SOUTHERN OTOLOGIC CLINIC

**today's date:** _____/____/____

**Mr./Mrs./Miss:** last _____ first _____ middle _____ age _____ birthdate ___/___/___

Street _____ City/State/Zip _____

Miles from Augusta _____ Nearest Large City _____

Home phone _____ _____ Cell phone _____ _____ Social Security Number_____

Occupation _____ Employer/School _____

Employer/School Address _____

City/State/Zip _____ Employer/School Telephone _____ _____

If Retired, Last Occupation/Employer _____

Pharmacy_____ Address _____ ZIP_____ Phone_____

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**Spouse/Parent:** last _____ first _____ middle _____ birthdate ___/___/___

Street _____ City/State/Zip _____Home phone ____ _____ Cell phone ____ _____

Occupation _____ Employer/School _____Social Security Number _____

Employer/School Address _____

City/State/Zip _____ Employer/School Telephone _____ _____

**Other Parent:** last _____ first _____ middle _____ birthdate ___/___/___

Street _____ City/State/Zip _____Home phone ____ _____ Cell phone ____ _____

Occupation _____ Employer/School _____Social Security Number _____

Employer/School Address _____

City/State/Zip _____ Employer/School Telephone _____ _____

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**Nearest Friend or Relative Not Living at the Same Address:**

last _____ first _____ middle _____ Relationship to Patient _____

Street _____ City/State/Zip _____ Telephone _____ _____

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**Local Doctor:** _____Street _____City/State/Zip _____

**Local ENT MD:** _____Street _____City/State/Zip _____

**Other Doctors Seen About the Present Illness:**

Name: _____Street _____City/State/Zip _____

Name: _____Street _____City/State/Zip _____

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**Referred to this Office by:** friend family phonebook internet Dr.: _____

**Would you like office record emailed to you? if so, give us your email address:** _____

SOUTHERN OTOLOGIC CLINIC

# Medical Summary

*date:* .....

*first:* ..... *middle:* ..... *last:* .....

*please list any medication allergies:*

| | | | |
|---|---|---|---|
| ***are you allergic to Latex?*** | no | yes | _____ |
| ***have you ever had any problem or reaction to anesthesia?*** | no | yes | _____ |
| ***do you have any bleeding tendency?*** | no | yes | _____ |
| ***do you take vitamin E, aspirin, Plavix, Coumadin?*** | no | yes | _____ |
| ***are you HIV positive?*** | no | yes | _____ |
| ***have you ever had hepatits or tested positive for any form of hepatitis?*** | no | yes | _____ |
| ***do you use any type of tobacco product?*** | no | yes | _____ |
| ***do you use alcoholic beverages?*** | no | yes | _____ |
| ***have you ever had Bells palsy or facial paralysis?*** | no | yes | _____ |

*please list any current medical conditions:*

*please list all medications you are taking:*

*please list all surgical procedures or operations you have had:*

| operation | date | surgeon |
|---|---|---|

_____ **William H. Moretz, Jr., M.D.**

reviewed and corrected as necessary


# Consent for Purposes of Treatment
# Privacy Rights
# Payment Policies

• I hereby authorize and consent to such diagnostic tests and treatments at the Southern Otologic Clinic P.C.(the Provider), including, but not limited to diagnostic procedures and minor or major surgical procedures as may be ordered by or performed by William H. Moretz, Jr., M.D., his assistants, designees, or consultants, and all other acts as may be necessary, appropriate, or helpful to these services. I acknowledge that NO GUARANTEE has been given to me, or will be given to me, concerning the results of examination and treatment.

• Health care personnel in training may, unless I request otherwise, be present and observe my care.

• I consent to the use or disclosure of my protected health information by Southern Otologic Clinic, P. C. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Southern Otologic Clinic, P.C. I understand that diagnosis or treatment of me by William H. Moretz, Jr., M.D. may be conditioned upon my consent as evidenced by my signature on this document.

