



**6133 POPLAR PIKE AT RIDGEWAY
MEMPHIS, TN 38119**

Tele: (901) 761-9720 Toll Free: (800) 477-SHEA Fax: (901) 680-1992 Email: p.shea@sheaclinic.com

Thank you for entrusting us with your medical care. Your appointment is with **Dr. Paul Shea**.

CONSULTATION AND EVALUATION OF YOUR PROBLEM WILL BE COMPLETE AND TIME-CONSUMING, SO PLEASE BE PREPARED TO REMAIN AT THE SHEA EAR CLINIC FOR MOST OF THE DAY, IF NECESSARY.

Please bring **ALL** medical records related to your problem with you. Please bring records made by other Ear, Nose and Throat Doctors, Speech and Hearing Centers and/or Hearing Aid Dealers. If you do not have copies of these records, please call or write to have them sent to the Shea Ear Clinic by mail, or fax to (901) 680-1992, well in advance of your appointment. If you cannot keep the assigned appointment, please select another date and time by calling the appointment secretary at (901) 761-9720 or toll free at 1-800-477-SHEA with at least a 48-hour notice.

At the time of your appointment you will be given a routine hearing test and, if necessary, special hearing tests and/or tests of your balance system. There is **no** need to fast the night before your office visit at Shea Ear Clinic. You can have a **light** breakfast the morning of your office visit.

If dizziness, vertigo or loss of balance is part of your reason for visiting the Shea Ear Clinic, you may need to undergo special balance tests during your visit. **If so, please discontinue the following medicines at least five (5) days prior to your office visit if you are taking them: Valium (diazepam), Antivert (meclizine), Dramamine, Phenergan (promethazine), Transderm Scop (scopolamine), Xanax (alprazolam), and Ativan (lorazepam).**

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, and is NOT accepting any new MEDICAID patients. Shea Ear Clinic does NOT participate with TENNCARE or most HMO Plans.** You are responsible for paying any co-pays, coinsurance and/or deductibles based on your insurance's contracted 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 discount rate for Shea Ear Clinic patients.** A listing of additional nearby hotels is listed on our website (www.SheaClinic.com). These hotels may or may not offer a special "Shea" rate. Also, for your convenience, there is also a map with directions posted on our website.

Because we may recommend you remain for an operation or other medical treatment, **you MUST bring one responsible adult to be with you should you decide to have the operation or treatment at this time (possibly the following day).** Otherwise, you will need to schedule an additional trip to have the operation or additional treatment in the future. Do **NOT** bring children or more than one responsible adult with you. If you come by car and receive general anesthesia during an operation, you will need a responsible adult to drive you home.



PAUL F. SHEA, M.D.

As a fourth generation Shea to pursue a career as an ear, nose, and throat doctor, Dr. Paul Shea grew up in a culture of medicine and worked alongside his father from a young age. Not only has he continued a remarkable legacy, but Dr. Paul Shea has made significant contributions to his field through research, teaching, and community involvement.

Since he was a young boy, Dr. Paul Shea watched his father operate on the ears of patients suffering from hearing loss, chronic infections, and many other debilitating conditions. It is not an exaggeration to say he literally grew up in an operating room. Twice in grade school he took his entire class on field trips to the Shea clinic. As a teenager, Dr. Paul Shea worked at Applied Research Corporation, a company started by his father that designed specialized drills for use in ear surgery. As an undergraduate at Vanderbilt University, Paul studied pre-med courses as well as English literature. Following this, Dr. Paul Shea did research for Charles Norris, Ph.D. at Tulane University in New Orleans, where he studied the effect of streptomycin on hair cells, the specialized nerve endings in the inner ear. This work proved pivotal as it provided the basis for the intratympanic perfusion procedure that was developed at the Shea clinic in the 1990's and is now widely used in the treatment of Meniere's disease and other disorders of the inner ear.

Dr. Shea graduated from medical school at Tulane University in 1995 and returned to Memphis where he completed a six-year residency at the University of Tennessee Health Science Center consisting of two years of general surgery followed by four years of Otolaryngology – Head and Neck Surgery. He then completed a fellowship in Neurotology at the Carolina Ear Research Institute in Raleigh, North Carolina under John T. McElveen, M.D. Paul earned his board certification in Otolaryngology-Head and Neck Surgery in 2002 and was recertified in Otolaryngology in 2011. Paul joined the Shea Ear Clinic in 2002 and has a practice in Otolaryngology and Neurotology with a special interest in chronic otitis media, otosclerosis, Meniere's disease, intratympanic perfusion, positional vertigo, cochlear implantation, and acoustic neuroma. He is an associate clinical professor at the University of Tennessee Department of Otolaryngology – Head and Neck Surgery, and is a member of the Memphis ENT Society, the Tennessee Medical Association, the American Neurotologic Society, and the Triological Society, for which he published his thesis last year, entitled "Hearing Results and Quality of Life After Streptomycin/Dexamethasone Perfusion for Meniere's Disease". He holds privileges at Methodist and Baptist Hospitals in Memphis. He is a former board member of the Memphis Oral School for the Deaf, where he helped lobby the Tennessee legislature to pass laws requiring mandatory universal hearing screening in newborns.

