KIM E. PERSHALL, MD

Name: :_____ Todays Date: _____

PATIENT REVIEW OF SYSTEMS

What was this appointment scheduled for? _____

** This appointment is specifically scheduled to evaluate and treat the condition/problem referenced. To ensure we provide you with the most focused high-quality care, we will only be able to address the condition/problem referred for, anything else will require another appointment.

What Doctor have seen for this problem? _____

Do you consider yourself generally: □ Healthy □ Not Healthy

Are you currently experiencing any of the following conditions:

EYES

□ Blurred Vision □ Painful Eyes □ Irritation From Light

EARS, NOSE, MOUTH & THROAT

□ Itching □ Blocked Nose □ Post Nasal Drip □ Rhinitis (runny nose) □ Sores In Mouth
□ Teeth Hurt □ Bruxism (grinding teeth) □ Difficulty Swallowing □ Painful Swallowing
□ Pressure in Ears □ Hearing Loss

RESPIRATORY (LUNGS)

□ Wheezing □ Cough □ Shortness of breath while sitting

CARDIOVASCULAR (HEART)

□ Palpitations/Fluttering of Heart □ Shortness of breath while exercising □ Chest Pain

MUSCULOSKELETAL

□ Soreness □ Weakness □ Cramping

INTEGUMENTARY (SKIN)

□ Itchy Skin □ Bleeding □ Lesions on Skin □Dry Skin

GASTROINTESTINAL (STOMACH)

□ Constipation □ Diarrhea □ Pain □ Reflux

GENITOURINARY

□ Pain with Urination □ Urination at Night □ Hesitation with Urination

HEMATOLOGIC / LYMPH NODES

□ Bleeding Easily □ Night Sweats

PSYCHIATRIC

□ Mood Swings □ Situational Stress □ Depression □Anxiety

ENDOCRINE

□ Hot Flashes □ Hair Loss/Growth □ Heat/Cold Intolerance

ALLERGY / IMMUNOLOGY

□ Sneezing □ Eye Irritation □ Reactions

NEUROLOGICAL (NERVES)

□ Twitch □ Ringing In Ears □ Dizziness/Vertigo □Abnormal Movements

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American Board of Otolaryngology

Fellow of the
American Academy of Otolaryngic Allergy

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3811 24th Street
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www.kpershallmd.com

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PATIENT HISTORY

Name:_____ Today's Date:_____

Date of Birth: _____ Height: _____ Weight: _____

Race: _____ Ethnicity: _____ Language: _____

PATIENT: **Have you ever had or currently have...**

- ☐ Alcoholism
- ☐ Anemia
- ☐ Angina/Heart Attack
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma/ Hay Fever
- ☐ Birth Defects
- ☐ Bleeding Disorder
- ☐ Cancer_____
- ☐ COPD/Lung Disease
- ☐ Covid
- ☐ Depression
- ☐ Diabetes
- ☐ Dialysis
- ☐ Epilepsy/Seizures
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV /Aids
- ☐ Kidney Disease
- ☐ Liver Problem
- ☐ Lung Problem
- ☐ Meniere's Disease
- ☐ Mental Illness
- ☐ Pacemaker
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid Problem
- ☐ Tuberculosis
- ☐ Other _____

Drug Allergies:

_____

Previous Hospitalizations and Surgeries: _____

_____

_____

Current Medications: _____

_____

_____

Have you had any Covid shots? ☐ Yes ☐ No If yes, When: _____

Are you currently on hospice care? ☐ Yes ☐ No If yes, Name: _____

FAMILY: **Has anyone in your family had or currently have...**

- ☐ Alcoholism
- ☐ Anemia
- ☐ Angina/Heart Attack
- ☐ Arthritis
- ☐ Asthma/Hay Fever
- ☐ Birth Defects
- ☐ Bleeding Disorder
- ☐ Cancer_____
- ☐ Diabetes
- ☐ Dialysis
- ☐ Emphysema/COPD
- ☐ Epilepsy/Seizures
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Failure
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Problem
- ☐ Lung Problem
- ☐ Meniere's Disease
- ☐ Mental Illness
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid Problem
- ☐ Tuberculosis
- ☐ Other_____

SOCIAL: **Do you...**

☐ Exercise	☐ Drink Alcohol	☐ Use Tobacco	☐ Use Drugs
Type:_____	Type:_____	Type:_____	Type:_____
How Often:_____	How Often:_____	How Often:_____	How Often:_____

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Patient Name: _____

INSURANCE DISCLOSURE

- By being a member of your insurance policy, the member agrees to pay any unmet deductibles and copays set by the insurance company. Failure by the responsible party to make such obligated payments, or failure to make payment arrangements with the collections/billing staff, will result in outside collection measures.

