SHEAEARCLINIC
EAR, NOSE AND THROAT

6133 POPLAR PIKE AT RIDGEWAY
MEMPHIS, TN 38119

Tel (901) 761-9720 Toll Free (800) 477-SHEA Email: chris.hall@sheaclinic.com

Thank you for entrusting us with your medical care. Your appointment is with **Dr. Chris Hall**.

First, please fill out the accompanying forms before arriving and bring these forms with you. This will enable us to key your information into the computer before you arrive. If you cannot do this, then please arrive 30-45 minutes early in order to give us time to do this before your appointment.

Here is a checklist of things to do before your visit:

- Please fill out any relevant questionnaires included in this packet.
- Please get the phone and fax numbers of your primary care physicians, your referring physicians and any other physicians with whom you will want us to communicate (see form).
- We would like to have the phone number of your pharmacy (see form). This may be easily found on any bottle of medicine from that pharmacy.
- Please read any information brochures / handouts accompanying this letter if they are relevant.
- If you have had a CT scan (usually of your sinuses), it is best to bring a copy of the scan (not just the report) with you. (They never seem to arrive if you just call and have them sent).
- If you have had a sleep study, either bring a copy with you or fax us back the name and number of the sleep lab, along with a signed authorization to obtain the results.
- Stop all antihistamines for one (1) week prior to your appointment.

Once the paperwork is done, I will talk with you about your symptoms and perform a head and neck examination. First, I will spray some medicine (Afrin® and lidocaine) in your nose to shrink and numb the membranes. Then, I will look in your ears, mouth, and throat. I may use a small mirror in the back of your throat to look at your vocal cords. I will palpate (feel) your neck to see if there are any masses. Finally, I will examine your nose and sinuses. If you need it, I will pass a small telescope into your nose to examine the internal structures, as well as the openings to the sinuses. If you have a throat or voice problem, and I cannot perform an adequate examination with a mirror, then I will pass a small flexible telescope through your nose and into your throat. These examinations do not hurt.

After the examination, we will discuss my initial diagnosis, and the various options we have for treatment.

The Physicians of Shea Ear Clinic participate in Medicare, Blue Cross/Blue Shield and most other Commercial Insurance plans. **SHEA EAR CLINIC DOES NOT PARTICIPATE IN ANY MEDICAID PLANS, INCLUDING TENNCARE.** You are responsible for paying any co-pays, coinsurance and/or deductibles based on your insurance's contract rates. Please check with your insurance company to learn if Shea Ear Clinic participates in your plan. **If Shea Ear Clinic is not a participating provider** in your insurance plan, you may or may not have out-of-network benefits. Regardless, you will be responsible for paying any deductibles and/or coinsurance at the time of service. If you do not have any out-of-network benefits, you will be considered a "self-pay" patient. **Self-pay patients are required to pay a $500.00 deposit before services are rendered**. **If your insurance plan requires a referral, you must obtain this referral prior to your appointment date.**

Most SHEA EAR CLINIC patients stay at the Sonesta Suites connected to the SHEA EAR CLINIC by a walkway. The telephone number is (800) 766-3782 and be sure to ask for the special SHEA EAR CLINIC rate. A listing of additional nearby hotels is included in this packet and may or may not offer a special "Shea" rate.

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NOTICE!

Registration Forms

MUST be completed

BEFORE signing in!

Please print clearly and bring completed forms with you at the time of your appointment.

PATIENT INFORMATION: Date: _____

Pharmacy: _____
Name Address Phone

Child's Name: _____
Last Middle First

Date of Birth: _____ Sex: _____ SSN: _____

Race: _____ Ethnicity: _____ Language: _____

Address: _____
Street City State Zip

Home # (____) _____Fax#(_____) _____ Email: _____

School: _____ Address: _____

PARENTS and/or GUARDIANS:

