TAMPA BAY HEARING & BALANCE Center
A division of Select Physicians Alliance

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NEW PATIENT PACKET

Welcome to Tampa Bay Hearing and Balance Center, a division of Select Physicians Alliance. Our physicians are specialists in Otology, Neurotology, and Skull Base Surgery. We look forward to your visit and providing you with top quality ear car.

COMPLETE THIS PRE-APPOINTMENT CHECKLIST AT LEAST 3 DAYS BEFORE YOUR VISIT

This packet contains VERY important instructions, signature forms, and questions that need to be completed prior to your visit with us. Please call if you have questions. Use the following as a checklist to prepare for your appointment.

☐ **1. Obtain authorization and/or referral (if required) for your visit.**
Your insurance policy may require an authorization and/or referral in order for you to see us. Make sure your Primary Care Physician (PCP) has faxed this information to **our office PRIOR to your appointment date**. Not doing so will require rescheduling your appointment. If your insurance does not require an authorization and/or referral, you do not need to obtain one from your PCP.

☐ **2. Login in to your Patient Portal to set up appointment reminders and complete check-in.**
Log on to your Patient Portal account with your PIN, phone number, and date of birth at www.tampabayhearing.com. Sign up for text message appointment reminders. Review your demographics and insurance information for accuracy. This service also allows you to complete the majority of your check-in process at our office prior to your arrival. If you do not have a Patient Portal PIN # please call us to obtain your PIN.

☐ **3. Have your referring and specialty physician offices fax medical records related to your chief complaint.**
You may need to sign a release form to have these records sent to us which takes time. It is important that you start this process right away. These documents include diagnostic testing such as MRI/CT scan reports of the ear and brain, audiology testing such as hearing tests and balance tests, lab testing/genetics testing/blood work, and your physician's notes related to the issue.

☐ **4. Obtain a CD or films of your brain/ear MRI or CT scan.**
If you have had an MRI or CT scan of your ears and brain, please obtain a CD or films and bring this with you to your appointment. You will most likely need to pick the CD or films up in person at the office where the test was performed. Do not rely on the office to mail your CD to us as they most often do not understand and only fax the report. Our physicians want to review the actual images of your ear/brain with you while you are visiting with us. **This is especially important if your visit is to establish whether or not you need surgery or if there are congenital malformations that we need to understand.**

☐ **5. Complete the attached otology questionnaire in its entirety.**

☐ **6. Determine which lab company is approved by your insurance company for lab testing.**

☐ **7. Sign the signature form online.**
The signature form contains our Notice of Privacy, Release of Billing Information, Assignment of Insurance Benefits, Medication History Authority, Permission for Treatment, and Policy on Responsibility for Patient Fees. To sign them online, login to your patient portal account at www.tampabayhearing.com/portal. Use your PIN number, your phone number, and your date of birth. Electronically sign the Signature Form located in the Download Forms button. Signing the form online will speed up your check-in time on arrival. A copy of the signature form is included in this packet for your records. You may also sign the signature form at check-in on the day of your appointment if you are unable to access the form online.

☐ **8. Send your completed packet prior to your visit by clicking submit above, emailing as an attachment to registration@tampabayhearing.com, faxing to (813) 315-4329 or mailing to address above.**

Patient Name: _____ Date of Birth: _____ *(nppcomplete)*

COMPLETE THESE TASKS AT LEAST 1 DAY BEFORE YOUR VISIT

- Prepare the items from the list below and have them ready to bring with you.
- Prepare for your trip to see us by reviewing the directions attached or customizing your trip via a service such as maps.google.com or your GPS. You may also scan the QR image to the right on your Smartphone.
- Make arrangements to arrive 30 minutes prior to your scheduled appointment time to check-in and be worked up your physician's medical assistant. Be sure to plan for downtown and highway traffic.

BRING THE FOLLOWING WITH YOU TO YOUR APPOINTMENT

- Your insurance ID card and photo ID such as a driver's license
- Your MRI/CT scan images on CD or Film of your ears and brain
- The name, phone number, and address of your preferred pharmacy
- Payment for co-pays or deductibles required by your insurance carrier at the time of service
- A book or laptop, headphones, & snack. We strive to keep our wait times reasonable. Due to the complex nature of the ear and its proximity to the brain, the problems our physicians are solving can cause a wait time. If you arrive very early there is a Starbucks, McDonalds, and cafeteria on the Tampa General Hospital campus.

INSURANCE INFORMATION

We will file insurance as a courtesy. Contact your insurance carrier to verify that your insurance considers Select Physicians Alliance (TIN 27-3337174) as participating or in network. Plans that we do not participate with or that we are out of network with will not be accepted unless the patient has out of network benefits. If there are no out of network benefits, patients will be considered self-pay and be responsible for payment at time of service. We will be happy to provide billing information to file a claim for reimbursement for services rendered.

Your insurance policy may require an authorization and/or referral in order to see us. Make sure your Primary Care Physician faxed the authorization and/or referral information to our office **PRIOR to your appointment date**. Not doing so will require rescheduling your appointment.

RECORDS REVIEW SERVICE

If you are visiting us for a 2nd or 3rd opinion, you may have accumulated many diagnostic reports for us to review as part of your visit. A normal office visit covered by insurance does not provide enough time for you and the doctor to review more than 4 to 6 diagnostic tests as well as establish your case adequately. We offer a records review service that is completed prior to your appointment. Insurance does not cover this service; however, we strive to keep the cost competitive, and we believe your overall experience with us will be more satisfactory if you and the physician can establish an information summary of your complex case before your visit. We strongly suggest using this service if you have a significant number of records. If you do not utilize this service, we may need to focus on one issue at a time in order to stay on schedule. We are intent on providing quality service, and it is important that we, together, allow appropriate time for records review if you have accumulated a significant ear health history. To get started, visit http://www.tampabayhearing.com/recordsreviewservice or call us at 813-844-4900.

