CENTA MEDICAL GROUP

Welcome to our ENT Practice! The physicians and staff of CENTA are pleased that you have chosen us as your health care provider. Please complete the enclosed registration forms and bring them to your appointment.

PLEASE NOTE: Adherence to the following CENTA policies is required, or your appointment will be rescheduled.

1. You must arrive to your appointment on time; we do not want you to miss your appointment.
2. Your current insurance card and any required insurance authorization must be provided before you see the physician.
3. All minors under the age of 18 must be accompanied by a parent or legal guardian for the first office visit. **Legal guardians must present court ordered documentation of guardianship at the time of check-in.** We recommend that the parent or legal guardian accompanies the minor on return visits. Surgeries and/or procedures cannot be scheduled without the parent or legal guardian present.
4. Payment is expected at the time of service if you do not have medical insurance. If you are covered by an active insurance plan, insurance co-payments, co-insurance and deductibles are required at time of check-in.

We have two locations to serve you. Please note which location your appointment is scheduled for and see directions below:

Columbia Location: **9 Richland Medical Park Dr., Suite 510**
(Harden Street Extension)
Columbia, SC 29203

From I-26, take I-126 to Elmwood Avenue. From Elmwood, turn left onto Bull Street. Turn right at the CVS onto Harden Street Ext. From I-77, take Hwy 277 into downtown Columbia. Turn left at the CVS onto Harden Street Ext. Our building is on the left immediately after the main hospital. We are located on the fifth floor. Parking is available in the main hospital lot or the garage attached to our building.

Lexington Location: **157 Corley Mill Rd.**
Lexington, SC 29072

Corley Mill Road is located near the intersection of I-20 and Hwy 378 (Exit 61). From I-20 W, take exit 61 and bear right, then turn right onto Corley Mill Road between Sparrow and Kennedy Tractor and TD Bank. From I-20 E, take exit 61 and turn left onto Hwy 378, then turn right onto Corley Mill Road. Our building is located on the left just past the bank.

(803) 256-2483 · www.centamedical.com

CENTA MEDICAL GROUP

Date: ______________________ Chart #: ______________________

Name: ______________________ Preferred Name: ______________________
Last First Middle Initial

Dob: ______________________ Female ☐ Male ☐ SSN: ______________________

Race: ______________________ Ethnicity: Hispanic/Non-Hispanic Language: ______________________

Address: ______________________

City: ______________________ State: __________ Zip: __________ Marital Status: M ☐ S ☐ W ☐ D ☐

Home #: ______________________ Work #: ______________________ Cell #: ______________________

Email Address: ______________________ @ ______________________

Employer: ______________________ Occupation: ______________________

Address: ______________________

City: ______________________ State: __________ Zip: __________

Spouse/Parent Information:

Name: ______________________
Last First Middle Initial

Address (If different than above): ______________________

City: ______________ State: ______ Zip: __________ Home #: ______________ Cell #: ______________

SSN: ______________________ DOB: ______________________

Employer: ______________________ Work #: ______________________

Emergency Notification:

Name: ______________________
Last First Middle Initial

Home #: ______________________ Work #: ______________________ Cell #: ______________________

Primary Insurance: ______________________ Policy Holder's DOB: ______________________

Policyholder's Name: ______________________ SSN: ______________________

Policy Number: ______________________ Group Number: ______________________

Secondary Insurance: ______________________ Policy Holder's DOB: ______________________

Policyholder's Name: ______________________ SSN: ______________________

Policy Number: ______________________ Group Number: ______________________

Other Insurance: ______________________ Policy Holder's DOB: ______________________

Policyholder's Name: ______________________ SSN: ______________________

Policy Number: ______________________ Group Number: ______________________

I hereby assign payment directly to the designated physician for all medical services provided and procedures performed. I realize that any remaining balance is my responsibility. I also authorize release of medical information required by my insurance company to process my medical claims.

Signature of Patient/Guarantor: ______________________ Date: ______________________

Printed Full Name: ______________________

CENTA
MEDICAL GROUP

You may give CENTA Medical Group written authorization to disclose your protected health information to anyone that you designate, such as a family member or personal representative. If you wish to authorize a person to receive your protected health information, please complete the form below. You may also use this form to give us consent to leave detailed information (results of labs, x-ray, prescription refills, etc.) on your home answering machine, voicemail at work, cellphone, email or another party that you designate.