MOTHER: _____Social Security No. _____

Street Address_____City/State/Zip _____

Telephone No.(_____)_____ Fax (_____)_____ E-Mail _____

Occupation _____ Employer _____

Employer's Street Address_____ Telephone No. (_____)_____

Employer's City/State/Zip_____

FATHER: _____ Social Security No. _____

Street Address_____ _____City/State/Zip _____

Telephone No. (_____)_____Fax(_____)_____ E-Mail _____

Occupation _____ Employer _____

Employer's Street Address _____Telephone No. (_____)_____

Employer's City/State/Zip_____

ADDITIONAL INFORMATION:

Nearest Relative or Friend not living at the same address: _____ / _____
Name Relationship

Telephone #:(_____)_____ Address: _____
Street City State Zip

PRIMARY INSURANCE INFORMATION:

_____
Name of Insurance Co. Individual Policy No. Name of Insured

_____
Street Address Group Policy No. Relationship to Patient

_____
City, State, Zip Insured Date of Birth Insured Social Security No.

SECONDARY INSURANCE INFORMATION:

_____

Name of Insurance Co. Individual Policy No. Name of Insured

_____

Street Address Group Policy No. Relationship to Patient

_____

City, State, Zip Insured Date of Birth Insured Social Security No.

OTHER DOCTORS INFORMATION:

Referring Doctor: _____ Telephone #: (_____)_____

Address: _____

Local General Doctor: _____ Telephone #: (_____)_____

Address: _____

During your testing prior to being seen by your doctor, certain tests must be done. If you are the patient or responsible for the patient, do you consent to have these tests performed on you or any child or other adult for whom you are responsible?

_____ Yes _____ No Signature: _____

ASSIGNMENT OF BENEFITS:

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government or medical benefits to the party who accepts assignment.

_____ _____ _____

Guarantor Signature Relationship to Patient Date

_____

Witness Signature

RELEASE OF PROTECTED HEALTH INFORMATION:

The Shea Ear Clinic has my permission to discuss my protected health information with the following people:

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Parent or Guardian Signature Date

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6133 POPLAR PIKE
MEMPHIS, TN 38119
PHONE: (901) 761-9720 / FAX: (901) 680-1992

PARENTAL CONSENT FORM

Child's Name _____ Date of Birth _____

The undersigned does hereby give permission for the above named child to be examined and treatment rendered in the offices of Shea Ear Clinic.

I authorize the listed adults, in whose care the minor will be entrusted, to consent to any medical treatment, surgical treatment, and/or hospital care, to be rendered to the minor, based on the advice of any Shea Ear Clinic physician licensed under the state medical board and the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the Shea Ear Clinic or the hospital.

Authorized Persons:_____

_____

_____

_____

I understand that I will be liable and agree to pay expenses incurred in connection with medical services rendered to the aforementioned child pursuant to this authorization.

_____
Parent or Guardian (Print)

_____ _____
Signature Date

_____ _____
Witness Date

SHEAEARCLINIC
EAR, NOSE AND THROAT

PATIENT FINANCIAL POLICY

The Shea Ear Clinic is a participating provider with many managed health care insurers to accommodate the needs of our patients.

We are committed to building a successful physician-patient relationship with you. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment of services is a part of the relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, phone number, insurance information, etc.).

Insurance Claims & Co-Pays
The patient must present an insurance card at each visit. All co-payments, co-insurance, deductibles and past due balances are due at the time of checkout. Insurance is a contract between you and your insurance company. Insurance programs have many individual requirements and the same insurance company may have different benefits based upon the employer group or individual policy.

If your insurance company has special requirements for your services, such as a special lab requirement, a limitation on the number of times a service can be performed, limitations on where outpatient services may be performed, or requirements for primary care referrals, you must advise our office of these provisions or you may be responsible for additional charges. The Shea Ear Clinic makes every attempt to minimize your out-of-pocket costs by following any provisions of which you make us aware.

Although we may estimate what your insurance company will pay, the insurance company makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, it is your responsibility to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance.

Referrals and Prior Authorizations
If your insurance company requires a referral and/or prior authorization, you are responsible for obtaining it. Failure to obtain the referral and/or prior authorization may result in a lower or no payment from insurance, and the balance will be your responsibility.