• I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The Southern Otologic Clinic, P.C. is not required to agree to the restrictions that I may request. However, if the Southern Otologic Clinic, P.C. agrees to a restriction that I request, the restriction is binding on the Southern Otologic Clinic, P.C. and William H. Moretz, Jr., M.D.

• I have the right to revoke this consent, in writing, at any time, except to the extent that the the Southern Otologic Clinic, P.C. or William H. Moretz, Jr., M.D. has taken action in reliance on this consent.

• My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

• I understand I have a right to review the the Southern Otologic Clinic, P.C.'s Notice of Privacy Practices prior to signing this document. The Provider's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Southern Otologic Clinic, P.C. The Notice of Privacy Practices for Southern Otologic Clinic, P.C. is provided in the office located at 818 St. Sebastian Way, Suite 204, Augusta, Georgia 30901. This Notice of Privacy Practices also describes my rights and the Provider's duties with respect to my protected health information.

• Southern Otologic Clinic, P.C. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

• I authorize payment of all insurance benefits , which may be otherwise payable to the patient or me, to be paid dIrectly to the Provider (Southern Otologic Clinic, P.C. or William H. Moretz, Jr., M. D.) but not exceeding the balance due of the Provider's regular charges for services. I understand that if the Provider accepts assignment on claims, that the patient or I am responsible for any co-insurance, deductible and noncovered services.

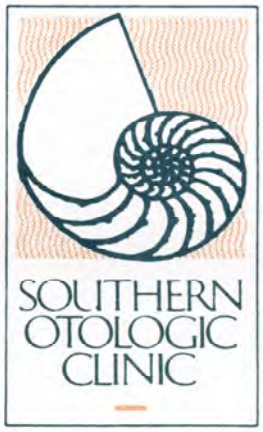
• The undersigned agrees whether he/she signed as insured, guarantor, guardian or Patient, that in consideration of the items and services to be rendered to the Patient, he/she individually obligates himself/herself to pay for the services in in accordance with the Provider's ( Southern Otologic Clinic, P.C. or William H. Moretz, Jr., M.D.) charges for professional services which may include coinsurance, deductibles, and charges for services that are not covered in full or in part by any third party payor furnishing health care insurance to ther Patient. I further understand that the Provider may not be a "participating Provider" with the Patient's insurer and that, in the event that the Southern Otologic Clinic, P.C. or William H. Moretz, Jr., M.D. do not participate with the Patient's insurer, the undersigned will be financially responsible for that portion of the charges not covered by the Patient's insurer. I understand that I will be billed for these charges after the Provider makes reasonable efforts to collect such charges from my third party payor and that my account will be considered in default after 90 days from the date of service or otherwise set forth under state law. Should the account be declared in default and referred to collections, whether it be a collection agency or an attorney, the Provider reserves the right to collect and the undersigned shall pay the Provider or its agents all collection costs and further agrees that the court may assess additional charges against the undersigned.

• I understand that William H. Moretz, Jr., M.D. is a member of the Medical Staff of University Hospital, not an employee or agent of University Hospital. In addition, I understand I may receive a separate bill for services (not rendered by the Southern Otologic Clinic, P.C., or William H. Moretz, Jr., M.D.) which may be rendered by other providers including radiology, anesthesiology or other professional or hospital services.

I CERTIFY THAT I HAVE READ (OR HAD READ TO ME) AND FULLY UNDERSTAND THIS DOCUMENT

Date: _____ Signed X _____

_____
relationship if other than patient




# Authorization to Release Medical Information

I authorize the release of my medical records from:

_____
name of doctor or hospital

_____
street address

_____
street address

_____
city/state/zip

To be forwarded to:

William H. Moretz, Jr., MD
Southern Otologic Clinic PC
818 St. Sebastian Way
Suite 204
Augusta, Georgia 30901

706 724 0668
fax 706 724 1124

Date: _____ Signed X _____

_____
patient's name | patient's date of birth | social security number

_____
street address

_____
city/state/zip

Records requested: _____