CENTER FOR THE CARE OF THE PROFESSIONAL VOICE
HABEN PRACTICE FOR VOICE & LARYNGEAL LASER SURGERY, PLLC

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WWW.PROFESSIONALVOICE.ORG

EXCEPTIONAL CARE FOR DISORDERS OF VOICE, SWALLOWING, BREATHING AND LARYNX CANCER

Name _____ PLEASE FILL OUT **ALL** PAGES

Describe your problem in a few words _____

When did it begin? _____

Did it come on: slowly? all-of-a-sudden? after _____

Anything make it better? _____

Anything make it worse? _____

Have you tried any treatments or medications? _____

If yes, have they helped? no a little a lot

Do you smoke now? no yes, _____ packs per day for _____ YEARS

If NO, have you ever smoked? no yes, _____ packs per day for _____ YEARS

I quit smoking in (year) _____

Do you drink any soda or beer? no yes, _____ per WEEK

Have you had a similar problem like this before? no yes, when? _____

Does your problem cause you any pain of discomfort? no yes

Severity of the problem? (least) 1/10 3/10 5/10 7/10 9/10 10/10 (most)

Do you … (circle all that apply)?

Eyes/Ears/ Nose: wear glasses/contacts? have cataracts, glaucoma, vision loss, blurry vision? Hearing loss/ aids, ringing in the ears, dizziness, ear pain/ drainage? Nasal blockage, nosebleeds, freq. sinus infections, post-nasal drip, allergies?

Breathing: use oxygen? have shortness of breath, chronic cough or wheezing?

Cardiac: have chest pain, enlarged heart, heart failure, irregular heartbeat, pacemaker? Chest pain when walking up two flights of stairs? High blood pressure, blood clots, use blood thinners/ aspirin?

GI: GERD/ heartburn, hiatal hernia, irritable bowel, diverticulitis, hemorrhoids?

Bladder: frequent urination, burning/pain/blood in urine, kidney stones large prostate?

Neurological: have migraines, headaches, weakness/numbness, tremors, or seizures?

Skin: have moles that have changed, rashes, sores that do not heal/itch?

Diabetes, TMJ, chronic pain, fibromalgia, depression, anxiety, autoimmune disease?

Chronic fatigue, alcohol/ chemical dependency, severe stress, psychiatric disorder?

ALLERGIES? _____

Disabled/disability: _____

Cancer History: _____

OTHER (list here): _____

CENTER FOR THE CARE OF THE PROFESSIONAL VOICE

EXCEPTIONAL CARE FOR VOICE, SWALLOWING & BREATHING DISORDERS

C C
P V

Medicine List

(Include ALL medicines taken, i.e., prescription, nonprescription, vitamins, and herbals)

Medicines: Generic, Name (Brand) & Strength Example: Lovastatin (Mevacor) 20mg	**DIRECTIONS** One tablet daily	**TIME(S) TAKEN** 6 PM	**Name of Prescriber if not Self** Dr. Jones	**Start Date** 8/6/07	**Stop Date***

*When a medicine is stopped, place the date in the “stop date” column and draw a line through that row.

CENTER FOR THE CARE OF THE PROFESSIONAL VOICE

EXCEPTIONAL CARE FOR VOICE, SWALLOWING & BREATHING DISORDERS

Welcome to our office

I, the undersigned, realize that I am financially responsible for all services rendered to me by the Haben Practice for Voice & Laryngeal Laser Surgery, PLLC.

For those insurances for which the Haben Practice for Voice & Laryngeal Laser Surgery accepts assignment, I realize that I am personally responsible for all co-payments, deductibles and non-covered services, as dictated by my insurance coverage.

Commercial Insurance: I hereby authorize release of information necessary to file a claim with my insurance company and assign payment of benefits to the physician indicated on the claim.

HMO Insurance: I understand that if I do not have a referral for my office visit and am unable to obtain one from my Primary Care Physician, that I will be financially responsible for all services rendered.

Medicare: I request that payment of authorized Medicare benefits be made on my behalf to the Haben Practice for Voice & Laryngeal Laser Surgery, PLLC, for any services rendered. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, any information required to process my Medicare claims.

I permit a copy of this authorization to be used in place of the original.

