SHEAEARCLINIC
EAR, NOSE AND THROAT

6133 POPLAR PIKE AT RIDGEWAY
MEMPHIS, TN 38119

Tel: (901) 761-9720 **Toll Free: (800) 477-SHEA** **Email: Victoria.Lim@sheaclinic.com**

Thank you for entrusting us with your medical care. Your appointment is with **Dr. Victoria Lim**.

First, please fill out the requested information and answer the relevant questions on the Shea Clinic patient portal. Otherwise, please complete the registration forms before arriving and, if possible, fax them to (901) 680-1992. This will enable us to key your information into the computer before you arrive. If you cannot do this, please arrive 45 minutes early in order to give us time to enter your information. PLEASE NOTE! As a courtesy to other patients, your failure to register through our patient portal or failure to arrive 45 minutes early to complete the registration process, may result in Shea Clinic having to reschedule 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.
- If your appointment is for allergy testing, please STOP using ALL antihistamines (such as Claritin, Allegra, Zyrtec or Benadryl) 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 place 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 will examine 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 Clinic participate in Medicare, Blue Cross/Blue Shield and most other Commercial Insurance plans. **Shea Clinic does NOT participate in any MEDICAID plans, and is NOT accepting any new MEDICAID patients. Shea 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 Clinic participates in your plan. **If Shea 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 Clinic patients stay at the Sonesta Suites connected to the Shea Clinic by a walkway. The telephone number is (800) 766-3782 and be sure to ask for the special discount rate for Shea Clinic patients. A listing of additional nearby hotels is listed on our website (www.SheaClinic.com). For your convenience, there is also a map with directions posted on our website.

PLEASE do **NOT** bring children or more than one responsible adult with you. If you are coming from out of town and are recommended for surgery, you will need one responsible adult with you should you decide to schedule your treatment for the next day. Otherwise, you will need to schedule your surgery at some point in the future when you will be accompanied by a responsible adult.

PATIENT INFORMATION

Date: _____

Pharmacy: _____
Name Address Phone

Patient'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

OTHER DOCTORS INFORMATION:

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.

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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

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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 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 _____ 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	□ 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? _____ **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**

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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 email and texting (Test Results or Appointment information). Email _____
Cell #_____Carrier_____

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 re-disclosure 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_____