Raza Pasha, MD / Philip A. Matorin, MD

Personal Health History Form

This form will be part of your medical record. Upon completion, please sign the last page.

Name: _____ Date: ____/____/20____
Last First MI

Who is your Primary Physician? _____

Have you seen an ENT physician before? Yes No Physicians Name: _____

Pharmacy Name and Phone Number: _____

The main problem that brings me to clinic is: _____

_____

Past Medical History

Check any conditions that you have or have had in the past.

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ COPD/Emphysema
- ☐ Diabetes
- ☐ Migraines
- ☐ Epilepsy (seizure)
- ☐ GERD/Peptic Ulcers
- ☐ Heart disease (heart attack, CHF)
- ☐ Hepatitis or liver disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Immune deficiency
- ☐ Stroke
- ☐ Multiple Sclerosis
- ☐ Alcoholism/Chemical Dependency
- ☐ Psychiatric Care
- ☐ Anxiety/ Depression /Panic Attacks
- ☐ Tuberculosis
- ☐ Sleep apnea
- ☐ Kidney disease
- ☐ Thyroid disorder

Have you had Cancer? ☐ Yes ☐ No Type and Treatment? _____

Do you have any other medical conditions? _____

Could you be pregnant (women in childbearing years)? ☐ Yes ☐ No

Past Surgical History

Check any ENT procedures you have had in the past.

- ☐ Tonsillectomy/Adenoidectomy
- ☐ Septoplasty
- ☐ Voice Box (Larynx) Surgery
- ☐ Ear tubes or other Ear Surgery
- ☐ Rhinoplasty
- ☐ Sinus Surgery
- ☐ UP3 (sleep apnea surgery)

List any other surgeries or procedures?

_____

_____

Social History

Do/have you smoked? ☐ Yes ☐ No Did you quit? ☐ Yes ☐ No How long ago? _____

If so, how much and how long have/did you smoke? _____ pack(s)/day for _____ year(s)

Do/have you drink alcohol? ☐ Yes ☐ No Did you quit? ☐ Yes ☐ No How long ago? _____

If so, how much do/did you drink? _____

Have you or currently use any "street drugs"? ☐ Yes ☐ No What type? _____

Medications and Medicine Allergies

List all prescription and non-prescription medications you currently take: ☐ None

Medication	Medication
Medication	Medication
Medication	Medication
Medication	Medication

Do you take aspirin? ☐ Yes ☐ No

What medications are you allergic or have had bad reactions? ☐ None

Medication Medication Medication

Family History

Does anyone in your family have any of the following?

☐ Cancer – What type? _____

☐ Allergies	☐ Diabetes	☐ Thyroid disease
☐ Bleeding disorders	☐ Heart disease	☐ Problems with anesthesia
☐ Cystic fibrosis	☐ Hearing Loss	

Are there any other diseases that run in your family? _____

Birth History (Patients under 12 years of age)

What type of delivery did you have? ☐ vaginal delivery ☐ cesarean delivery
☐ full term ☐ premature ____ week(s) ☐ late ____ week(s)

Were there any complications during or after delivery? ☐ none

☐ Intensive Care Stay	☐ Jaundice	☐ Meningitis	☐ Other: _____
☐ Intubated (breathing machine)	☐ Low birth weight	☐ Neonatal Infection	

Are your child's immunizations up-to-date? ☐ yes ☐ no ☐ scheduled

Review of Symptoms

Have you had any of the following in the last 48 hours?

☐ Changes in vision	☐ Fever (>100.5°)	☐ Numbness or weakness
☐ Diarrhea/Constipation	☐ Irregular heart beat	☐ Problems urinating
☐ Difficulty in breathing	☐ Muscle Aches	☐ Skin changes
☐ Feeling anxious	☐ Nausea or vomiting	☐ Unexplained weight loss

Have you had any of the following in regards to your ears? ☐ No

☐ Dizziness/Vertigo	☐ Ear drainage	☐ Ear fullness or pressure
☐ Ear pain	☐ Noise or ringing in the ears	☐ Worsening hearing

Have you had any of the following in regards to your throat? ☐ No

☐ Bad breath	☐ Difficulty Swallowing	☐ Dry mouth
☐ Gagging	☐ Hoarseness	☐ Heartburn
☐ Lump in throat	☐ Post nasal drip	☐ Pain on swallowing

Do you have problems with any of the following? ☐ No

☐ Daytime tiredness	☐ Gasping at night	☐ Mouth breathing
☐ Snoring	☐ Stop breathing at night	

Please rate by circling the following symptoms from 0 (no problem) to 5 (severe problem), when you experience the symptom.

