care or payment for care. Your request must be made in writing to our practice manager.

We are not required to agree to your request if we feel it is in your best interest to use or disclose that information. However, if we do agree, we will comply with your request unless that information is needed for emergency treatment.

An Accounting of Disclosures: You have the right to request a list of the disclosures of your health information we have made outside of our practice that were not for treatment, payment, or health care operations. Your request must be made in writing and must state the time period for the requested information.

Your first request for a list of disclosures within a 12 month period will be free. If you request an additional list within 12 months of the first request, we may charge you a fee for the cost of providing the subsequent list. We will notify you of such costs and afford you the opportunity to withdraw your request before any costs are incurred.

Request Confidential Communications: You have the right to request how we communicate with you to preserve your privacy. For example- you may request that we call you only at your work number, or by mail at a special address or postal box. You request must be made in writing and must specify how or where we are to contact you. We will accommodate all reasonable requests.

File a Complaint: If you believe we have violated your medical informationprivacy rights, you have the right to file a complaint with our practice manager or directly to the Secretary of Health and Human Services.

To file a complaint with our manager, you must make it in writing within 180 days of the suspected violation. Provide as much detail as you can about the suspected violation. You should know that there would be no retallation for your filing a complaint. Send your concerns to: J. Byron Mullins, M.D. 7449 Las Colinas Blvd #100, Irving, Texas 75063

Uses or Disclosures Not Covered:

Uses or disclosures of your health information not covered by this notice or the laws that apply to us may only be made with your written authorization. You may revoke such authorization in writing at any time and we will no longer disclose your health information about you for the reason stated in your written authorization. Disclosures made in reliance on the authorization prior to the revocation are not affected by the revocation.

For more information:

If you have any questions or would like additional information, you may contact our practice manager.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our main phone number.

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

Print name: _____ Signature: _____ Date: _____

7449 Las Colinas Blvd, Suite 100• Irving, Texas, 75063 • Tel (972)432-8282 • Fax (972)432-0552
LasColinasENTallergy.com

LasColinas
Ear, Nose, Throat & Allergy

J. Byron Mullins M.D.

Las Colinas Ear, Nose, Throat, and Allergy is required by CMS to report on the following items. Accounting on such items does not reflect the views of the practice. Please use the "Refuse to report" option if you care to not participate.

Please check all that apply:

Race/ Raza:

( ) American Indian or Alaska Indian ( ) African American ( ) Native Hawaiian or Other

( ) White ( ) Refuse to report

Ethnicity/ Etnicidad:

( ) Latino Hispanic ( ) Non-Latino or Non-Hispanic ( ) Refuse to report

Language/ Lenguaje:

( ) English ( ) French ( ) German ( ) Japanese ( ) Mandarin ( ) Russian ( ) Spanish
( ) Other ( ) Refuse to report

Medication History Consent:
I authorize Las Colinas Ear, Nose, Throat, and Allergy to retrieve Medication History from the national pharmacy database for me or my dependent, in order to reconcile prescriptions purchased through my current and/or previous insurance and therefore properly render treatment.

Pharamcy Information:

Preferred Pharmacy Name _____

Address or Location _____ City _____

Signature _____ Date _____

Print Name _____

7449 Las Colinas Blvd, Suite 100• Irving, Texas, 75063 • Tel (972)432-8282 • Fax (972)432-0552
LasColinasENTallergy.com