- In agreement with your insurance company, this office is legally obligated to bill you for any required copayment and unmet deductibles. IF we failed to do this we would be held responsible for breaking our contract agreement causing possible interruption in patient care and other legal ramifications.

- If at any time it is found that you were covered under more than one insurance plan and you did not provide this information to our office, we WILL NOT file the unknown insurance and you will be responsible for the balance of all charges that were incurred.

PAYMENT AGREEMENT

This Agreement is between Dr. Kim Pershall, M.D. and responsible party for patient.

- I understand I will be responsible for patient's:
  - Referrals from primary care physician
  - Deductibles
  - Copays
  - Non-Covered Services
  - Verification that other facilities Dr. Pershall may refer me to are in my insurance network

- I understand that insurance verification and pre-certification are not a guarantee of payment. Any discrepancies with my insurance company and all claims not paid by insurance within 45 days of the date of service become my responsibility to pay immediately.

- I / We understand that Dr. Pershall has a commitment of ownership in Covenant Surgicenter, LTD. And Sightline Lubbock IMRT.

SIGNATURE: _____ DATE: _____

Patient or Responsible Party

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PATIENT INFORMATION

PLEASE ANSWER ALL QUESTIONS!

Office visit payments and co-payments are due at the time that services are rendered. We will be glad to assist you in filing your insurance, but can not accept insurance as payment.

Today's Date:_____ Pharmacy:_____ Address:_____
Referring Doctor:_____ Phone Number:_____ City:_____
Primary Care Physician:_____ Phone Number:_____ City:_____
How did you hear about us:_____

PATIENT: Age: _____
Name:_____ M.I. _____ Date of Birth: _____ Gender:_____
Mailing Address: _____ City: _____ State: _____ Zip Code:_____
Home Phone:_____ Cell Phone: _____ Work Phone: _____
Social Security #:_____ Email Address: _____
Marital Status: S M D W Employer: _____ Fulltime: _____ Part-time: _____

IN CASE OF EMERGENCY:
Name: _____ Relation: _____
Address: _____ Phone: _____

PARENT OR SPOUSE:
Name:_____ M.I. _____ Date of Birth: _____ Gender:_____
Street Address: _____ City: _____ State: _____ Zip Code:_____
Home Phone:_____ Cell Phone: _____ Work Phone: _____
Social Security #:_____ Email Address: _____
Employer: _____ Employment Status: _____

INSURANCE POLICY:
Insurance Company: _____ Policy #: _____
Policy Holder: _____ Date of Birth: _____ Phone: _____
Social Security #: _____ Relationship to Patient: _____
Insured's Employer: _____

ACCOUNT #: _____

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CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I understand that as part of my health care, Dr. Pershall originates and maintains medical records describing my health history, symptoms, examination and test results, diagnoses, treatment, financial and demographic information, as well as any plans for future care or treatment. Dr. Pershall also originates and maintains billing records. I understand and consent to this information being used or disclosed for the following purposes:

- Planning my care and treatment
- Communications between Dr. Pershall and healthcare professionals that act under the direction of Dr. Pershall and participate in my diagnoses, evaluations and treatment;
- Collection of fees for medical services;
- Determining liability for payment and obtaining reimbursement;
- Conducting healthcare operations, including: the evaluation of health care services, appropriateness and quality of health care treatment, and the qualifications of health care practitioners.

I have been provided with a copy of Dr. Pershall's *Notice of Privacy Practices* that provides information about how Dr. Pershall uses and discloses Protected Health Information about me. I understand that I have the following rights and privileges:

- The right to review the *Notice* prior to signing the consent, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations. Dr. Pershall is not required to agree to requested restrictions, but is bound to any restrictions agreed to.

I understand that as proved in the *Notice of Privacy Practices*, the terms of the notice may change. If they do, I may obtain a revised copy from the Privacy Office by calling (806) 796-0202.