1. Need to blow nose	0	1	2	3	4	5
2. Sneezing	0	1	2	3	4	5
3. Runny nose	0	1	2	3	4	5
4. Cough	0	1	2	3	4	5
5. Post-nasal discharge	0	1	2	3	4	5
6. Thick nasal discharge	0	1	2	3	4	5
7. Ear fullness	0	1	2	3	4	5
8. Dizziness	0	1	2	3	4	5
9. Ear pain	0	1	2	3	4	5
10. Facial pain/pressure	0	1	2	3	4	5
11. Difficulty falling asleep	0	1	2	3	4	5
12. Wake up at night	0	1	2	3	4	5
13. Lack of sleep	0	1	2	3	4	5
14. Wake up tired	0	1	2	3	4	5
15. Fatigue	0	1	2	3	4	5
16. Reduced productivity	0	1	2	3	4	5
17. Reduced concentration	0	1	2	3	4	5
18. Frustrated/restless/irritable	0	1	2	3	4	5
19. Sad	0	1	2	3	4	5
20. Embarrassed	0	1	2	3	4	5

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of the office staff responsible for errors or omissions that I may have made in completing this form.

_____ _____ - _____ - 20___

Signature of Patient Date

TEXAS OTOLARYNGOLOGY PARTNERS

Raza Pasha, M.D., P.A. Philip A. Matorin, M.D., P.A.

REGISTRATION INFORMATION

Date_____ Cell Phone_____ Work Phone_____ Email_____

Patient Last Name_____ First Name_____ Initial_____

Street Address_____

City_____ State_____ Zip_____

Sex ☐ M ☐ F Age_____ Birth date_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Social Security #_____ Driver's License #_____

Insured Name_____ How and where did you learn about this clinic?_____

Last Name First Name Initial

Relationship To Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Condition/ Illness Related To ☐ Illness ☐ Employment ☐ Auto ☐ Other

EMPLOYER

Company Name_____ Occupation_____

Address_____ Phone_____ ☐ Full-time ☐ Part-time

City_____ State_____ Zip_____ Years Employed_____

SPOUSE (PARENT)

Name_____ Birthdate_____ SSN:_____

Last Name First Name Initial

Employer Name_____ Years Employed_____

Address_____ Phone_____ Occupation_____

City_____ State_____ Zip_____ ☐ Full-time ☐ Part-time

PATIENT INSURANCE INFORMATION

Please list any and all insurance and/or employee health care plan coverage you or your spouse may have

Insurance Company or Health Care Plan Name_____

Policy/Group #:_____ Effective Date:_____

Name of Insured: ID #:

SPOUSE COINSURANCE INFORMATION

Please list any and all coinsurance and/or employee health care plan coverage you or your spouse may have

Insurance Company or Health Care Plan Name_____

Policy/Group #:_____ Effective Date:_____

Name of Insured: ID #:

MEDICAL AND LEGAL INFORMATION

Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury someone else might be legally liable for? ☐ Yes ☐ No Your Initials:_____

If you answered yes, please fill out accident specific form, available at the front desk.