Patient's Name: ______________________________ Date of Birth: ______________

If child is under 18 years of age, we need:

Mother's/Guardian's Name: ____________________ Father's/Guardian's Name: ____________________

At my request, I authorize CENTA Medical Group to disclose my protected health information to:

Name: ____________________ Relationship: ______________ Phone #: ______________

Name: ____________________ Relationship: ______________ Phone #: ______________

Name: ____________________ Relationship: ______________ Phone #: ______________

At my request, I also authorize CENTA Medical Group to communicate my protected health information to me via the following methods:

- ☐ Leave detailed message on my home answering machine. Phone number: ____________________
- ☐ Leave detailed message on my voicemail at work. Phone number: ____________________
- ☐ Leave detailed message on my cellphone voicemail. Phone number: ____________________
- ☐ Fax detailed medical information. FAX number: ____________________
- ☐ Email detailed medical information. Email address: ____________________

I authorize the release of information pertaining to:

The diagnosis or treatment of AIDS, including results of HIV tests	☐ Yes	☐ No/NA
The diagnosis or treatment of drug and/or alcohol abuse	☐ Yes	☐ No/NA
The treatment and/or consultation for mental health or psychiatric disorders	☐ Yes	☐ No/NA

I authorize the following person(s) to accompany my child at follow-up office visits in my absence:

Name: ____________________ Relationship: ______________ Phone #: ______________

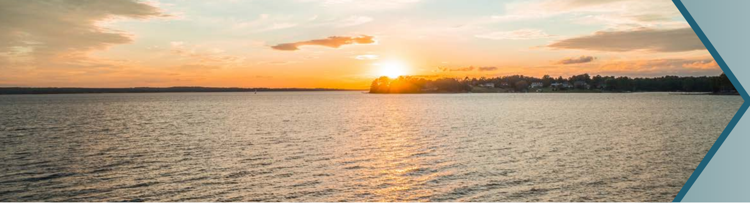
Name: ____________________ Relationship: ______________ Phone #: ______________

I understand that I may cancel this authorization at any time. However, if I cancel this authorization, I also understand that the cancellation will **not** affect any action CENTA Medical Group took in reliance on this authorization before receipt of written notice of cancellation.

I understand that electronic media and delivery methods such as email pose certain risks to the privacy and security of my Protected Health Information that may be beyond the control of CENTA Medical Group. I agree to assume such risks personally and to hold CENTA Medical Group harmless in the event my Protected Health Information is breached or compromised as a result of my directing and authorizing CENTA Medical Group to transmit or deliver such information electronically.

______________________________ ______________________________

Patient's Signature (If a Minor, Legal Guardian's Signature) Date



CENTA MEDICAL GROUP

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.

The Health Insurance Portability and Accountability Act (HIPAA; "Act") of 1996, revised in 2013, requires us as your health care provider to maintain the privacy of your protected health information, to provide you with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We are required to maintain these records of your health care and to maintain confidentiality of these records.

The Act also allows us to use your information for treatment, payment, and certain health operations unless otherwise prohibited by law and without your authorization.

- Treatment: We may disclose your protected health information to you and to our staff or to other health care providers in order to get you the care you need. This includes information that may go to the pharmacy to get your prescription filled, to a diagnostic center to assist with your diagnosis, or to the hospital should you need to be admitted. If necessary to ensure that you get this care, we may also discuss the minimum necessary with friends or family members involved in your care unless you request otherwise.
- Payment: We may send information to you or to your health plan in order to receive payment for the service or item we delivered. We may discuss the minimum necessary with friends or family members involved in your payment unless you request otherwise.
- Health operations: We are allowed to use or disclose your protected health information to train new health care workers, to evaluate the health care delivered, to improve our business development, or for other internal needs.
- We are required to disclose information as required by law, such as public health regulations, health care oversight activities, certain lawsuits and law enforcement.

Certain ways that your protected health information could be used or disclosed require an authorization from you: disclosure of psychotherapy notes, use or disclosure of your information for marketing, disclosures or uses that constitute a sale of protected health information, and any uses or disclosures not described in this NPP. We cannot disclose your protected health information to your employer or to your school without your authorization unless required by law. You will receive a copy of your authorization and may revoke the authorization in writing. We will honor that revocation beginning the date we receive the written signed revocation.

You have several rights concerning your protected health information. When you wish to use one of these rights, please inform our office so that we may give you the correct form for documenting your request.