Self-Pay Accounts
Self-Pay accounts are patients without insurance coverage or patients without any out-of-network benefits. Self-pay patients are required to pay a $500.00 deposit before services are rendered. All guarantors are required to provide proof of their social security number or provide the Shea Ear Clinic with a $500.00 deposit before services are rendered.

Missed Appointments
The Shea Ear Clinic requires a 24-hour notice of appointment cancellation. Appointments missed and are not previously cancelled may be charged a fee of $25.00.

Returned Checks
The charge for a returned check is $40.00, payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check.

Outstanding Balance Policy
It is our office policy that all past due accounts be sent two statements. In the event an account is turned over for collection, the person financially responsible for the account will be responsible for all collection costs, including attorney fees and court costs.

Medical Records Policy
The Shea Ear Clinic will provide your medical records to a referred physician as a courtesy. Any other requests will require the prepayment of a $20.00 retrieval fee plus $.40 per copied page. This fee is subject to change without notice at any time.

Forms Completion Policy
Requests for the Shea Ear Clinic, our physicians or members of our staff to complete forms will require the prepayment of a $20.00 retrieval fee plus $25.00 per page. This fee applies to all requests for the completion of any disability papers or consultation forms.

I accept and understand the Shea Ear Clinic Financial Policy.

Guarantor Signature	Date
Printed Name of Guarantor	Witness

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NEW PATIENT VISIT/CONSULTATION

First Name: _____ Middle Name: _____ Last Name: _____

What do other people call you? _____

Who referred you to Shea Ear Clinic? _____

Reason for today's visit? _____

Have you ever been diagnosed with any of the following diseases?

	Yes	No		Yes	No
Asthma	___	___	Diabetes	___	___
Kidney Disease	___	___	Thyroid Disease	___	___
Lupus	___	___	Lung Disease	___	___
Bleeding Tendencies	___	___	Nervous System Problems	___	___
Heart Disease	___	___	Tuberculosis	___	___
Epilepsy	___	___	Osteoarthritis	___	___
High Blood Pressure	___	___	Alcoholism	___	___
Hepatitis	___	___	Sickle Cell Disease	___	___
Rheumatoid Arthritis	___	___	Colitis	___	___
Anemia	___	___	Stomach Ulcers ___	___	
Cancer	___	___	Sarcoidosis	___	___
High Cholesterol	___	___	Depression/Anxiety	___	___
Gastric Reflux	___	___	Obstructive Sleep Apnea	___	___

Are you on CPAP? _____

Other medical conditions? _____

List all operations that you have had: (i.e. ear surgery, tonsils, hernias, appendix, gallbladder, etc.)

Procedure	Date	Complications

Please list all current medications, dosages, and how many times per day.

_____ _____

_____ _____

_____ _____

Are you allergic to any medications/drugs? Yes _____ No _____

List all drug allergies below and your reaction to each.

_____ _____ _____

_____ _____ _____

Height_____ Weight_____

Do you smoke or use tobacco? _____ What form? _____
How much per day? _____ For how long? _____
Do you drink alcohol? Yes_____ No_____ Beer_____ Wine_____ Other _____
How much? _____ For how long? _____
Do you drink coffee or tea? _____ How much per day? _____
Do you use much salt in your diet? _____
How many children do you have? _____What are their ages?_____
Have you ever worked around loud noise? _____ Doing what? _____ For how long? _____

Has anyone in your family had:
High Blood Pressure _____ Heart Disease _____ Diabetes _____
Bleeding Problems _____ Lung Disease _____ Stroke _____
Cancer (explain who and what type): _____

Are your parents living? _____What at are their ages now, or when they died? _____

Have you recently had the following:

	Yes	No		Yes	No
Chest Pain	___	___	Nausea/Vomiting	___	___
Breathing Difficulties	___	___	Loss of Control of Bowels	___	___
Numbness/Tingling	___	___	Blood in Urine	___	___
Vision Changes	___	___	Fainting Spells	___	___
Abdominal Pain	___	___	Cough with Blood	___	___
Bloody/Tarry Stools	___	___	Headaches or Migraines	___	___
Pain/Burning Urination	___	___	Unexpected Weight Loss	___	___
Irregular Heartbeat	___	___	Diarrhea	___	___
Cough	___	___	Difficulty Starting Urination	___	___
Dizziness	___	___	Loss of Bladder Control	___	___
Fever or Chills	___	___	Sinus Disease	___	___

Please explain further any "YES" answers. _____
_____

Have you had a CT scan of the head? Yes ___ No ___ Approx. Date: _____
Result: _____

Have you had an MRI of the head? Yes ___ No ___ Approx. Date: _____
Result: _____

The above information is accurate to the best of my knowledge.

_____ _____
Patient/Guardian Signature Date

I have reviewed the above information with the patient.

_____ _____
Physician Signature Date

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Sinus Questionnaire

Name: _____ **Date:** _____

Do you currently have problems, or do you have a history of having problems, with your sinuses or allergies?_____
(Notice! If the answer to the above is "No" or "Not Applicable" there is no need to complete the rest of this form)

How long have you had problems with your sinuses or allergies?_____

Which of the following symptoms do you seem to have <u>all</u> the time?

□ Nasal obstruction	□ Cough	□ Sneezing
□ Post nasal drainage	□ Sore throat	□ Nasal itching
□ Watery/itchy eyes	□ Hoarseness	□ Nosebleeds

Which of the following symptoms typify your episodes of acute sinusitis?

□ Facial pain/pressure	□ Post nasal drainage	□ Cough
□ Headache	□ Bad breath	□ Fever
□ Nasal obstruction	□ Toothache	□ Sore throat

How many times per year do you typically get a sinus infection requiring antibiotics?

□ Never □ 1-3 □ 3-5 □ > 5

Are your symptoms: □ about the same all year □ usually worse in the spring and fall

Have you ever been tested for allergies in the past? □ No □ Yes, skin test □ Yes, blood test

If yes, what year were you tested? _____

Do you remember what you were allergic to? □ Dust □ Cats □ Dogs □ Pollen □ Mold □ Grass □ Trees

Did you ever take allergy shots? □ No □ Yes

If yes, how long did you take them? _____**When did you stop?** _____

Have you found any medications which seem to help your symptoms? _____

What medications have your taken in the past?

□ Antihistamines (Zyrtec, Claritin)	□ Decongestants (Sudafed, Zyrtec-D)	□ Intranasal Steroid Sprays (Flonase, Nasonex, Nasacort)	□ Over the counter medications	□ Cromolyn

Have you ever had asthma? □ No □ Yes **Have you ever had nasal polyps?** □ No □ Yes

Have you had a CT scan of your sinuses?

□No □Yes Approx. Date _____ Result _____

The above information is accurate to the best of my knowledge.

_____ _____
Patient/Guardian Signature Date

HIPAA Notice of Privacy Practices

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your protected health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of your PHI. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

< How we may use and disclose your PHI
< Your privacy rights in regard to your PHI
< Our obligations concerning the use and disclosure of your PHI
< How you can lodge a complaint about how we handle your PHI without your approval for certain matters

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our office in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT: John Gross, Privacy Officer
Shea Ear Clinic
6133 Poplar Pike
Memphis, TN 38119

C. WE MAY USE OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS

1. **Treatment.** Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your friends or family members involved in your care.

2. **Payment.** Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as friends or family members. Also, we may use your PHI to bill you directly for services and items.

3. **Health Care Operations.** Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, to conduct cost-management and business planning activities for our practice, or to train new healthcare workers.

4. **Treatment Options**. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

5. **Release of Information to Family/Friends.** Our practice may release your PHI to a friend or family member who is involved in your care or who assists in taking care of you. For example, a guardian may ask that a neighbor take their parent or child to the physician's office for treatment. This neighbor may have access to this patient's medical information. We may also release information to friends or family members involved in your payment for health services we provide.

6. **Disclosures Required By Law.** Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES WITHOUT YOUR APPROVAL

The following categories describe unique scenarios in which we may use or disclose your PHI without your consent or authorization.