DIRECTIONS

Plan your trip to arrive at our office 30 minutes ahead of your appointment, understanding that you will need some time to park or valet your car and that there may be traffic coming to downtown Tampa. Our website at www.tampabayhearing.com has tools available to help customize your trip. If you are traveling a great distance and are planning to stay overnight in Tampa, our website lists several local area hotels. For those with smartphones you may scan the QR image above to give you GPS directions to the Tampa General Hospital Campus. **We are located on the same campus as Tampa General Hospital,** on Davis Island, in downtown Tampa, Florida**.**

Build **EXTRA TIME** for traffic delays into your trip to downtown Tampa**.** Park using the **valet service for $5** located directly in front of Harbourside Medical Tower (circled in the picture below picture). Follow traffic signs to **EAST Pavilion Entrance/Harbourside Medical Tower**. Or use the **visitor parking garage entrance for $3.** Patients with valid handicap identification park for free in designated areas on floors 1, 3, and 5 of the visitor parking garage. The walking bridge from the visitor parking garage to the Harbourside Medical Tower is located on the 3rd floor (GREEN level).

 Patient Name: _____ Date of Birth: _____ *(nppcomplete)*

Tampa General Hospital Campus

FROM I-4: Follow I-275 South to Exit Downtown East – West and bear right through the exit ramp towards Ashley Street. Take Ashley Street Southbound to Kennedy Blvd. Turn Right on Kennedy Blvd and proceed to Hyde Park Ave. Turn Left on Hyde Park Ave and continue over the bridge to Davis Island staying in the left lane to TGH/Harbourside Medical Tower.	**FROM I-4 ALTERNATE ROUTE:** Take I-275 South to Exit 42 (Armenia Ave./Howard Ave. Exit) Take Armenia Ave Southbound to Kennedy Blvd. Turn Left on Kennedy Blvd and proceed to Hyde Park Ave. Make a Right hand turn onto Hyde Park Ave and continue over the bridge to Davis Island staying in the left lane to TGH/Harbourside Medical Tower.
FROM Crosstown/Selmon Expressway Westbound: Exit Hyde Park Ave onto Brorein Ave and continue to the first traffic light. Turn left onto Hyde Park Ave and continue over the bridge to Davis Islands staying in the left lane to TGH/Harbourside Medical Tower.	**FROM Crosstown/Selmon Expressway Eastbound:** Take the Willow Ave. exit to Platt St. and continue straight on Platt St to Hyde Park Ave (three traffic lights). Make a right turn onto Hyde Park Ave and continue over the bridge to Davis Island staying in the left lane to TGH/Harbourside Medical Tower.
FROM the north: Take I-75 to I-4 then I-4 to Downtown Exit 45A and bear right through the exit ramp towards Ashley Street. Take Ashley Street Southbound to Kennedy Blvd. Turn Right on Kennedy Blvd and proceed to Hyde Park Ave. Turn Left on Hyde Park Ave and continue over the bridge to Davis Island staying in the left lane to TGH/Harbourside Medical Tower.	**FROM the south:** Take I-75 to the Crosstown/Selmon Expressway Westbound. Exit Hyde Park Ave onto Brorein Ave and continue to the first traffic light. Turn left onto Hyde Park Ave and continue over the bridge to Davis Island staying in the left lane to TGH/Harbourside Medical Tower.
FROM Hwy. 60 (Westbound) or Hwy. 41: Take Kennedy Blvd. to Hyde Park Ave. Turn left onto Hyde Park Ave. and continue over the bridge to Davis Island staying in the left lane to TGH/Harbourside Medical Tower.	**FROM Hwy. 60 (Eastbound):** Take Kennedy Blvd. to Hyde Park Ave. Turn right onto Hyde Park Ave. and continue over the bridge to Davis Island staying in the left lane to TGH/Harbourside Medical Tower.

 Patient Name: _____ Date of Birth: _____ *(nppcomplete)*

REGISTRATION INFORMATION

Patient Demographics		**Guarantor (Responsible Party)**	
First Name:		First Name:	
Middle Initial:		Middle Initial:	
Last Name:		Last Name:	
Suffix:		Suffix:	
Date of Birth:		Date of Birth:	
Gender:		Gender:	
Social Security:		Social Security:	
Marital Status:		Marital Status:	
Street Address:		Street Address:	
City:		City:	
State:		State:	
Zip:		Zip:	
Email Address:		Email Address:	
Cell Phone:		Cell Phone:	
Work Phone:		Work Phone:	
Home Phone:		Home Phone:	

Language:	
Race:	
Ethnicity:	
Guardian Name:	
Occupation:	
Employer Name:	
Employer Phone:	
Emergency Contact:	
Emergency Phone:	

Primary Insurance		**Secondary Insurance**	
Policy Holder Name:		Policy Holder Name:	
ID/Certification #:		ID/Certification #:	
Policy/Group #:		Policy/Group #:	
Issue Date:		Issue Date:	
Plan Name:		Plan Name:	
Expiration Date:		Expiration Date:	
Specialist Copay:		Specialist Copay:	
Address:		Address:	
City:		City:	
State:		State:	
Zip:		Zip:	
Phone:		Phone:	

Physician References	
Primary Care Physician:	
Referring Physician:	
Neurologist:	
Cardiologist:	
Audiologist:	
How did you hear about us?	**Advertisement Internet Friend Physician Family Member Other**

Preferred Pharmacy:

Pharmacy Name: _____ Phone: _____

Address: _____

Insurance Approved Lab Company: Select the laboratory approved by your insurance

◯ Quest Diagnostics ◯ Labcorp ◯ Tampa General Hospital ◯ Baycare

Chief Complaint: Select the main complaint below that is most bothersome to you AND select R=Right L=Left or B=Both as appropriate.