Pregnant ☐ Yes ☐ No Pacemaker ☐ Yes ☐ No Family Physician_____

Person to contact in emergency (Name and Phone #)_____

Attorney_____ Telephone:_____

Address

Patient Agreement & Authorization For The Release Of Medical And Health Plan Documents For The Claims Processing & Reimbursement As Required by Federal and State Laws

Legal Assignment Of Benefits And Designation Of Authorized Representative

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to the above named healthcare provider(s), as my designated Authorized Representative(s), all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above named provider(s) to release all medical information necessary to process my claims under HIPAA. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from such provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named provider(s), to the full extent permissible under the law and under any applicable employee group health plan(s), insurance policies or liability claim, any claim, chose in action, or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s) under any applicable insurance policies, employee benefits plan(s) or public policies with respect to medical expenses incurred as a result of the medical services I received from the above named provider(s), and to the full extent permissible under the law to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but are not limited to, (1) obtaining information about the claim to the same extent as the assignor; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by such provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, bring suit by such provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____

Signature of Insured / Guardian Date

Raza Pasha, M.D., P.A. Philip A. Matorin, M.D., P.A.

FINANCIAL POLICY

Thank you for choosing us for your medical care. Our goal is to provide you with the highest quality medical care at affordable cost. To make our services available to as many patients as possible on an affordable basis, we have adopted the financial collection policy outlined below. We ask you to read the policy carefully and sign prior to any treatment.

- WE MAY ACCEPT ANY ASSIGNABLE INSURANCE WITH APPLICABLE COVERAGE.
- WE OFFER FINANCIAL ASSISTANCE (DISCOUNT, WAIVER OR REDUCTION OF DEDUCTIBLES, CO-PAYS AND CO-INSURANCE) UNDER OUR INDIGENCY POLICY TO ALL ELIGIBLE PATIENTS ON CASE-BY-CASE BASIS.
- FULL PAYMENT IS DUE AT TIME OF SERVICE UNLESS ARRANGED OTHERWISE.
- WE ACCEPT CASH, CHECKS, OR VISA/MASTERCARD, AND AMERICAN EXPRESS CARD.
- WE OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL.

Dishonored checks will be charged back to the patient's account with a service fee of $25.00. Dishonored checks not redeemed within 20 working days of written notice to the maker will be referred to the prosecutor for collection.

Regarding Insurance

We may accept assignment of insurance benefits at our discretion if acceptable insurance identification is provided. Acceptable insurance identification is defined as a valid insurance card, policy/plan with applicable coverage, or telephone verification. As a courtesy to our patients, verifiable and assignable insurance will be billed by this surgeon's office. However, you will be personally responsible for your account balance regardless whether or not if your insurance will pay for the total balance of your claims, unless you're eligible for discounts under our indigence policy predetermined before the services are rendered. Your insurance policy/employee benefits plan is a contract between you and your insurance company/employee benefits plan. We are not a party to that contract. In the event we do not accept assignment of benefits we require that you be pre-approved on our extended payment plan by providing a credit card or personal checking account with authorization to charge that amount for the balance due, if your insurance company/employee benefits plan has not paid your account in full within 45 days or has determined your claims to be your responsibility for the reasons of annual deductible, co-payment, non-covered services and not medically necessary.

We incorporate by reference the document entitled Consent/Disclosure Form that details the Legal Assignment of Benefits and Designation of Authorized Representative. This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original.

If a patient chooses or is required to bill his/her own insurance, this office will provide an itemized statement and a HCFA-1500 Form to the patient, but will treat the account as a self-pay.

Regarding Discount

We may offer discounts, reduction or waiver of deductibles, co-insurance and co-pay to any eligible patients based on medical needs and ability to pay on a case-by-case basis under our Corporate Indigency Policy in accordance with applicable federal and state laws. You may apply for medical indigency discount assistance by asking our practice manager to determine if you are eligible.

Regarding Surgeon and Facility Charges

We will disclose to every patient our surgeon charges as clearly as practically possible before your medical or surgical procedures if it is known to us. Please feel free to ask our staff if you have any questions about charges and your payment responsibilities.

As you may be aware, your insurance company requires your doctors and surgeons to charge and bill the services separately from surgical facilities or hospitals. You shall not be surprised that you will receive separate surgeon, anesthesiologist, diagnostic labs, radiologists, pathologists, and others in addition to the surgical facility bills for your surgery. If you have any questions about your surgical facility bills, please direct your questions to that surgical center.