1. **Public Health Risks.** Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths
- Reporting child abuse or neglect
- Preventing or controlling disease, injury or disability
- Notifying a person regarding potential exposure to a communicable disease
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition
- Reporting reactions to drugs or problems with products or devices
- Notifying individuals if a product or device they may be using has been recalled
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance

2. **Health Oversight Activities.** Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general. We may use your information to report diseases to the health department.

3. **Lawsuits and Similar Proceedings.** Our practice may disclose your PHI in response to a court or administrative order if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. **Law Enforcement.** We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. **Serious Threats to Health or Safety.** Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

6. **National Security**. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

E. YOUR RIGHTS REGARDING YOUR PHI

1. **Confidential Communications.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work, or to send communications in a sealed envelope instead of a postcard. You may be asked to pay for additional costs incurred to comply with your request. In order to request a type of confidential communication, you must make written request to our Privacy Officer specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. **Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI only to certain individuals involved in your care or the payment for your care, such as family members and friends. You may request to not have trainees or interns involved in your care. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to our Privacy Officer. Your request must describe in a clear and concise fashion:

(a) the information you wish restricted;
(b) whether you are requesting to limit our practice's use, disclosure or both; and
(c) to whom you want the limits to apply.

3. **Inspection and Copies.** You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to John Gross, SEC Privacy Officer, 6133 Poplar Pike, Memphis, TN 38119 (901) 761-9720 in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying records associated with your request.

4. **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to our Privacy Officer. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request and the reason supporting your request in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. **Accounting of Disclosures**. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain disclosures that our practice has made of your PHI. We are not required to list use of your PHI as part of the routine patient care, payment, or health operations in our practice for paper records. Example of routine patient care, payment, or health operations excluded from an accounting from paper charts include: the doctor sharing information with the nurse, the billing department using your information to file your insurance claim, and discussion of your PHI for purposes of improving our health care delivery system. In order to obtain an accounting of disclosures, you must submit your request in writing John Gross, SEC Privacy Officer, 6133 Poplar Pike, Memphis, TN 38119 (901) 761-9720. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years with paper charts or three years for listings to include treatment and payment from electronic records, from the date of the request, and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. **Right to a Paper Copy of This Notice**. You are entitled to receive a paper copy of our notice of privacy practices. You will be offered a copy on your first visit to the practice. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact our Privacy Officer at (901) 761-9720.

7. **Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice, or with the Secretary of the Department of Health and Human Services; Office of Civil Rights, 200 Independence Avenue, SW, Washington, D.C., 20201, or phone (202) 619-0257 or toll free (877) 696-6775. To file a complaint with our practice, contact John Gross, SEC Privacy Officer, 6133 Poplar Pike, Memphis, TN 38119 (901) 761-9720. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. **Right to Provide an Authorization for Other Uses and Disclosures.** Our practice will obtain your written authorization for uses and disclosures that are not covered by this notice or permitted by applicable law, such as for research or marketing. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

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 healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare 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:

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6133 POPLAR PIKE
MEMPHIS, TN 38119
PHONE: (901) 761-9720 / FAX: (901) 680-1992

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I AUTHORIZE THE RELEASE OF ALL MY MEDICAL RECORDS INCLUDING ANY APPLICABLE BILLING:

FROM:

Name of Doctor or Hospital

Mailing Address

City/State/Zip

TO BE FORWARDED TO:

Name of Doctor

SHEA EAR CLINIC
6133 Poplar Pike
Memphis, TN 38119

Patient's Name (**Please Print**)

Street Address

City/State/Zip

Date of Birth | Date of Last Office Visit

Signature of Patient (Parent or Guardian) | Date Signed

Signature of Witness | Date Signed

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6133 POPLAR PIKE
MEMPHIS, TN 38119
PHONE: (901) 761-9720 / FAX: (901) 680-1992

Patient Insurance Policy

Shea Ear Clinic has enrolled in numerous managed care and traditional insurance plans, health maintenance organizations (HMO's), and many other reimbursement programs in an effort to accommodate the needs and requests of our patients.