Signed by: _____ _____ _____

Signature of Patient or Legal Guardian | Date | Relationship to Patient

_____ _____

Print Patient's Name | Print Name of Legal Guardian, if applicable

Patient/guardian must be provided with a signed copy of this authorization form.

AMBULATORY CARE
INVOLVEMENT IN CARE DISCUSSION FORM
(Reference HIPPA policy OP23.2)

Patient Name: _____ DOB: _____
Medical Record #: _____

Haben Practice for Voice & Laryngeal Laser Surgery, PLLC, may discuss protected health information, including lab/test results and payment issues with the following people:

Date	Name	Relationship	Comments

COMMUNICATION REQUESTS:

E-mail address: _____

Phone patient using the following number (#) _____

YES	NO	
[ ]	[ ]	May phone patient at work (#) _____
[ ]	[ ]	May leave messages on patient's answering machine
[ ]	[ ]	Other: _____

Primary Physician Name: _____

Primary Physician Address: _____

Pharmacy You Would Like Us To Use, With Phone Number:

This will remain in effect until notified differently by the above patient.
Note: This Discussion form is a worksheet for use by staff to facilitate discussion with whom the patient identifies. It does not require the patient's signature.

Haben Practice for Voice & Laryngeal Laser Surgery

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **Haben Practice for Voice & Laryngeal Laser Surgery** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by **Haben Practice for Voice & Laryngeal Laser Surgery** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Haben Practice for Voice & Laryngeal Laser Surgery** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Haben Practice for Voice & Laryngeal Laser Surgery**.

With this consent, **Haben Practice for Voice & Laryngeal Laser Surgery** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **Haben Practice for Voice & Laryngeal Laser Surgery** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked “Personal and Confidential.”

With this consent, **Haben Practice for Voice & Laryngeal Laser Surgery** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **Haben Practice for Voice & Laryngeal Laser Surgery** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **Haben Practice for Voice & Laryngeal Laser Surgery** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Haben Practice for Voice & Laryngeal Laser Surgery** may decline to provide treatment to me.

Signed by: _____ _____ _____

Signature of Patient or Legal Guardian | Date | Relationship to Patient

_____ _____

Print Patient’s Name | Print Name of Legal Guardian, if applicable

Patient/guardian must be provided with a signed copy of this authorization form.

ROCHESTER RHIO

Regional Health Information Organization

RHIO CONSENT FORM

PROVIDER:_____

In this Consent Form, you can choose whether to allow the provider named above to obtain access to your medical records through a computer network operated by the Rochester RHIO, which is part of a statewide computer network. This can help collect the medical records you have in different places where you get health care, and make them available electronically to our office.

You may use this Consent Form to decide whether or not to allow the provider named above to see and obtain access to your electronic health records in this way. You can give consent or deny consent, and this form may be filled out now or at a later date. **Your decisions will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent may not be the basis for denial of health services.**

If you check the **"I GIVE CONSENT"** box below, you are saying "Yes, the above named provider's staff involved in my care may see and get access to all of my medical records through the Rochester RHIO."

If you check the **"I DENY CONSENT"** box below, you are saying "No, the provider named above may not be given access to my medical records through the Rochester RHIO for any purpose."

The Rochester RHIO is a not-for-profit organization. It shares information about people's health electronically and securely to improve the quality of health care services. This kind of sharing is called ehealth or health information technology (health IT). To learn more about ehealth in New York State, read the brochure, "Better Information Means Better Care." You can ask this provider for it, or go to the website www.ehealth4ny.org.

Please carefully read the information on the back of this form before making your decision.

Your Consent Choices. You can fill out this form now or in the future. You have two choices.

- ☐ **I GIVE CONSENT for the Provider named above to access ALL** of my electronic health information through the Rochester RHIO in connection with providing me any health care services, including emergency care.
- ☐ **I DENY CONSENT for the Provider named above to access** my electronic health information through the Rochester RHIO for any purpose, *even in a medical emergency*.

  NOTE: UNLESS YOU CHECK THIS BOX, New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through the Rochester RHIO.