Hearing Loss:	Ear Noise:	Ear Pain:	Ear Tumor:	Dizziness/Imbalance
◯ R ◯ L ◯ B	◯ R ◯ L ◯ B	◯ R ◯ L ◯ B	◯ R ◯ L ◯ B	

History of Present Illness: These questions are designed to help you prepare for your appointment. Read the questions through first. Then write a concise answer next to each question below. We will clarify and get more detail during your visit with us.

- **When** did the main problem you circled above start?
- Does the beginning of the main problem have a **context** such as a cold, stress, noise exposure, other?
- Select whether the main problem is ◯ **PRESENT IN EPISODES** or ◯ **CONSTANTLY PRESENT**.
- Approximately **how long** does the main problem last when it is present?
- **Where** is the main problem located? ◯ RIGHT ◯ LEFT ◯ BOTH
- What makes the main problem **worse**?
- What makes the main problem **better**?
- How would you describe the **nature** of the main problem? Use descriptive words such as muffled, spinning, tin like, bell ringing, lightheaded, etc.
- What **other symptoms happen at the same time** as the main problem you circled above?
- How **severe or intrusive** is the problem we are trying to address?
- Have you taken any medication, typically for a significant hospitalization; that is known to be **toxic** to the ears? Name the medication:
- Do you have a history of **viral infection** such as any of the various herpes viruses (examples: fever blisters, shingles, chicken pox, other)? Name the virus(es):

Past Medical History: Select all conditions you have experienced previously and write approximate date to the right of each historical item

Condition	Date	Condition	Date
Urinary incontinence		Fainting/syncope	
Kidney stones		Heart attack/problems	
Chronic renal failure		High cholesterol	
Dialysis treatments		High blood pressure	
Bladder problem		Low blood pressure	
Kidney problem		Abnormal heart beat	
Sexual function problem		Cancer: _____ (type)	
Asthma		Chemotherapy or Radiation	
Pneumonia		Arthritis	
Sinusitis		TMJ/jaw pain	
Sleep apnea		Ear pain	
Memory loss		Migraine	
Speech disturbance		Sinus headache	
Stroke		Tension headache	
Seizures		Back pain	
Incoordination		Neck pain	
B12 deficiency		Poor vision in one eye	
Multiple Sclerosis		Cataracts	
Low sugar		Macular degeneration	
Diabetes Type 1		Double vision	
Diabetes Type 2		Distorted vision	
Thyroid disorder		Glaucoma	
Depression		Ocular migraine	
Unusual stress		Measles	
Anxiety		Chicken pox	
Treatment by psychiatrist		Shingles	
Reflux/hiatal hernia		Fever blisters	
Colitis		Herpes	
Crohn's disease		Hepatitis	
Diverticulitis		Meningitis	
Diverticulosis		Tuberculosis	
Liver failure		Lupus	
Anemia		HIV or AIDS	

Review of Systems: Select all current symptoms that apply. If no symptom exists for the section, please select "*NONE*".

CONSTITUTIONAL			
	NONE	Fever	Change in weight
	Night sweats/chills	Fatigue	
SKIN			
	NONE	Healing Problems	Rash
	Discolorations		
EYES			
	NONE	Glaucoma	Visual Disturbance
	Dry Eyes	Double Vision	

EARS, NOSE, THROAT			
	NONE	Epistaxis	Change in voice
	Ringing in the ears	Allergies	Snoring
	Ear pain or itch	Throat pain	Sinus problems
	Ear drainage	Hearing loss	
CARDIOLOGY			
	NONE	Chest pain	Irregular heart rhythm
	Murmur	Leg swelling	
ENDOCRINOLOGY			
	NONE	Sleep problems	Temperature intolerance
	Excessive thirst		
GASTROENTEROLOGY			
	NONE	Loss of appetite	Nausea or vomiting
	Heartburn	Change in bowel habits	Difficulty swallowing
HEMATOLOGY/LYMPH			
	NONE	Easy bruising	Bleeding/bruising disorder
	Blood clot in legs	Blood transfusions	
MUSCULOSKELETAL			
	NONE	Joint stiffness	Arthritis
	Osteoporosis treatment	Pain in jaw w/ chewing	Muscle weakness
	Bone pain	Leg cramps	Joint pain
	Joint Swelling	Back pain	Neck pain
	Muscle aches		
RESPIRATORY			
	NONE	Asthma	Shortness of breath
	Cough	Blood in sputum	
NEUROLOGY			
	NONE	Headache	Paralysis/weakness
	Tingling numbness	Dizziness	Memory loss

Allergies:

Medication	Allergic Reaction

Current Medications:

Medication	Start Date	Dosage	How Often	Time of Day	Reason for Taking

 Patient Name: _____ Date of Birth: _____ *(nppcomplete)*

Surgical History: Select the type of surgery you have had in the past and write approximate date when it was performed

Surgery	Date	Surgery	Date
Ear ◯R ◯L ◯Both		Stomach	
Appendix		Cataracts	
Tonsils & adenoids		Prostate	
Sinus		Stents	
C-Section		Heart bypass	
Hysterectomy		Carotid arteries	
Breast		Other: _____	

