PATIENT REGISTRATION

Jacksonville Hearing & Balance Institute At Center One

PATIENT NAME (FIRST, MIDDLE, LAST)		**DATE OF BIRTH**			
SOCIAL SECURITY NUMBER		**GENDER**	☐ Male ☐ Female		
RESPONSIBLE PARTY'S NAME (if other than patient)					
HOME ADDRESS		**APT NUMBER**			
CITY		**STATE**		**ZIP**	
HOME PHONE	( ) -	**CELL PHONE**	( ) -		
EMAIL ADDRESS		**PREFERRED CONTACT**	☐Home Phone ☐Cell Phone ☐Email		
MARITAL STATUS	☐ Single ☐ Married ☐ Widowed ☐ Divorced	**LANGUAGE**	☐ English ☐ Other:		
RACE	☐ White ☐ Black ☐ Asian/Pacific Islander ☐ Hispanic ☐ American Indian ☐ Other ☐ Do not wish to respond				
ETHNICITY	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Do not wish to respond				
EMERGENCY CONTACT NAME		**PHONE NUMBER**	( ) -		
EMPLOYER NAME		**WORK NUMBER**	( ) -		
PRIMARY INSURANCE		**POLICY NUMBER**			
POLICY HOLDER'S NAME		**POLICY HOLDER'S DATE OF BIRTH**			
SECONDARY INSURANCE		**POLICY NUMBER**			
POLICY HOLDER'S NAME		**POLICY HOLDER'S DATE OF BIRTH**			
IS THIS APPOINTMENT RELATED TO AN AUTO-ACCIDENT OR WORK-RELATED INJURY?			☐ Yes ☐ No		
IF YES, WHAT WAS THE DATE OF INJURY?					

LEGAL GUARDIAN, SPOUSE, PARENT OR POWER OF ATTORNEY INFORMATION

FULL NAME		**RELATIONSHIP TO PATIENT**			
PHONE NUMBER	( ) -	**DATE OF BIRTH**			
HOME ADDRESS		**APT NUMBER**			
CITY		**STATE**		**ZIP**	

ADDITIONAL INFORMATION

HOW DID YOU HEAR ABOUT US?			
REFERRING PHYSICIAN		**PRIMARY CARE PHYSICIAN (PCP)**	
WHAT PHARMACY DO YOU USE?		**PHONE NUMBER**	( ) -
PHARMACY ADDRESS/STREET			
DO YOU HAVE A LIVING WILL?	☐ Yes ☐ No		

I CERTIFY THAT, TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT SIGNATURE		**TODAY'S DATE**			
PARENT, GARDIAN OR LEGAL REPRESENTATIVE SIGNATURE					

Jacksonville Hearing & Balance Institute (JHBI) is a part of North Florida Surgeons (NFS)

NORTH FLORIDA surgeons

PATIENT REGISTRATION CONTINUED

Jacksonville Hearing & Balance Institute At Center One

PRIVACY NOTICE ACKNOWLEDGMENT
I acknowledge that I have received a copy of **Jacksonville Hearing and Balance Institute "JHBI"/North Florida Surgeons "NFS"** privacy notice. I understand that I am responsible to read this notice and notify **JHBI/NFS**, in writing, of any request for restrictions in the use or disclosure of my individually identifiable health information. **JHBI/NFS** has the right to revise this notice at anytime and will post a copy of the current notice in the office in a visible location at all times. **JHBI/NFS** will provide me with a copy of its most recent notice upon my request.

EMAIL CONSENT
I acknowledge that I have received and read a copy of the **JHBI/NFS** E-mail consent (available upon request). I understand that if I want to correspond by email that I must agree to the terms of the E-mail consent, check the appropriate box. ☐ **I WANT** to correspond by email. I understand the risks associated with the communication of email between the practice and me. I consent to the conditions outlined in the E-mail consent. Any questions I may have had were answered to my satisfaction. ☐ **I DO NOT** want to correspond with the practice by E-mail.

RECORDS RELEASE
I hereby authorize **JHBI/NFS**, and its agents, to release all medical records concerning my treatment as requested by other physicians or hospitals to said physicians or hospitals.