I understand that I may revoke this consent in writing, except to the extent that Dr. Pershall has already taken action in reliance thereon.
I also understand that by refusing to sign or revoking this consent, Dr. Pershall may refuse to treat me.
I wish to restrict the use or disclosure of my health information as follows: _____

_____

I understand that my confidential information may be released to the following individuals: Hospitals, referring physicians, transcriptionist and insurance companies, collection agencies, and legal entities.

_____ _____ _____
Signature of Patient or Representative | Relation of Representative | Date

_____
Printed Name

FOR OFFICE USE ONLY

_____ _____ _____ _____
Signature of Employee | **Title** | **Date** | **Account #**

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NOTICE OF PRIVACY PRACTICES

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. If you should have any questions about this Notice, please contact Business Administrator at 806-796-0202.

Dr. Pershall and all of his employees understand that medical information about you and your health is personal and are committed to protecting this information. Dr. Pershall will create a record of the care and service you receive. Dr. Pershall needs this record: As a basis for planning your care and treatment; as a means of communication among the many health care professionals who contribute to your care; as a means by which you and third-party payor can verify that service billed were actually provided; a tool for educating health professionals; a source of information for public health officials; and to provide you with quality care and to comply with certain legal requirements.

The methods in which Dr. Pershall may use and disclose medical information about you: For treatment, for payment, for health care operations, appointment reminders, research, and to avert a serious threat to health or safety. As required by law, Dr. Pershall will disclose medical information about you when required to do so by federal or Texas laws or regulations. Special situations may include: Organ and tissue donation, military and veterans, workers' compensation, qualified personnel and public health risks, lawsuits and disputes, law enforcement and coroners.

You have the following rights regarding medical information Dr. Pershall collects and maintains about you: Right to inspect and copy, right to amend, right to an accounting of disclosures, right to request restrictions, and the right to request confidential communications.

Dr. Pershall reserves the right to change the terms of the notice and to make new notice provisions effective for all PHI maintained. Should changes be made, the changes will be posted in a prominent area of the office, and available to patients up on request.

If you believe your privacy rights have been violated, you may file a complaint with Dr. Pershall or with the Office of Civil Rights, U.S. Department of Health and Human Services. To file the complaint with Dr. Pershall, contact with Business Administrator at 806-796-0202. The address of the Office Civil Rights is:

Office of Civil Rights
U.S. Dept of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

All complaints should be submitted in writing. *You will NOT be penalized for filing a complaint.*

_____ _____ _____

Printed Name of Patient | Signature of Patient or Representative | Date

_____ _____

Name of Representative (if applicable) | Relationship

If you would like a copy of this Privacy Notice, please ask the receptionist to make you a copy. Otherwise, it will become a part of your patient folder. Thank you

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IN OFFICE PRODECURE WAIVER AND INFORMATION

Patient name: _____ Account Number: _____

Please be aware that certain procedures performed in our office are not included in the standard office visit. These prodedures will be billed separately and in addition to the physician office visit charge. We have become aware that some insurance carriers are classifying the procedures as a "surgical procedure". As such, your insurance company may apply a surgical deductible and or coinsurance responsibility to you. Be assured, we are following accepted billing and coding guidelines and that all procedures are performed in the best interest for your care.

Please understand that most procedures and certain diagnostic tests will be performed on a separate day.

Examples of in-office procedures / diagnostic test include:

** Flexible laryngoscopy or nasal endoscopy: This procedure involves passing a long thin fiber optic scope through the nasal cavity and into the throat. The fiber optic scope enables the physician to visualize areas of the nose and throat not readily seen using the laryngeal mirrors or nasal instruments.

** Comprehensive audiometric exam: Our audiologist till test your hearing thresholds in a sound proof booth by presenting a series of tones and recording the level at which you respond.

** Tympanogram: This test measures the movement of the eardrum by varying the pressure in your ear canal.

** Cerumen or ear wax removal: Removal of ear wax that involves using the microscope or is more involved than brief clearance with a curette.

** Ventilating ear tube placement: This includes microscope, surgery instruments and extra time.

** Excision of lesions: This includes surgery instruments, topical anesthesia and extra time.

** Dizziness testing: This includes specialized equipment and extra time with the audiologist.

** Allergy testing: This includes allergy testing supplies and approximately 2 hours of one on one with the allergy technician.

I hereby authorize Dr Kim E Pershall to examine, treat and perform diagnostic tests and office procedures that the provider and the patient, and/or responsible party, may deem necessary.

_____ _____

Patient and/or responsible party signature Relation to patient

Date: _____