Hospitalization: For issues other than surgeries listed above, enter the date and reason for hospitalization below

Hospitalization Reason	Date

Family History: Select the relevant condition and enter relationship to family member who has dealt with this condition

Condition	Family Member	Surgery	Family Member
Balance problems		Hearing loss	
Vertigo		Otosclerosis (hardened ear bones)	
Ménière's Disease		Migraines	
Convulstions/seizures			

Social History: Enter occupation and select any other items that apply to your social history

Occupation:				
Caffeine:	◯None	◯Occasional	◯Moderate	◯Frequent
Smoking:	◯Never Smoker	◯Current Daily	◯Current Sometimes	◯Former Smoker
	◯Light Smoker	◯Heavy Smoker	◯Other tobacco use	
Alcohol:	◯Rare	◯Occasional	◯Moderate	◯Heavy
Stress:	◯Mild	◯Moderate	◯High	
Exercise:	◯Some	◯Occasional	◯Moderate	◯Frequent
Scuba Diving History:	◯No	◯Yes		
Frequent Air Travel:	◯No	◯Yes		
Diet:	◯Regular	◯Vegan	◯Vegetarian	

Tinnitus Severity Index

Today's Date: _____

Patient Name: _____ Date of Birth: _____

For the questions below, select the number that best describes you.

Does your tinnitus:	Never	Rarely	Sometimes	Usually	Always
Make you feel irritable or nervous?	1	2	3	4	5
Make you feel tired or stressed?	1	2	3	4	5
Make it difficult for you to relax?	1	2	3	4	5
Make it uncomfortable to be in a quiet room?	1	2	3	4	5
Make it difficult for you to concentrate?	1	2	3	4	5
Make it harder to interact pleasantly with others?	1	2	3	4	5
Interfere with your required activities like work, home, care, or other responsibilities?	1	2	3	4	5
Interfere with your ability to sleep?	1	2	3	4	5
How often do you experience discomfort from tinnitus?	1	2	3	4	5

Additional comments:

Signature Form:

Please opt to sign the Signature Form at http://www.tampabayhearing.com/portal by logging into the Patient Portal and clicking the Medical Forms tab. Doing so will save time at your check in. We have included the signature form in this packet if you choose to sign them manually. If you signed it online, you do not need to sign it again below and can keep these for your records. This signature covers our Notice of Privacy Policy, Assignment of Insurance Benefits, Authorization of Release of Release Confidential Prescription Information, Permission for Treatment, and Policy on Responsibility for Patient Fees.

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

Revised as of July 31, 2013

By law, we are required to make available to you a copy of our Notice of Privacy Practices ("Notice"). By signing below you acknowledge that you received, or been offered and declined, a copy the Notice.

A current copy of the Notice is also posted in the office, or is available to you upon request. If the Notice is revised, you may review and obtain the new version at any time.

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 have any questions or wish to receive additional information about the matters covered by this Notice of Privacy Practices ("Notice"), please contact the Privacy Officer, for Select Physicians Alliance ("SPA") Sheryl A. Watts, COO, at 1149 Nikki View Dr., Brandon, FL 33511or call: (813) 571-7184.

This Notice is provided to you in compliance with the requirements of the Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health Act, Title XIII of the American Recovery and Reinvestment Act of 2009 (the "HITECH Act") and associated regulations, as may be amended (collectively referred to as "HIPAA") describing SPA's legal duties and privacy practices with respect to your Protected Health Information ("PHI"). SPA is required to abide by the terms of this Notice currently in effect, and may need to revise the Notice from time to time. Any required revisions of this Notice will be effective for all PHI that SPA maintains. A current copy of the Notice will be posted in each office and you may request a paper, or electronic, copy of it.

PHI consists of all individually identifiable information which is created or received by SPA and which relates to your past, present or future physical or mental health condition, the provision of health care to you, or the past, present or future payment for health care provided to you.

USE AND DISCLOSURE OF PHI FOR WHICH YOUR CONSENT OR AUTHORIZATION IS NOT REQUIRED

HIPAA permits SPA to use or disclose your PHI in certain circumstances, which are described below, without your authorization. However, Florida law may not permit the same disclosures. SPA will comply with whichever law is stricter.

1. **Treatment**: SPA may use and disclose your PHI to provide, coordinate or manage your health care and related services, including consulting with other health care providers about your health care or referring you to another health care provider for treatment. For example, SPA may discuss your health information with a specialist to whom you have been referred to ensure that the specialist has the necessary information he or she needs to diagnose and/or treat you. Further, SPA may contact you to remind you of a scheduled appointment.

2. **Payment**: SPA may use and disclose your PHI, as needed, to obtain payment for the health care it provides to you. For example, SPA may disclose to a third-party payer the treatment you are going to receive to ensure that the payer will cover that treatment. Additionally, SPA may disclose to a third party payer or grant funding service, as necessary, the type of services you received to reimbursement for your treatment.

3. **Health Care Operations**: SPA may use or disclose your PHI in order to carry out its administrative functions. These activities include, but are not limited to, quality assessment and improvement activities, reviewing the competence or qualification of health care professionals, conducting training programs in which students provide treatment under the supervision of one of SPA's health care professionals, business planning and development, business management and general administrative activities. For example, SPA may disclose your PHI to accreditation agencies reviewing the types of services provided.

4. **Required by Law**: SPA may use or disclose your PHI to the extent that such use or disclosure is required by law.