AUTHORIZATION FOR VERBAL RELEASE OF MEDICAL INFORMATION
I hereby authorize **JHBI/NFS** to discuss my medical, payment, scheduling, and healthcare information pertaining to my treatment and care to the following individuals:

FULL NAME		**RELATIONSHIP TO PATIENT**	
FULL NAME		**RELATIONSHIP TO PATIENT**	
FULL NAME		**RELATIONSHIP TO PATIENT**	
FULL NAME		**RELATIONSHIP TO PATIENT**	

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO ALL OF THE TERMS AND CONDITIONS CONTAINED ON THIS PAGE.					
PATIENT SIGNATURE		**TODAY'S DATE**			
PARENT, GARDIAN OR LEGAL REPRESENTATIVE SIGNATURE					
RELATIONSHIP TO PATIENT		***FRONT OFFICE INITALS***			

FINANCIAL AGREEMENT

Jacksonville Hearing & Balance Institute At Center One

PATIENT NAME		DATE OF BIRTH			

FINANCIAL RESPONSIBILITY

I understand that in consideration of the services provided to the patient, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered at **Jacksonville Hearing and Balance Institute "JHBI"/North Florida Surgeons "NFS"**. I am responsible for any applicable deductible or co-payments prior to the provision of services. **JHBI/NFS** will provide me with an estimate of my total financial responsibility and the date by which this amount must be paid in full. I understand that due to the individual needs of each treatment, or procedure this fee is only an estimate. In the event my care exceeds the amount of the estimate, I will be financially responsible for the balance. I further understand that such payment is not contingent on any insurance, settlement or judgment payment. **JHBI/NFS** may file a claim for payment with my insurance company as a courtesy to me. If the insurance company fails to pay **JHBI/NFS** in a timely manner for any reason, then I understand that I will be responsible for prompt payment of all amounts owed to **JHBI/NFS**. Should the account be referred to a collection agency or attorney for collection, the undersigned agrees to pay the collection agency's fee (based on a percentage of your account balance, the current percentage is 33%) and all costs of collection, including a reasonable attorney's fee.

RESPONSIBILITY TO PROVIDE PROOF OF INSURANCE AND OBTAIN REFERRAL

I understand that it is my responsibility to provide **JHBI/NFS** with a copy of my current insurance card and to obtain a referral from my Primary Care Physician (if required by my insurance). **JHBI/NFS** is not obligated to see patients without a valid referral. If I do not have insurance, I will be considered a Private Pay patient and be financially responsible for the total amount of the services provided. I will notify **JHBI/NFS** immediately upon any change in my insurance.

INSURANCE WAIVER

I understand that if I do not have a copy of a current insurance card and valid referral, if required, that I can be seen as a "Private Pay" patient. I agree that neither **JHBI/NFS** nor I will file a claim for the visit. A waiver will be completed for each visit that I am seen as a Private Pay patient. I will be required to pay the total cost of the visit in advance.

Please be aware that when we verify your benefits, your healthcare insurance company discloses to us that verification of benefits is not a guarantee for payment. Payment will be finalized according to your plan's benefits when your healthcare insurance company receives and processes the claim.

ASSIGNMENT OF BENEFITS

I hereby authorize and assign all payments and/or insurance benefits for medical services and/or surgical procedures rendered to patient, directly to **JHBI/NFS**. I hereby authorize **JHBI/NFS** to release medical information necessary to obtain payment. I understand that I am financially responsible for all charges not covered by my insurance plan.

ASSIGNMENT OF MEDICARE BENEFITS

I hereby authorize and assign all payments of authorized Medicare benefits for medical services and/or surgical procedures rendered to patient, directly to **JHBI/NFS**. I hereby authorize **JHBI/NFS** to release medical information necessary to obtain payment. I understand that I am financially responsible for all charges not covered by Medicare for which I have signed an ABN.

LEGAL/DISABILITY FORMS AND LETTERS

I understand that LEGAL/DISABILITY FORMS which need completion by a Physician require a pre-paid fee of **$25.00**. The expected fee for a written letter by a Physician is **$125.00**. Once payment has been received please allow 10 business days for completion of documents requested.

BY SIGNING THIS FINANCIAL AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO ALL OF THE TERMS AND CONDITIONS CONTAINED ON THIS FINANCIAL AGREEMENT PAGE.