- You have the right to access your records and/or to receive a copy of your records, with the exception of psychotherapy notes. Your request must be in writing, and we must verify your identity before allowing the requested access. We are required to allow the access or provide the copy within 30 days of your request. We may provide the copy to you or to your designee in an electronic format acceptable to you or as a hard copy. We may charge you our cost for making and providing the copy. If your request is denied, you may request a review of this denial by a licensed health care provider.
- You have the right to request restrictions on how your protected health information is used for treatment, payment, and health operations. For example, you may request that a certain friend or family member not have access to this information. We are not required to agree to this request, but if we agree to your request, we are obligated to fulfill the request, except in an emergency where this restriction might interfere with your care. We may terminate these restrictions if necessary to fulfill treatment and payment.
- We are required to grant your request for restriction if the requested restriction applies only to information that would be submitted to a health plan for payment for a health care service or item for which you have paid in full out-of-pocket, and if the restriction is not otherwise forbidden by law. For example, we are required to submit information to federal health plans and managed care organizations even if you request a restriction. We must have your restriction documented prior

- to initiating the service. Some exceptions may apply, so ask for a form to request the restriction and to get additional information. We are not required to inform other covered entities of this request, but we are not allowed to use or disclose information that has been restricted to business associates that may disclose the information to the health plan.
- You have the right to request confidential communications. For example, you may prefer that we call your cellphone number rather than your home phone. These requests must be in writing, may be revoked in writing, and must give us an effective means of communication for us to comply. If the alternate means of communication incurs additional cost, that cost will be passed on to you.
- Your medical records are legal documents that provide crucial information regarding your care. You have the right to request an amendment to your medical records, but you must make this request in writing and understand that we are not required to grant this request.
- You have the right to an accounting of disclosures. This will tell you how we have used or disclosed your protected health information. We are required to inform you of any breach that may have affected your protected health information.
- You have the right to receive a copy of this notice, either electronic or paper or both.
- You have the right to opt out of fundraising communications.

If you have any questions about our privacy practices, please contact our Privacy Officer at the number below.

You have the right to file a complaint with us or with the Office for Civil Rights. We will not discriminate or retaliate in any way for this action. To file a complaint, please contact the applicable party:

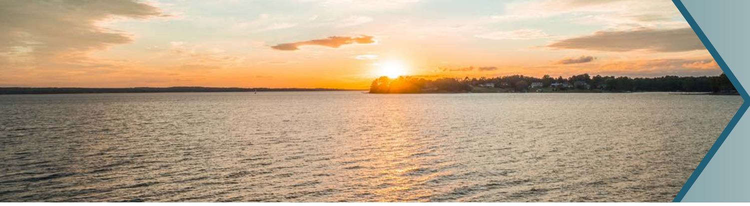
Privacy Officer: Karen Luper

Phone number: (803) 256-2483

Office for Civil Rights

http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

We are required to abide by the policies stated in this Notice of Privacy Practices, which became effective on: 9-23-2013



CENTA MEDICAL GROUP

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal health care operations such as quality assessments and physician certifications

I received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

Patient Name or Legal Guardian: ______________________________

Signature: ______________________________

Date: ______________________________

PRACTICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date: ____________________ Initials: __________

Reason: ______________________________

____

4/7/17

CENTA MEDICAL GROUP

Financial Policies

Thank you for choosing our practice! We believe that establishing a written financial policy is mutually beneficial for all parties. It is our goal to avoid any miscommunication or concerns regarding financial matters in order to focus our energies on providing healthcare services to our patients. Our staff is available to assist you should you have any questions.

1. **Payment is expected at the time of service.** This includes co-pays, co-insurance and deductibles. **Charges for procedures such as scopes and tubes are not included in your office visit charge and may be applied toward your deductible by your insurance plan.**

2. **Insurance**

   a. **Insurance Card –** Your insurance card must be presented prior to being seen, or your appointment may have to be rescheduled.

   b. **Insurance Claims –** We will file insurance for you under most circumstances as long as you provide us with current information on your insurance plan. Each insurance plan offers its own specific benefits. You are ultimately responsible for understanding the details of your particular coverage and the payment of all charges that you incur.

   c. **Out of Network Provider –** If we are out of network with your insurance company, payment will be due at time of service and our self-pay deposit and discount policies below will apply. As a courtesy, we will file your claim to your insurance company.

   d. **Authorizations –** If your insurance company requires referral authorization from your primary care provider, it is your responsibility to obtain this information and provide it to our office before services are provided.