5. **Public Health**: SPA may disclose your PHI to a public health authority, employer or appropriate governmental authority authorized to receive such information for the purpose of: (a) preventing or controlling disease, injury or disability; reporting disease or injury; conducting public health surveillance, public health investigations and public health interventions; or at the direction of a public health authority, to an official of a foreign government agency in collaboration with a public health authority; or reporting child abuse or neglect; (b) activities related to the quality, safety or effectiveness or activities or products regulated by the Food and Drug Administration; (c) notifying a person who may have been exposed to a communicable disease or may otherwise be at risk of spreading a disease or condition.

6. **Abuse, Neglect or Domestic Violence**: SPA may disclose your PHI to a government authority authorized to receive reports of abuse, neglect or domestic violence if it reasonably believes that you are a victim of abuse, neglect or domestic violence. Any such disclosure will be made: 1) to the extent it is required by law; 2) to the extent that the disclosure is authorized by statute or regulation and SPA believes the disclosure is necessary to prevent serious harm to you or other potential victims; or 3) if you agree to the disclosure.

7. **Health Oversight Activities**: SPA may disclose your PHI to a health oversight agency for any oversight activities authorized by law, including audits; investigations; inspections; licensure or disciplinary actions; civil, criminal or administrative actions or proceedings; or other activities necessary for the oversight of the health care system, government benefit programs, compliance with government regulatory program standards or applicable laws.

 Patient Name: _____ Date of Birth: _____ *(nppcomplete)*

8. **Judicial and Administrative Proceedings**: SPA may disclose your PHI in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal, or in response to a subpoena, discovery request, or other lawful process upon receipt of "satisfactory assurance" that you have received notice of the request.

9. **Law Enforcement Purposes**: SPA may disclose limited PHI about you for law enforcement purposes to a law enforcement official: (a) in compliance with a court order, a court-ordered warrant, a subpoena or summons issued by a judicial officer or an administrative request; (b) in response to a request for information for the purposes of identifying or locating a suspect, fugitive, material witness or missing person; (c) in response to a request about an individual that is suspected to be a victim of a crime, if, under limited circumstances, SPA is not able to obtain your consent; (d) if the information relates to a death SPA believes may have resulted from criminal conduct; (e) if the information constitutes evidence of criminal conduct that occurred on the premises of SPA ; or (f) in certain emergency circumstances, to alert law enforcement of the commission and nature of a crime, the location and victims of the crime and the identity, or description and location of the perpetrator of the crime.

10. **Coroners, Medical Examiners and Funeral Directors**: SPA may disclose your PHI to a coroner or medical examiner for the purpose of identification, determining a cause of death or other duties authorized by law. SPA may disclose your PHI to a funeral director, consistent with all applicable laws, in order to allow the funeral director to carry out his or her duties.

11. **Research**: SPA may use or disclose your PHI for research purposes, provided than an institutional review board authorized by law or a privacy board waives the authorization requirement and provided that the researcher makes certain representations regarding the use and protection of the PHI.

12. **Serious Threat to Health or Safet**y: SPA may disclose your PHI, in a manner which is consistent with applicable laws and ethical standards, if the disclosure is necessary to prevent or lessen a serious threat to health or safety of a person or the public, or the information is necessary to apprehend an individual.

13. **Specialized Government Functions**: SPA may also disclose your PHI, (a) If you are a member of the United States or foreign Armed Forces, for activities that are deemed necessary by appropriate military command authorities to assure the proper execution of a military mission; (b) to authorized federal officials for the conduct of lawful intelligence, counter-intelligence and other national security activities authorized by law; (c) to authorized federal officials for the provision of protective services to the President, foreign heads of state, or other people authorized by law and to conduct investigations authorized by law; or (d) to a correctional institution or a law enforcement official having lawful custody of you under certain circumstances.

14. **Workers' Compensation**: SPA may disclose your PHI as authorized by, and in compliance with, laws relating to workers' compensation and other similar programs established by law.

USES AND DISCLOSURES TO WHICH YOU MAY OBJECT

15. If you do not object to the following uses or disclosures of your PHI, SPA may: 1) disclose to a family member, other relative, a close personal friend, or other person identified by you the information relevant to their involvement in your care or payment related to your care; 2) notify others, or assist in the notification, of your location, general condition, or death; or 3) disclose your PHI to assist in disaster relief efforts.

OTHER USES AND DISCLOSURES OF PHI

16. Any use or disclosure of your PHI that is not listed herein will be made only with your written authorization. You have the right to revoke such authorization at any time, provided that the revocation is in writing, except to the extent that: 1) SPA has taken action in reliance on the prior authorization; or 2) If the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

YOUR RIGHTS REGARDING YOUR PHI

17. **Restriction of Use and Disclosure**: You have the right to request that SPA restrict the PHI it uses and discloses in carrying out treatment, payment and health care operations. You also have the right to request that SPA restrict the PHI it discloses to a family member, other relative or any other person identified by you, which is relevant to such person's involvement in your treatment or payment for your treatment. By law, SPA is not obligated to agree to any restriction that you request. If SPA agrees to a restriction, however, it may only disclose your PHI in accordance with that restriction, unless the information is needed to provide emergency health care to you. If you wish to request a restriction on the use and disclosure of your PHI, please send a written request to the Privacy Officer which specifically sets forth: 1) that you are requesting a restriction on the use or the disclosure of your PHI; 2) what PHI you wish to restrict; and 3) to whom you wish the restrictions to apply (e.g., your spouse). SPA will not ask why you are requesting the restriction. The Privacy Officer will review your request and notify you whether or not SPA will agree to your requested restriction. You also have the right to request to restrict disclosure of your PHI to a health plan, if the disclosure is for payment or health care operations and the disclosure pertains to a health care item or service for which you have paid out of pocket in full.