PATIENT SIGNATURE		TODAY'S DATE			

FINANCIAL AGREEMENT CONTINUED

Jacksonville Hearing & Balance Institute At Center One

ARBITRATION AGREEMENT

THIS ARBITRATION AGREEMENT is made between **North Florida Surgeons, P.A**., for and on behalf of itself and its subsidiaries, affiliated professional associations, physicians (including physicians providing medical services through a subsidiary of North Florida Surgeons, P.A.), agents, employees, servants, or any of the foregoing, referred to hereinafter as "Doctor" and the above referenced patient ("Patient"). It is the intention of the parties to this Arbitration Agreement to bind not only themselves, but also their heirs, personal representatives, guardians and any persons deriving claims through or on behalf of the patient.

It is understood by the Patient that he or she is not required to use **North Florida Surgeons, P.A**. or any Doctor and that there are numerous other physicians located near Patient who are qualified to provide care to Patient.

In the event of any controversy or dispute, which might arise between Doctor and the Patient, regardless of whether the dispute concerns the medical care rendered, including any negligence claim relating to the diagnosis, treatment, or care of the Patient, or payment of surgical fees, or any other matter whatsoever, then the parties agree that the dispute shall be resolved by arbitration as provided by the Federal Arbitration Act, 9 U.S.C. §§ 1-16.

Other than what may be in conflict with this Arbitration Agreement, the laws of the State of Florida shall apply to any dispute between Doctor and the Patient. The Florida Rules of Civil Procedure shall apply for discovery purposes only.

Prior to commencing any action under this Arbitration Agreement, Patient must comply with the presuit notice and investigation requirements of Chapter 766, Florida Statutes. Any arbitration under this Arbitration Agreement must be commenced by the filing of an application for arbitration within the applicable statute of limitations for the controversy or dispute at issue.

This arbitration shall be in lieu and instead of any trial by Judge or Jury. Each party shall choose one arbitrator and the two arbitrators shall choose a third arbitrator. All arbitrators shall be selected from the following Florida counties: Alachua, Clay, Duval, Nassau, St. Johns and Volusia. The panel of arbitrators shall hear and decide the controversy, and the decision shall be binding on all parties and may be enforced by a court of law if necessary. Arbitration shall be conducted in Duval County, Florida.

In the event that either party to this Arbitration Agreement refuses to go forward with arbitration, the party compelling arbitration reserves the right to proceed with arbitration, including the appointment of the arbitrator and hearings to resolve the dispute, despite the refusal to participate or the absence of the opposing party. The arbitrators shall render a binding decision without the participation of the party opposing arbitration or despite his or her absence at the arbitration hearing.

Except for legal reporting requirements, all arbitration proceedings and outcomes under this Arbitration Agreement will be confidential and private. The parties shall be required to attend non-binding mediation in Duval County, Florida prior to arbitration.

The Patient understands that the Patient has a constitutional right under Article 1, Section 21 of the Florida Constitution of Access to Courts as follows: "The courts shall be open to every person for redress of any injury, and justice shall be administered without sale, denial or delay." The Patient understands and acknowledges that signing this Arbitration Agreement waives this constitutional right.

Should any sentence(s) of this Arbitration Agreement be declared unenforceable or in conflict with the law, the sentence(s) shall be severed and the validity of the remaining parts and provisions shall not be affected by such holding.

The Patient has had an opportunity to read this Arbitration Agreement, or to have it read to him or her if necessary. The Patient understands English or has had this Arbitration Agreement translated for him or her by _____. The Patient has had an opportunity to ask questions about this Arbitration Agreement. The Patient understands this Arbitration Agreement and has no unanswered questions.

The Patient has not been coerced or compelled to sign this Arbitration Agreement, and does so of his or her own free will. The Patient may consult with an attorney before signing this Arbitration Agreement.

BY SIGNING THIS ARBITRATION AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO ALL OF THE ABOVE TERMS AND CONDITIONS.

PATIENT SIGNATURE		**TODAY'S DATE**			
PARENT, GARDIAN OR LEGAL REPRESENTATIVE SIGNATURE					
WITNESS SIGNATURE		***PHYSICIAN SIGNATURE***			

PATIENT MEDICAL HISTORY

Jacksonville Hearing & Balance Institute At Center One

PATIENT NAME		DATE OF BIRTH			
CHIEF COMPLAINT (Reason for your visit)					

PAST MEDICAL HISTORY (Check if you have ever been diagnosed with the following)