3. **Minor Children Patients**

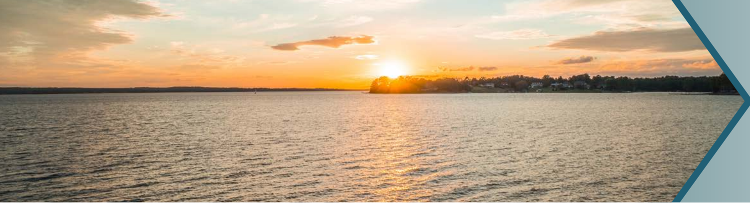
   a. **Responsible Party –** All minors under the age of 18 **must** be accompanied by a parent or legal guardian for the first office visit. **Legal guardians must present court ordered documentation of guardianship at time of check-in.** Surgeries and/or procedures cannot be scheduled without a parent or legal guardian present. Charges for services rendered to minor children are due at the time of service and are the responsibility of the parent seeking treatment for the child.

   b. **Minor Children of Divorced Parents –** Payments, co-pays, co-insurance and deductibles are due at the time of service from the parent who seeks treatment for the child regardless of any court-ordered responsibility for medical costs.

   c. **Financial Responsibility of Both Parents –** The stated terms of this Financial Policy shall not modify the duty of both parents to provide for the welfare of their minor children. We expressly reserve the right to hold either or both parents responsible for any and all reasonable and necessary medical expenses.

   d. **Non-Custodial Parent –** The non-custodial parent must be listed on the HIPAA form with correct address and phone#.

4. **Self-Pay Patient Discounts –** We collect a $150 deposit from our self-pay patients at check-in for those who do not have active health insurance. We offer a discount at check-out to self-pay patients when payment is satisfied at the time of service. Federal law does not allow us to discount service for those patients who have health insurance. Self-pay discounts do not apply to co-pays, co-insurance, deductibles, some non-covered services and medical supplies.



5. **Surgery Deposits –** We will collect a surgery deposit of $250 to hold your day of surgery. Past due accounts must be satisfied in full prior to scheduling surgery.

6. **No Professional Courtesy Discounts –** It is our policy not to extend professional courtesy discounts.

7. **Past Due Balances –** Past due balances on your account are to be paid in full prior to receiving additional services. Please contact our Billing Department at (803) 520-5447 with questions or to make a payment. Accounts may be turned over to a third party for collection if 60 days past due.

8. **Missed Appointments –** If you fail to keep a scheduled office or office procedure appointment and do not give our office at least 24 hours of advance notice of cancellation, you will be charged $35 and you may not be allowed to schedule future appointments.

9. **Other Charges –** A service charge of $35 will be charged to your account for returned checks. Please contact our Medical Records Department at (803) 520-5449 regarding chart duplication requests and possible charges.

I have read, understand and agree to the above Financial Policies. I understand that all charges not covered by my insurance company, as well as co-payments, co-insurance and deductibles, are my responsibility.

Patient Signature or Authorized Person	Relationship to Patient
Patient Printed Name	Date

CENTA MEDICAL GROUP

Health History *(13 years & older)*

Patient name: ______________________ DOB: ____________ Date: ____________

Reason for today's visit: ______________________ Referring physician: ____________

ALLERGIES

Medication Allergies	Type of Reaction		Medication Allergies	Type of Reaction

Have you ever had an allergy test? ☐ Yes ☐ No If yes, when & where was test done? ____________

Have you ever taken allergy shots? ☐ Yes ☐ No How much relief from shots? ☐ Minimal ☐ Partial ☐ Significant

If yes, are you still taking them? ☐ Yes ☐ No Have you ever had any reactions to anesthesia? ☐ Yes ☐ No

LIST ALL MEDICATIONS YOU ARE TAKING (Prescription, over-the-counter or herbal) ☐ None

Medication	Dosage	How Often Taken		Medication	Dosage	How Often Taken

Pharmacy name & number (include address if known)

____

MEDICAL / SURGICAL HISTORY: HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?