18. **Marketing and Sale of PHI**: Most uses and disclosures of PHI for marketing and the sale of PHI require your authorization.

19. **Fundraising**: SPA may contact you for purposes of fundraising to support its programs. You have the option to opt-out of this type of communication.

20. **Confidential Communications**: You have the right to receive confidential communications of your PHI. You may request that you receive communications of your PHI from SPA in alternative means or at alternative locations. SPA will accommodate all reasonable requests, but certain conditions may be imposed.

To request that SPA make communications of your PHI by alternative means or at alternative locations, please send a written request to the Privacy Officer setting forth the alternative means by which you wish to receive communications or the alternative location at which you with to receive such communications. SPA will not ask why you are making such a request.

21. **Access to PHI**: You have the right to inspect and obtain a copy of your PHI maintained by SPA. Under HIPAA, you do not have the right to inspect or copy information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding, or information that SPA is otherwise prohibited by law from disclosing.

If you wish to inspect or obtain a copy of your PHI, please send a written request to the Privacy Officer. If you request a copy of your PHI, SPA may charge a fee for the cost of copying and mailing the information. You may also request that a copy of your PHI be transmitted to you electronically.

HIPAA permits SPA to deny your request to inspect or obtain a copy of your PHI for certain limited reasons. If access is denied, you may be entitled to a review of that denial. If you receive an access denial and want a review, please contact the Privacy Officer. The Privacy Officer will designate a licensed health care professional to

review your request. This reviewing health care professional will not have participated in the original decision to deny your request. SPA will comply with the decision of the reviewing health care professional.

22. **Amending PHI**: You have the right to request that SPA amend your PHI. To request that an amendment be made to your PHI, please send a written request to the Privacy Officer. Your written request must provide a reason that supports the request amendment. SPA may deny your request if it does not contain a reason that supports the requested amendment. Additionally, SPA may deny your request to have your PHI amended if it determines that: 1) the information was not created by SPA and amendment may be made elsewhere; 2) the information is not part of a medical or billing record; 3) the information is not available for your inspection; or 4) the information is accurate and complete.

23. **Notification of Breach**: SPA will notify you following a breach of your PHI as required by law.

24. **Accounting of Disclosure of Your PHI**: You have the right to request a listing of certain disclosure of your PHI made by SPA during the period of up to six (6) years prior to the date on which you make your request. Any accounting you request will not include: 1) disclosures made to carry out treatment, payment or health care operations; 2) disclosures made to you; 3) disclosures made pursuant to an authorization given by you; 4) disclosures made to other people involved in your care or made for notification purposes; 5) disclosures made for national security or intelligence purposes; 6) disclosure made to correctional institutions or law enforcement officials; or 7) disclosures made prior to April 14, 2003. The right to receive an accounting is subject to certain other exceptions, restrictions and limitations set forth in applicable statutes and regulations.

To request an accounting of the disclosures of your PHI, please send a written request to the Privacy Officer. Your written request must set forth the period for which you wish to receive an accounting. SPA will provide one free accounting during each twelve (12) month period. If you request additional accountings during the same twelve (12) month period, you may be charged for all costs incurred in preparing and providing that accounting. SPA will inform you of the fee for each accounting in advance and will allow you to modify or withdraw your request in order to reduce or avoid the fee.

25. **Obtaining a Copy of this Notice**: You have the right to request and receive a paper or electronic copy of this Notice at any time.

COMPLAINTS

26.If you believe that your privacy rights have been violated, you may file a complaint with SPA or with the Secretary of Health and Human Services. To file a complaint with SPA, please contact the Privacy Officer at the address listed on page 1 of this notice. All complaints must be submitted in writing. SPA WILL NOT RETALIATE AGAINST YOU FOR FILING A COMPLAINT. *Select Physicians Alliance, P.L. 1149 Nikki View Dr., Brandon, FL 33511*

Assignment of Insurance Benefits

I authorize my insurance company to pay and hereby assign directly to Tampa Bay Hearing and Balance Center all benefits, if any, otherwise payable to me for services as described on the attached forms.

I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned has personally signed the particular claim. I understand that I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Tampa Bay Hearing and Balance Center, will be credited to my account in accordance with the above said assignment.

Authorization of Release Confidential Prescription Information

I hereby authorize all pharmacies and insurers as may have access to my medication history for the past two years as may exist in a privacy respecting database to release information to Tampa Bay Hearing & Balance Center.

Optimizing our ability to care for you and lowering your risk of adverse reaction to medications and other treatment is the goal of obtaining your medication information. This consent grants permission to health care providers, pharmacists and the active staff of the above named prescription data management services to release a list of all medications for which these entities have medication records which may be of a personal and private nature. Note that these databases may be incomplete if your pharmacy does not participate in database sharing. Neither will this list include over-the-counter medications and supplements/vitamins which you use. This list will not contain information on how well you utilized the prescriptions or why you may have stopped the prescription. To the degree you have supplied allergy information, this database should provide an allergy list but if you have developed an allergy which you have not told a participating pharmacy service about, it will not be listed. Thus, we still need you to bring us a list of all medications and supplements which you use and a complete list of your allergies, including the type of allergic reaction you experienced to the degree that you can give that information to us. Please sign below indicating that all prescription information is to be released.

The patient or legal representative may revoke this consent at any time by written notice to the Tampa Bay Hearing and Balance Center. Revoking this release-of-information consent will not have any effect on any information already used or disclosed before the written notice is received.