While we are pleased to be able to provide this service to you, it is extremely difficult for us, Shea Ear Clinic, to keep track of all of the individual requirements of the various insurance plans. Each plan has different stipulations regarding how often services may be rendered and, even more importantly, where those services may be performed.

Even within the same insurance company, the plan may differ depending upon what type of contract the insured's employer has negotiated.

Providing quality medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance contract guidelines, provided YOU let us know at EACH time of service, exactly what those guidelines constitute.

Unfortunately, if you do not inform us of any special requirements for services, such as lab work, CT scans, or the use of Shea Ear Clinic's ambulatory surgery center (ASC), that are not covered, we will not receive the necessary payment from your insurance company.

In cases resulting in procedures being performed, services being provided and/or supplies being utilized, which are not covered by your plan, the Shea Ear Clinic will not be financially responsible for any reduction in payment or any penalty sustained by the guarantor.

With your cooperation and help, you should be able to receive all of the benefits offered to you, and we will be able to concentrate on the caring for your medical needs.

SHEAEARCLINIC
EAR, NOSE AND THROAT

PATIENT RESPONSIBILITIES

Patients at Shea Ear Clinic have a responsibility to:

1. **Provide accurate and complete information about the present complaint, past illnesses, hospitalizations, medications, and other matters which relate to their health.**

2. **Report their level of pain or unexpected changes in their condition.**

3. **Report whether they clearly understand plans for their care and what is expected of them.**

4. **Follow both the treatment plan recommended by the physician and the Shea Ear Clinic rules and regulations affecting their care and conduct, including the instructions of nurses and other health professionals.**

5. **Accept the outcome of their actions should they refuse treatment or choose not to follow the physician's order.**

6. **Be considerate of the rights of other patients and Shea Ear Clinic staff and for assisting with the control of noise.**

7. **Be respectful of the property of other persons and of the Shea Ear Clinic.**

8. **Meet all of the financial obligations of their health care.**

6133 POPLAR PIKE
MEMPHIS, TN 38119
PHONE: (901) 761-9720 / FAX: (901) 680-1992

PHYSICIAN REFERRAL POLICY

IF THE PATIENT'S INSURANCE REQUIRES A PHYSICIAN REFERRAL, THE REFERRING PHYSICAIN MUST CALL YOUR INSURANCE COMPANY AND OBTAIN A REFERRAL AUTHORIZATION PRIOR TO YOUR APPOINTMENT.

IT IS THE PATIENT'S RESPONSIBILITY TO BRING THEIR REFERRAL INFORMATION WITH THEM, OR HAVE THEIR REFERRING PHYSICIAN SEND THE REFERRAL LETTER BY MAIL OR FAX TO:

SHEA EAR CLINIC
6133 POPLAR PIKE
MEMPHIS, TN 38119

FAX: (901) 683-8440

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PRE-CERTIFICATION POLICY

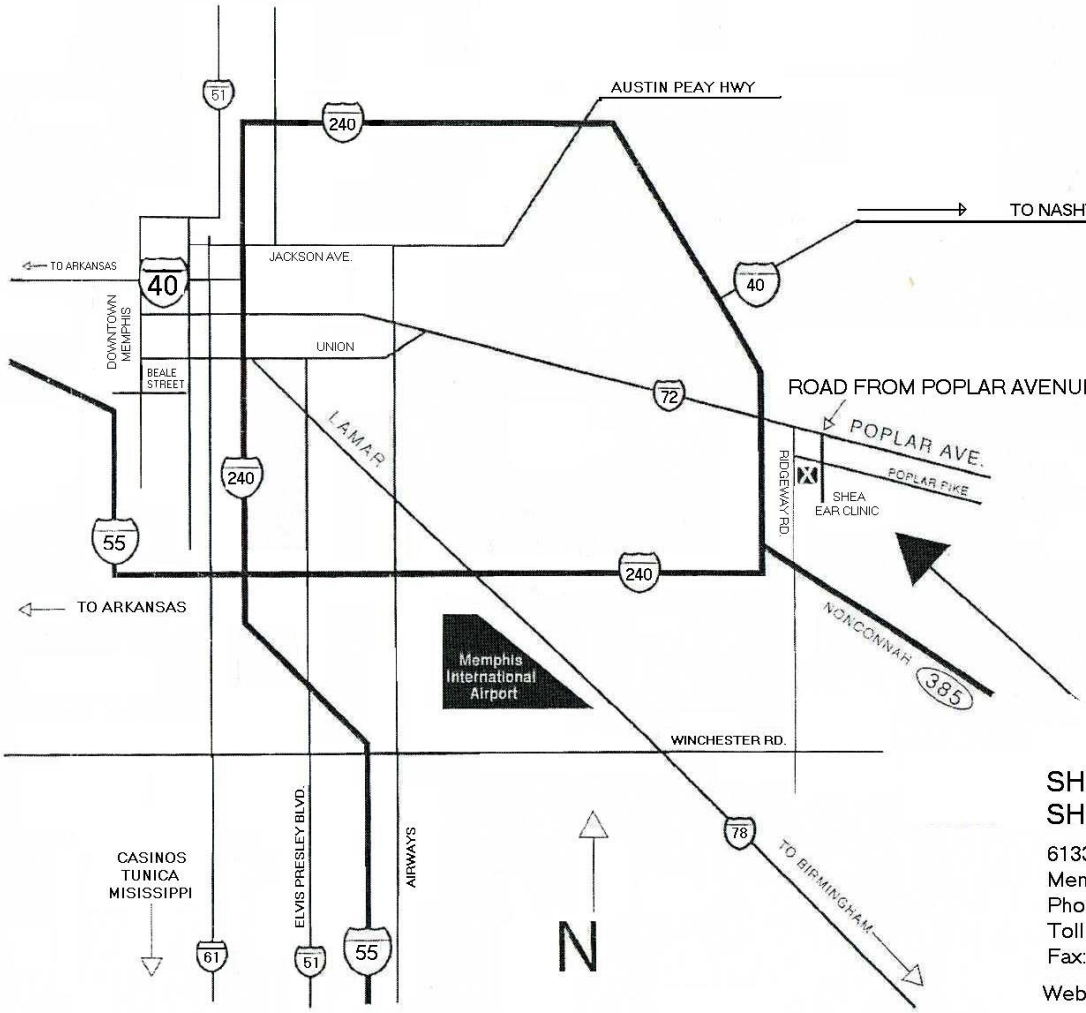
Shea Ear Clinic has adopted the following policy for pre-certification on all insurance plans, health maintenance organizations and other reimbursement plans excluding Medicare:

1. **When provided with complete insurance carrier information at admission, we will assist patients in pre-certifying their admission and stay as directed by their insurance company. Patients should contact their employer if they are unsure of their policy requirements regarding pre-certification.**

2. **Regardless of the outcome of pre-certification efforts, Shea Ear Clinic will NOT be financially responsible for any reduction in payment or any penalty sustained by the patient or the guarantor. Nor will Shea Ear Clinic accept responsibility for pre-certification. Any failure of Shea Ear Clinic personnel to assist in this process will NOT make the Shea Ear Clinic financially liable.**

3. **Shea Ear Clinic will hold the patient, or guarantor, responsible for all balances not paid by the patient's insurance company, HMO or other insurance reimbursement plan, regardless of the conditions of pre-certification, or the outcome of the process.**

4. **Shea Ear Clinic acknowledges the pre-certification process may often be a complex and labor intensive exercise. With a vast multitude of insurance companies, insurance plans within the insurance companies, and other less traditional reimbursement plans, it is the patient's and/or the guarantor's responsibility to know the requirements of their policy. As the owner of the policy, it is imperative the guarantor understand all of the parameters of the plan they own. Accordingly, Shea Ear Clinic will not be held financially responsible when the plan requirements are not fulfilled to the satisfaction of ANY third party payor.**



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Website: www.sheaclinic.com