He is married to Jessica and has a stepdaughter named Elizabeth. He is an avid motorsports enthusiast and restores classic automobiles as a hobby.

PATIENT INFORMATION

Date: _____

Pharmacy: _____
Name Address PhonePatient's Name: _____
Last Middle First

Date of Birth: _____ Sex: _____ SSN: _____

Marital Status: _____ Race: _____ Ethnicity: _____ Language: _____

Address: _____
Street City State Zip

Home # (____) _____ Work # (____) _____ Cell# (____) _____

Email: _____ Preferred Communication () Email () Text () Telephone Call

EMERGENCY CONTACT:Relative or Friend not living at the same address: _____ / _____ / _____
Name Telephone Relationship**EMPLOYMENT INFORMATION:**

Current Employer: _____ Occupation: _____

Employer's Address: _____
Street City State Zip

If retired, give last employer and occupation: _____ When did you retire? _____ Year

If disabled, who declared you disabled and for what reason? _____

SPOUSE INFORMATION:

Name: _____ DOB: _____ SSN: _____

Employer: _____ Cell #: _____ Occupation: _____

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's Date of Birth Insured's Soc Sec Number

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's Date of Birth Insured's Soc Sec Number

Referring Doctor: _____ Telephone #: (____) _____

Address: _____

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

Address: _____

Cardiologist: _____ Telephone #: (____) _____

Address: _____

Certain tests are often required prior to being seen by your doctor. If you are the patient or are 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's Signature Relationship to Patient Date Witness

PATIENT RESPONSIBILITIES

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 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 Clinic staff and for assisting with the control of noise.
7. Be respectful of the property of other persons and of the Shea Clinic.
8. Meet all of the financial obligations of their health care.

PHYSICIAN REFERRAL POLICY

If the patient's insurance requires a physical referral, the referring physician 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 physicians send the referral letter by mail or fax to:

**SHEA CLINIC
6133 POPLAR PIKE
MEMPHIS, TN 38119
FAX: (901) 683-8440**

PRE-CERTIFICATION POLICY

Shea 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 Clinic will NOT be financially responsible for any reduction in payment or any penalty sustained by the patient or the guarantor. Nor will Shea Clinic accept responsibility for pre-certification. Any failure of Shea Clinic personnel to assist in this process will NOT make the Shea Clinic financially liable.
3. Shea 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 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 Clinic will not be held financially responsible when the plan requirements are not fulfilled to the satisfaction of ANY third party payor.



PATIENT FINANCIAL POLICY

The Shea 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 and a government-issued pictured identification card or provide the Shea Clinic with a \$500.00 deposit before services are rendered.

Missed Appointments

The Shea Clinic requires a 24-hour notice of appointment cancellation. Appointments missed and are not previously cancelled may be charged a fee of \$25.00 in which case this fee must be paid prior to scheduling additional appointments.

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" payment 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 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 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 Clinic Financial Policy.

Guarantor Signature

Date

Printed Name of Guarantor

Witness



NEW PATIENT VISIT/CONSULTATION

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

What do other people call you? _____ Who referred you to Shea 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	___	___
Other medical conditions? _____					Are you on CPAP? _____

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

<u>Procedure</u>	<u>Date</u>	<u>Complications</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

_____	_____
_____	_____
_____	_____

Are you allergic to any medications/drugs? Yes _____ No _____ If yes, please 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? _____

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): _____

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: _____

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 all the time?

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

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

- Facial pain/pressure
- Headache
- Nasal obstruction
- Post nasal drainage
- Bad breath
- Toothache
- Cough
- Fever
- 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? _____ What were you were allergic to? Dust Cats Dogs Pollen Mold Grass Trees

Did you ever take allergy shots? No Yes If yes, for how long? _____ When did you stop? _____

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

What medications have you 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 Approximate Date _____ Result _____

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

Patient/Guardian Signature

Date



Medical Information Release Form
(HIPAA Release Form)

Name: _____

Date of Birth: ____/____/____

Yes ___ No ___ I hereby authorize the Shea Ear Clinic to communicate my medical information including the diagnosis, records; examination rendered to me and billing information. This information may be released to the following individuals:

1. Name _____ Phone # _____
Relationship _____ Alternate # _____

2. Name _____ Phone # _____
Relationship _____ Alternate # _____

Messages

Yes ___ No ___ I give permission to leave messages on my answering machine/voice mail (Test Results or Appointment information). Phone # _____
Alternate # _____

Yes ___ No ___ I give permission to communicate with me via texting and email (Test Results or Appointment information). Cell # _____
Email _____

Yes ___ No ___ I give permission to call my place of employment. Phone # _____

Yes ___ No ___ I give permission to leave messages on my voice mail at work (Test Results or Appointment information). Phone # _____

Yes ___ No ___ I give permission to release information to my employer or my school regarding absences. Employer _____ School _____

Rights of Patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending written notification to the Privacy Officer or Administrator . I understand that revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that the information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I understand I have the right to refuse to sign this authorization and that my treatment will not be conditional on signing. The Release of Information will remain in effect until terminated by me in writing.

Signature of patient or representative _____ Date _____

Signature of Shea Clinic representative _____ Date _____



SHEA EAR CLINIC

EAR, NOSE AND THROAT

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