☐ Allergies	☐ Cancer/Tumors	☐ Liver Disease	☐ Migraine Headaches
☐ Anemia/Bleeding Disorder	☐ Depression	☐ High Blood Pressure	☐ Seizures/Epilepsy
☐ Anxiety	☐ Diabetes	☐ Hearing Loss	☐ Sickle Cell Disease
☐ Arthritis	☐ Ear Infections	☐ Immunodeficiency	☐ Stroke
☐ Asthma/Chronic Lung Disease	☐ Glaucoma	☐ Kidney Disease	☐ Thyroid Disease
☐ Other (please list):			
☐ **NONE OF THESE APPLY**			

SURGICAL HISTORY (Be sure to include prior ear surgeries)

Type of Surgery	Surgery Date	Type of Surgery	Surgery Date

What is your reaction to anesthesia?	☐ No Reaction ☐ Difficulty Breathing ☐ Difficulty Waking ☐ Other:

FAMILY MEDICAL HISTORY (Check all that apply to any family member(s))

☐ Autoimmune Disease	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparent
☐ Cancer (list):	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparent
☐ Diabetes	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparent
☐ Hearing Loss	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparent
☐ Heart Disease	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparent
☐ High Blood Pressure	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparent
☐ Lung Disease	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparent
☐ Sickle Cell Disease	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparent
☐ Stroke	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparent
☐ Thyroid Disease	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparent
☐ Other (list):	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparent
☐ **NO RELEVANT FAMILY HISTORY**					

SOCIAL HISTORY

Occupation					
Alcohol Consumption	☐ None ☐ Daily ☐ Weekly ☐ Occasionally ☐ Socially				
Tobacco Use	☐ Never ☐ Former ☐ Current	**Type**	☐ Cigarettes ☐ Pipe ☐ Chew ☐ Smokeless ☐ Snuff		
How many packs a day?		**When did you quit?**		**How many years did you smoke?**	
Drug Use	☐ None ☐ Marijuana ☐ Cocaine ☐ Crack ☐ Heroin ☐ Other:				

PATIENT MEDICAL HISTORY CONTINUED

Jacksonville Hearing & Balance Institute At Center One

CURRENT MEDICATIONS (Include insulin, steroids, inhalers, oxygen, eye drops, etc) ☐ **LIST ATTACHED**		
Medication Name	**Strength**	**Frequency**
EXAMPLE: AMOXICILLIN	*500MG*	*THREE TIMES A DAY*
☐ **NO CURRENT MEDICATIONS**		

ALLERGIES AND ADVERSE REACTIONS (Include allergies to antibiotics, latex, dye, pain medications if applicable)
☐ **NO KNOWN ALLERGIES**

REVIEW OF SYSTEMS (Check all conditions that **CURRENTLY** apply)	
Constitutional	☐ Chills ☐ Fatigue ☐ Fever ☐ Weight Loss ☐ Weight Gain ☐ Night Sweats
HEENT (Head, Eyes, Ears, Nose, Throat)	☐ Double Vision ☐ Dizziness ☐ Dysphagia (difficulty swallowing) ☐ Ear Drainage ☐ Hoarseness ☐ Lump in throat ☐ Visual Changes ☐ Hearing Loss
Respiratory	☐ Shortness of Breath ☐ Wheezing
Cardiovascular	☐ Chest Pain ☐ Heart Murmur ☐ Palpitations
Gastrointestinal	☐ Abdominal Pain ☐ Constipation ☐ Diarrhea ☐ Heartburn ☐ Vomiting
Genitourinary	☐ Dysuria (Pain while urinating)
Hematologic	☐ Easy Bruising ☐ Easy Bleeding
Metabolic/Endocrine	☐ Heat intolerance ☐ Cold intolerance ☐ Increased Thirst
Neurological	☐ Difficulty falling asleep ☐ Numbness in extremities ☐ Syncope ☐ Tingling ☐ Tremor ☐ Weakness
Psychiatric	☐ Anxiety ☐ Depression ☐ Hallucinations
Other (please list):	
☐ **NONE OF THESE APPLY**	

I CERTIFY THAT I HAVE DISCLOSED ALL OF MY MEDICAL HISTORY KNOWN TO ME. I ACKNOWLEDGE THAT I AM RESPONSIBLE TO MAKE YOUR OFFICE AWARE OF ANY CHANGES TO MY MEDICAL HEALTH.					
PATIENT SIGNATURE		**TODAY'S DATE**			
PARENT, GARDIAN OR LEGAL REPRESENTATIVE SIGNATURE					
RELATIONSHIP TO PATIENT		***PROVIDER SIGNATURE***			