_____ Print Name of Patient

_____ Patient Date of Birth

_____ Signature of Patient or Patient's Legal Representative

_____ Date

_____ Print Name of Legal Representative (if applicable)

_____ Relationship of Legal Representative to Patient (if applicable)

Details about patient information in the Rochester RHIO and the consent process:

1. **How Your Information Will be Used**. Your electronic health information will be used by your healthcare provider named on this form **only** to:

   - Provide you with medical treatment and related services
   - Check whether you have health insurance and what it covers
   - Evaluate and improve the quality of medical care provided to all patients.

NOTE: The choice you make in this Consent Form does NOT allow health insurers to have access to your information for the purpose of deciding whether to give you health insurance or pay your bills. You can make that choice in a separate Consent Form that health insurers must use.

2. **What Types of Information about You Are Included**. If you give consent, the provider named on this form may access ALL of your electronic health information available through the RHIO. This includes information created before and after the date of this Consent Form. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may relate to sensitive health conditions, including but not limited to:

   - Alcohol or drug use problems
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - HIV/AIDS
   - Mental health conditions
   - Sexually transmitted diseases

3. **Where Health Information About You Comes From**. Information about you comes from places that have provided you with medical care or health insurance ("Information Sources"). These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, community-based eldercare services, emergency medical services and other ehealth organizations that exchange health information electronically. A complete list of current Information Sources is available from the Rochester RHIO. You can obtain an updated list of Information Sources at any time by checking the Rochester RHIO's website at www.grrhio.org or by calling 877.865.RHIO (7446).

4. **Who May Access Information About You, If You Give Consent.** Only these people may access information about you: doctors and other health care providers who serve on the provider named on this form's medical staff who are involved in your medical care; health care providers who are covering or on call for this provider's doctors; and staff members who carry out activities permitted by this Consent Form as described above in paragraph one.

5. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call the provider named on this form at:_____; or visit the Rochester RHIO's website:www.grrhio.org; or call the NYS Department of Health at 1-877-690-2211 .

6. **Re-disclosure of Information.** Any electronic health information about you may be re-disclosed by the provider named on this form to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. Some state and federal laws provide special protections for some kinds of sensitive health information, including HIV/AIDS and drug and alcohol treatment. Their special requirements must be followed whenever people receive these kinds of sensitive health information. The Rochester RHIO and persons who access this information through the Rochester RHIO must comply with these requirements.

7. **Effective Period**. This Consent Form will remain in effect until the day you withdraw your consent.

8. **Withdrawing Your Consent**. You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to the Rochester RHIO. You can also change your consent choices by signing a new Consent Form at any time. You can get these forms on the Rochester RHIO's website at www.grrhio.org, or by calling 877.865.RHIO (7446). **Note: Organizations that access your health information through the Rochester RHIO while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.**

9. **Copy of Form**. You are entitled to get a copy of this Consent Form after you sign it**.**

Medicare Payer Questionnaire

PLEASE PRINT:
Name: _____ Date of Birth: _____ Age: _____

1. Are you employed? □ Y □ N
   - If no, and you are retired, please give retirement date:
     _____

2. Are you covered by a group health insurance plan through anyone's current employer? □Y □ N
   - Name/Address of Insurance: _____
   - Name of policy Owner: _____ Relation: _____ ID# _____
   - Name of Employer: _____
   - Number of Employees: □ 1-19 □ 20-49 □ 50-99 □100+

3. If you are under 65 years of age, are you disabled? □ Y □ N If yes, date last worked: _____

4. Is today's visit related to and/or authorized by:
   Government Reseach Grant □ Y □ N Black Lung Program □ Y □ N

   Veterans Affairs (VA) □ Y □ N Native American Health Plan □ Y □ N

   Other Government program (other than Medicaid): □ Y □ N
   If yes, specify which program: _____

5. Do you have End Stage Renal Disease that has been diagnosed within the pass 30 months? □ Y □ N

   Date of first dialysis treatment: _____ Date of self-dialysis training: _____ Date of kidney transplant: _____

6. If you spouse is retired, please answer:

   Spouse's Name: _____ Retirement Date: _____

7. Is today's visit due to any type of accident? □ Y □ N

   If yes, what kind: □ Auto □Job Related □Liability (other party is responsible) □ Other

   Date of injury/illness: _____

   Description of accident: _____