This authorization form expires when the above specified information has been transmitted/received, or not later than a year from the date of signature. The patient or legal representative may inspect and/or request a copy of all medical records but a copying charge may be assessed.

The patient or legal representative may refuse to sign or to allow the above specified information to be released or transmitted with recognition that lack of information can affect diagnosis and treatment. The physician will not refuse to care for a patient without this information unless it is viewed by the physician to be critical information in which case the physician may suggest an alternative provider.

Permission for Treatment

Permission is hereby granted for physicians, resident physicians in training, audiologists, audiologists in training, employees, or agents of the Tampa Bay Hearing and Balance Center to render such medical treatment as is deemed necessary.

AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT OR PAYMENT

As part of your healthcare, this practice originates and maintains paper and/or electronic records describing your health history, symptoms, examinations, test results, diagnoses, and treatment, any plans for future care or treatment and payment for the services or treatment we provided. We use this information to:

- Plan your care and treatment
- Communicate with other health professionals or entities who contribute to your healthcare
- Submit your diagnosis and treatment information for payment for the services or treatment provided to you

"ONLY AS PERMITTED OR REQUIRED BY FEDERAL OR STATE LAW", WE MAY USE YOUR PROTECTED HEALTHCARE INFORMATION TO DO THE FOLLOWING:

- To disclose, as may be necessary, your health information (including HIV+/AIDS status, drug/alcohol abuse notes and qualified mental health notes) to other healthcare providers and healthcare entities (such as: referrals to or consultation with, other healthcare professionals, laboratories, hospitals, etc.) or to others as may be required by law or court order concerning your treatment, payment and/or healthcare.
- To request from other healthcare entities and/or healthcare providers (i.e. doctors, dentists, hospitals, labs, imaging centers, etc.) specific healthcare information we may need for planning your care and treatment.
- To submit the necessary information to your insurance company(s) for coverage verification as well as the diagnosis and treatment information to your insurance company(s), other agencies and/or individual(s) for payment of our services or treatment we provided to you.
- To leave appointment reminders or other minimum necessary information related to your healthcare or healthcare payments on your answering machine, your mobile voice mail or with a household family member.
    - [ ] Please check here if you do not want us to leave messages on your answering machine or with a household family member.
    - [ ] Please check here if you do not want us to leave a message on your mobile voice mail.
- To discuss your health or payment information (only the minimum necessary in our judgment) with family members or other persons who are or may be involved with your healthcare treatment or payments.
- If you choose, please list by name and relationship the persons with whom we may share your healthcare or payment information:

  _____

  _____
- You may request a copy of, or as a new patient, will be given a copy of our "*Notice of Patient Privacy Practices"* that provides a more complete description of health information uses and disclosures as required by the HIPAA standard.

- You have read or have had the right to read the "*Notice of Patient Privacy Practices"* prior to signing this authorization.

Policy on Responsibility for Patient Fees

To communicate effectively, we have created this policy to help the undersigned understand the responsibilities for payment of our fees. If at any time you as the responsible party have questions or problems with our fees or payment process, please don't hesitate to talk to our Billing Department at **(813) 315-4327**

We require that all charges be paid promptly as we present them. In some cases, our fees may be adjusted, based on whether we participate in or accept insurance or government program payments, allowances, or limitations. But, if we present a charge, it means that we have taken any such adjustment into account and that the amount remaining must be paid, then, promptly. If you are to be reimbursed directly by a program for the cost of your care, you must still pay our charges promptly, whether or not you have received that reimbursement.

If you do not agree with patient responsibility amounts or reimbursement amounts set by the insurance company or government program, that matter is between the responsible party and that program. We are happy to provide factual information about the patient's care and billing to assist appeals with such entities, but we still require the charges be paid promptly, even if the issue with any reimbursement program has not been resolved.

Payment for our services is due at the time that those services are provided, and we expect that all charges we present at a visit will be paid at the time of the visit. This includes, among other things, copay amounts, program deductibles, earlier charges that remain unpaid, and charges for services that we believe are not covered by, or are left over as patient-responsible party's duty to pay after coverage by insurance or government programs. We may also present charges by written statement via the mail or through our Patient Portal (http://www.tampabayhearing.com/portal) following a visit. If we do this, we expect that each charge will be paid in full by return mail or through the Patient Portal online bill payment system (http://www.tampabayhearing.com/portal) the first time it is presented.

We or our agents may send statements and reminders of charges made and amounts that we believe must be paid, or may call the undersigned about the same. By accepting our services, the undersigned is consenting to receive these communications.

In consideration of the services rendered to the patient, the undersigned agrees to accept full financial responsibility for the patient's account in accordance with the regular rates and terms of the facility. Should the account be referred for collection procedures, the undersigned shall pay responsible attorney's fees and collection expenses. At present, that fee is a minimum of 30% of charges collected and is payable before the patient is seen in the offices of the Tampa Bay Hearing and Balance Center at next visit.