While we don't anticipate any unforeseeable circumstances, we have no control over any such event(s) that may arise. Should you require additional medical or surgical care in any event of the post surgical complications and reactions, you may incur additional expenses at this facility or outside this facility, such as a hospital.
The charges only include the stated date of services at this facility and do not include any other date of services from us or other providers and facilities.

Regarding PPO and HMO Network Participation

As you may know, you may have choice to choose a surgeon or surgical facilities with or without PPO or HMO participation under different insurance coverage and benefits levels. We are dedicated to providing highest quality care to every patient; however, we have no power to change your insurance coverage or network limitations. Most health care plan or insurance policies may provide surgical coverage to non-PPO providers and facilities, but at lower percentage of insurance reimbursement. Although it is your responsibility to verify your insurance coverage for non-PPO/HMO providers, we will always disclose to you as to our participation status to your insurance plan. We also provide every patient with information regarding financial assistance or discounts with high deductible plans or coinsurance per our Corporate Indigency Policy in accordance with federal and state laws.

We will verify your insurance coverage and obtain pre-certification, if applicable, for all services as a courtesy to you before your medical services. Please understand that all insurance verification is not a guarantee of insurance payment.

Compliance & Disclosure under Texas Occupation Code – Section 102.006

In compliance with Section 102.006 of Texas Occupations Code in connection with my informed consent and personal choice of doctors and facility solely based on the quality and safety of care, reputation of patient satisfaction, and my knowledge in my decision-making in

Patient's Initials _____

exercising my rights with respect to the in-network or out-of-network coverage and cost sharing, my attending doctor(s) and/or clinic (facility) have disclosed to me at the time of initial contact and at the time of referral with respect to the choice of a doctor or facility solely in the interest of my healthcare quality and safety, as a result of my informed consent and personal choice of doctor(s) and/or facility: (A) his/her affiliation, if any, with the doctor or facility for whom the patient is referred and (B) that he/she will receive, directly or indirectly, remuneration for referring upon my such request and exercising my rights of freedom of choice for the provider(s) and facility under the in-network or out-of-network coverage as provided by my health plan, in compliance with all applicable federal and state laws, Medicare, ERISA, PPACA and the Section 102.006 of Texas Occupations Code.

Town Park Surgery Center, Oprex, Altus HMS, Altus DME (Group Care), ASC Houston Management, Altus Houston Hospital, Altus Pharmacy (Altus Rx), Oak Pharmacy, Custom Rx, Altus Pharmacy Management, Clarus Imaging Center, Westside Surgical Hospital, and Zerenity Sleep Center are all entities owned by local area physicians. As such, Drs. Pasha and Matorin may have an affiliation and receive remuneration in these entities.

- As an alternative to receiving your treatment at/by Town Park Surgery Center, Town Park Surgery Center, Oprex, Altus HMS, Altus DME (Group Care), ASC Houston Management, Altus Houston Hospital, Altus Pharmacy (Altus Rx), Oak Pharmacy, Custom Rx, Altus Pharmacy Management, Clarus Imaging Center, Westside Surgical Hospital, and Zerenity Sleep Center, you may choose another facility or health care service provider.
- You have free choice to obtain medical services elsewhere and you will not be treated differently by your physician if you choose a health care facility or service provider other than those entities.

If you have any questions, you may contact Manny Gerardo at (281) 920-5558.

Your responsibility for Cooperation

If we accept your insurance assignment as a payment from your insurance reimbursement, you agree to timely cooperate with your insurance company or health plan in the course of insurance claim processing, such as insurance inquiries, requests for additional information, claims status verification or any inquiries for the purpose of your claim processing. You also agree to notify us immediately of any insurance inquiry or request for additional information and provide us with a copy of any documentation received from the insurance company or submitted to insurance company from you.

In an event that you do receive insurance payment checks for your surgeries rendered by this doctor, you agree to submit such insurance reimburse check to our office with five (5) business days after your receipt of insurance checks. In a failure or refusal to forward or send us the insurance reimbursement checks for the medical services from this provider, all of your discount arrangement will be voided, and the total balance is due immediately, as there is no justification for you to keep the insurance payment for our services as you promised to pay for our services. You further agree to compensate us for any legal fees if we have to retain any legal services to collect balances.