	Surgery/Management
Cardiovascular:	
Heart attack	☐ Yes ________
High blood pressure	☐ Yes ________
Angina	☐ Yes ________
Pulmonary:	
Asthma	☐ Yes ________
Chronic lung disease	☐ Yes ________
Tuberculosis	☐ Yes ________
Gastrointestinal:	
Hepatitis	☐ Yes ________
Esophageal reflux	☐ Yes ________
Peptic ulcer disease	☐ Yes ________
Eye:	
Glaucoma	☐ Yes ________
Endocrine:	
Diabetes	☐ Yes ________
Thyroid	☐ Yes ________
Hematological:	
Clotting factor deficiency	☐ Yes ________
Anemia	☐ Yes ________
Sickle cell disease	☐ Yes ________
Neurological:	
Stroke	☐ Yes ________
Migraine headaches	☐ Yes ________
Seizures	☐ Yes ________
Musculoskeletal:	
Osteoporosis	☐ Yes ________
Arthritis	☐ Yes ________
Kidney/Bladder:	
Kidney/bladder infections	☐ Yes ________
Other Medical Problems:	
Cancer	☐ Yes ________
Mental illness	☐ Yes ________
Sexually transmitted disease	☐ Yes ________
HIV or AIDS	☐ Yes ________
History of ENT Procedures:	
Myringotomy	☐ Yes ________
Ear tubes	☐ Yes ________
Mastoidectomy	☐ Yes ________
Tympanoplasty	☐ Yes ________
Tonsillectomy	☐ Yes ________
Tonsillectomy w/adenoidectomy	☐ Yes ________
Septoplasty	☐ Yes ________
Injection into turbinate	☐ Yes ________
Excision of turbinate	☐ Yes ________
Cauterization of turbinate	☐ Yes ________
Laryngectomy	☐ Yes ________

CENTA MEDICAL GROUP

REVIEW OF SYSTEMS: CHECK ANY OF THE FOLLOWING PROBLEMS YOU HAVE RECENTLY HAD:

General Health Problems: ☐ Weight change ☐ Fever ☐ Feeling tired or poorly

Head Symptoms: ☐ Headache ☐ Sinus pain

Otolaryngeal Symptoms: ☐ Earache ☐ Hearing loss ☐ Ringing in ears ☐ Nosebleeds ☐ Hoarseness ☐ Throat pain

Neck Symptoms: ☐ Neck pain ☐ Lump or swelling in the neck ☐ Difficulty swallowing (dysphagia)

Gastrointestinal Symptoms: ☐ Decrease in appetite ☐ Difficulty swallowing (dysphagia) ☐ Heartburn

Neurological Symptoms: ☐ Light headedness ☐ Spinning/dizziness (vertigo) ☐ Mouth droops (facial weakness) ☐ Sense of smell ☐ Taste disturbances

Cardiovascular Symptoms: ☐ Chest pain or discomfort

Pulmonary Symptoms: ☐ Shortness of breath ☐ Cough ☐ Wheezing

Eye Symptoms: ☐ Eye pain ☐ Itching of the eyes

Hematological Symptoms: ☐ Easy bleeding ☐ Easy bruising tendency

Genitourinary: ☐ Pain during urination

Skin Symptoms: ☐ Rashes

Psychological Symptoms: ☐ Depression ☐ Sleep disturbances

FAMILY HISTORY:

No significant family history ☐ Yes
Reactions to anesthesia ☐ Yes
Recklinghausen's disease ☐ Yes
Loss of hearing ☐ Yes
Meniere's disease ☐ Yes
Allergies ☐ Yes
Heart disease ☐ Yes
High blood pressure ☐ Yes
Hardening of the arteries ☐ Yes
Asthma ☐ Yes
Other: ______________________________

Stroke ☐ Yes
Migraine headaches ☐ Yes
Diabetes mellitus ☐ Yes
Thyroid cancer ☐ Yes
Goiter or thyroid disease ☐ Yes
Bleeding problems ☐ Yes
Exposure to HIV ☐ Yes
Heartburn/reflux ☐ Yes
Hepatitis ☐ Yes
Kidney disease ☐ Yes

SOCIAL HISTORY:

Tobacco use? ☐ Yes ☐ No ☐ Former

Type of Tobacco	Packs/Day	For ? Years	Yr. Quit?
Cigarettes			
Other: (list type)			

Do you consume alcohol? ☐ Yes ☐ No ☐ Former

Type of Alcohol	Frequency?	Amt?	Last Drink?

Exposed to secondhand smoke? ☐ Yes ☐ No

Caffeine consumption? ☐ Yes ☐ No Type: ______________________ Amount per day? __________

Drug use: ☐ Yes ☐ No Type: ______________________ Amount per day? __________

Marital status: ____

Patient signature: ________________________________ Date: ________________