Cancellation Policy and "No Show" Fees

We require that you give our office at least 24 business hour notice if you need to cancel or reschedule an office or diagnostic testing appointment. We require at least 72 business hour notice to cancel surgery. Business hours are Monday through Friday from 8:00 AM to 4:30 PM. Please understand that we have scheduled paid staff and physician time to provide you service. The following fees apply for missed appointments or late cancellations:

Office visits	$50.00
Pre-op appointment	$100.00
Surgery	$200.00
In-office procedures	$100.00

Examples of in-office procedures are testing for hearing or balance problems such as Audiogram, Videonystagmography, Evoked Potentials, Electrocochleography, Otoacoustic Emissions, Cochlear Implant Counseling and Programming

Medical Records Request Fees

After receiving your signed authorization we will send medical records at your request to the physician of your choice free of charge. All other requests for release of confidential information have the following charges:

$1.00 per page – up to 25 pages
$.25 cents per page – 26 and more pages

Form Fees
The following fees will apply for filling out forms which take time to complete, to sign, and to enter into your medical record:

Non-Government Disability Forms	$35.00
Non-Surgery related FMLA Forms	$35.00

The following fees apply for the documents below if the request is not made during an office visit.

Physician Statement or Letter	$25.00 - $250.00
Fee is determined based on the information needing to be reviewed	
Miscellaneous Form	$15.00 for 1st page
	$10 per page for additional pages

Prescription Authorization and Refill Fees
Patients requesting prescription refills at any time other than during an office visit will be charged a fee. To avoid these charges, please request all of your prescription needs at the time of your regular visit with your physician. This includes any prescription that needs to be called, faxed, or mailed to any pharmacy or pharmacy provider, local or mail-order. Please understand that managing these requests requires staff and physician time.

Prescription Refill Services	$25.00

In addition, some frequently prescribed medications are no longer being covered by insurance due to changes in prescription drug coverage. If you are prescribed a drug that is not covered by your insurance, we can complete the authorization for you. These authorizations are ultimately approved by your insurance plan and not your physician. If approved, the approval is typically valid for 1 year. An appeal can be filed for denied prior authorizations at your request.

Prior Authorization Completion	$35.00
Appeal for Denied Authorization	Price determined by physician
Fee is determined based on the information needing to be reviewed and physcian time involved	

If you would like to avoid the fee for authorization, you may also contact your insurance carrier and request the name of a similar medication that is covered by your plan. If there is a similar medication available, your medication may be adjusted by your physician at no charge to you. Another option is to pay for your prescription at your pharmacy without using your insurance benefits. Sometimes, the self-pay cost of your medication is less than the prescription co-pay required by your insurance. You will need to contact your pharmacy for these details.

Signature Page

To sign the Signature Form in your patient portal and expedite the check-in process, click this link: Signature Form

The undersigned has read and agrees to the information stated above for the:

- Notice of Privacy Practices for Protected Health Information
- Assignment of Insurance Benefits
- Authorization of Release Confidential Prescription Information
- Permission for Treatment
- Authorization for the use or Disclosure of Health Information for Treatment or Payment
- Policy on Responsibility for Patient Fees

Patient Name (Print): _____

Legal Representative (Print): _____ Relationship to Patient: _____

Signature of Patient or Legal Representative: _____ Date: _____

TAMPA BAY HEARING & BALANCE Center
A division of Select Physicians Alliance

Loren J Bartels MD FACS Christopher J Danner MD FACS
Kyle P Allen MD MPH Jay B Farrior MD

5 Tampa General Circle Suite 610 / Harbourside Medical Tower / Tampa, FL 33606
P: (813) 315-4327 F: (813) 315-4329 http://www.tampabayhearing.com

Authorization for Release of Confidential Information

Patient Name: _____ DOB: _____ SSN: _____

Parent or legal representative *(if applicable)*: _____

Under Federal rules 45CFR 164.501 from the Health Insurance Portability and Accountability Act of 1996 (HIPAA):

I Hereby Authorize: ***(Sender of medical record information)***	**To Release Protected Health Information To:** ***Receiver of medical record information***
Name:	**Tampa Bay Hearing and Balance Center** *div of Select Physicians Alliance* 5 Tampa General Circle Suite 610 Harbourside Medical Tower Tampa, FL 33606 P: **(813) 315-4327** F: **(813) 315-4329**
Address:	
Address:	
City, State ZIP:	
Fax Number:	
Phone Number:	

Information to be released: **Including dates from _____ to _____**

__All hearing tests (dates) __All balance tests (dates) __All ear, brain, sinus and neck imaging reports and films (dates) __all allowed blood tests in last 12 months and other as specified:

__Medical evaluations (dates) __Heart tests __Pathology reports __Hospital records

__Emergency medical reports __Other:

This consent grants permission to health care providers and the active staff of the above named health care facilities to receive and/or to release above specified medical information to each other which may be of a personal and private nature. This release does not cover privileged information related but not limited to drug and alcohol abuse, HIV status, psychological problems or other information in the medical records unless specifically designated below. Checked items below are specific authorization for release of privileged information and must be initialed by the patient/representative:

__Psychology and psychiatry diagnoses and medications (not notes): initial/date

__HIV and other sexually transmissible disease information: initial/date

__Genetic Testing: initial/date

__Drug and alcohol abuse information: initial/date

The patient or legal representative may revoke this consent at any time by written notice to the Tampa Bay Hearing and Balance Center. Returning a copy of this notice with a signature on the next line is sufficient: authorization revoked: Date _____. Revoking this release-of-information consent will not have any effect on any information already used or disclosed before the written notice is received. This authorization form expires on (date) or when the above specified information has been transmitted/received, or not later than a year from the date of signature. The patient or legal representative may inspect and/or request a copy of all medical records but a copying charge may be assessed. The patient or legal representative may refuse to sign or to allow the above specified information to be released or transmitted with recognition that lack of information can affect diagnosis and treatment. The physician will not refuse to care for a patient without this information unless it is viewed by the physician to be critical information in which case the physician may suggest an alternative provider.

PATIENT SIGNATURE & DATE:	
WITNESS SIGNATURE & DATE:	