Indigency Policy and Agreement

As fully explained in our Corporate Indi gency Policy, indigency discount is no different than all PPO discounts from BCBS or all other commercial insurers in compliance with all applicable federal and state laws with respect to indigency assistance without any routine waiver or cost sharing, advertising, or solicitation, for underinsured or uninsured patients. Once indigence is determined, collection is no longer undertaken with regard to the patient for the forgiven amount without waiving any patient financial and legal obligation or responsibility to the provider's actual total charges AND patient's right and eligibility, assigned to the provider, to claim for the reimbursement, under the health plan coverage, based on the provider's actual total and reasonable charges in accordance with Provider's Corporate Indigency Policy, as the Indigence determination itself is a good effort to collect, and hospitals or doctors are NOT required under any federal or state laws, Medicare, ERISA & PPACA, to take low-income, medically indigent, uninsured or underinsured patients to court, garnish their wages, or seize their homes, or send claims out to a collection agency when those patients don't or can't pay their hospital or doctor bills.

It would be possible to receive a discount based on being medically indigent, if you declare that without following indigent assistance, seeking for and continuing with medically appropriate and important health care would be impossible for you to or make you indigent if you were forced to pay full charges for your medically necessary care expenses. You would be required to request for such indigent assistance only after you are fully informed of the important medical treatment options and necessity solely based on your particular medical needs and availability of this provider's Indigency policy.

"Nothing in the Centers for Medicare & Medicaid Services" (CMS') regulations, Provider Reimbursement Manual, or Program Instructions prohibit a healthcare provider from waiving collection of charges to any patients, Medicare or non-Medicare, **including income, uninsured or medically indigent individuals, if it is done as part of the healthcare provider's Indigency policy."**

"By **"Indigency policy"** we mean a policy developed and utilized by a healthcare provider to determine patient's financial ability to pay for services. By **"medically indigent,"** we mean patients whose health insurance coverage, if any, does not provide full coverage for all of their medical expenses, relationship to their income, would make them indigent if they were forced to pay in full charges for their medical expenses."

We are committed to serving you with the highest quality care possible at affordable cost. Every staff member at our office is ready to help you at all times.

If you have any questions regarding our financial policies, please do not hesitate to ask us at any time. We thank you for your cooperation.

I have read the Financial Policy. I understand and fully agree to this Financial Policy.

X _____ _____

Signature of Patient or Responsible Party Patient Name (print) Date

X _____ _____

Signature of Co-Responsible Party

Raza Pasha, M.D., P.A. Philip A. Matorin, M.D., P.A.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have a certain right to privacy regarding my Protected health information. I understand that the information can and will be use to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment for third- party payers.
- Conduct normal healthcare operations, such as quality assessment and physicians certifications.

I have reviewed, read the office's Notice of Privacy Practices, posted in the lobby. I understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practice from time to time and that I may contact this organization at any time to obtain a current copy of Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

X _____ _____ _____

Signature of Patient or Responsible Party | Patient Name (print) | Date

Raza Pasha, M.D., P.A.

Philip A. Matorin, M.D., P.A.

PATIENT CONSENT FOR DISCLOSURE

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided to right to request confidential communications be made by alternative means, such as sending correspondence to the individual's office, instead of the home.

Patient Name: _____, _____, _____
(Last) (First) (Middle)

Home Phone: _____

O Ok to leave a message with detailed information

O Leave message with call back number only

Daytime Phone: _____

O Ok to leave a message with detailed information

O Leave message with call back number only

Cell Phone: _____

O Ok to leave a message with detailed information

O Leave message with call back number only

Authorized persons that can obtain my personal health information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

If Patient is a Minor:

Parent or Guardian (Printed Name): _____, _____, _____
(Last) (First) (Middle)

Relationship to Patient: Self Parent Legal Guardian Other

X _____ _____
Signature of Patient or Responsible Party Patient Name (print) Date