Michigan Ear Institute, P.L.L.C.

Office Use_____

PATIENT INFORMATION (PLEASE PRINT)

Today's Date:_____

Full Legal Name

_____
First Middle Initial Last

Address _____

_____

City_____State_____ Zip _____

_____

Home Phone # (____) _____

Cell Phone # (____) _____

Emergency # (____) _____

E- Mail _____

Occupation: _____

Sex ☐ M ☐ F

Marital Status ☐ S ☐ M

☐ W ☐ D

Birthdate _____

Soc. Sec # _____

Height _____ Weight_____

Language: ☐ English

☐ Other:_____

Race: ☐ Caucasian

☐ African American

☐ Middle Eastern

☐ Asian

☐ Hispanic

☐ Other

Ethnicity: ☐ Hispanic

☐ Non Hispanic

NAME:_____ **Date of Birth:**_____/_____/_____

INSURANCE INFORMATION ***(Please bring all insurance cards to your appointment and a PICTURE ID)***

IS THIS AN ACCIDENT OR WORK RELATED INJURY? ☐ **Yes** ☐ **No**

**Primary Insurance Company:*_____ Is this an HMO? ☐ Yes ☐ No

Subscriber's Name (if different than patient) _____

Relationship to patient_____ Subscriber date of birth: _____

Subscriber SS#:_____

Subscriber Employer:_____ Employer Phone #: _____

**Secondary Insurance Company:*_____ Is this an HMO? ☐ Yes ☐ No

Subscriber Name_____

Relationship to patient_____ Subscriber date of birth: _____

Subscriber SS#:_____

Subscriber Employer:_____ Employer Phone #:_____

*Tertiary Insurance Company:*_____ Is this an HMO? ☐ Yes ☐ No

Subscriber Name_____

Relationship to patient_____ Subscriber date of birth: _____

Subscriber SS#:_____

Subscriber Employer:_____ Employer Phone #: _____

Referring Physician Name: (Please bring information)

_____ Phone #:_____

_____

_____ Fax #:_____

Primary Care Physician - Family Doctor ***(MUST HAVE FOR HMO INSURANCE)***

_____ Phone #:_____

_____

_____ Fax #:_____

Additional Doctors that need to be updated on your visit, please provide your information.

NAME:_____ **Date of Birth:**_____/_____/_____

Chief Complaint: Primary reason for your visit.

_____

_____

Describe your present problem:

EARS	**Right**	**Left**	**Duration**
Hearing loss	_____	_____	_____
Fluctuating Hearing	_____	_____	_____
Ear Fullness	_____	_____	_____
Ringing/Tinnitus/ Buzzing	_____	_____	_____

Have you ever worn a Hearing Aid? ☐ Yes ☐ No

Have you had a problem with ear infections? ☐ Yes ☐ No

Have you had significant noise exposure (example working with loud machines or guns such as in military exposure or hunting)? ☐ Yes ☐ No

Have you had surgery on your ears? ☐ Yes ☐ No

If Yes , what type: _____

Do you have dizziness? ☐ Yes ☐ No

When did it begin?_____

How long does it last?_____

How often does it happen?_____

Is it ☐ Mild ☐ Moderate ☐ Severe

Does your dizziness affect your ability to work? ☐ Yes ☐ No

Does your dizziness affect your ability to drive? ☐ Yes ☐ No

Describe your dizziness: Check appropriate boxes

☐ Spinning/Vertigo ☐ Lightheadness ☐ Off Balance ☐ Positional

Is it associated with ☐ Headache or ☐ Nausea

Have you ever been diagnosed with Migraine headaches? ☐ Yes ☐ No

Do you have problems with: (Check box if appropriate.)

☐ Numbness on the face ☐ Double Vision ☐ Blurred Vision

☐ Difficulty Swallowing ☐ Hoarseness ☐ Tongue Weakness ☐ Shoulder Weakness

NAME:_____ **Date of Birth:**_____/_____/_____

Past Medical History: Circle any of the following medical conditions that you have or have had:

☐ High Blood Pressure

☐ Irregular Heart Beat

☐ Heart Attack
☐ Angina

☐ Pacemaker

☐ High Cholesterol

☐ Stroke

☐ Cancer – Type _____

☐ TMJ

☐ Thyroid Disease

☐ Sleep Apnea or CPAP

☐ Emphysema/ COPD

☐ Asthma

☐ Prostate enlargement BPH

☐ Diabetes

☐ Fibromyalgia

☐ Arthritis

☐ HIV/AIDS

☐ Ulcer, Reflux or GERD

☐ Bleeding Problems

☐ Depression or Anxiety

☐ Dialysis or Renal Failure

☐ Seizures or Convulsions

Other: _____

Have you had any previous serious injury? Please describe

_____

_____

_____

Have you had any surgeries?

_____

_____

_____

NAME:_____ **Date of Birth:**_____/_____/_____

Medications: List below the medications you are taking. Please include prescription and over the counter medications such as aspirin, cold medicines or antihistamines . (If possible bring your meds with you or a current list.)

Medication:	Dose	How Often	Why do you take this?

Do you take Vitamins and Supplements? ☐ Yes ☐ No PLEASE DO NOT LIST

Allergies: Are you allergic to any medications? ☐ Yes ☐ No
If so, please list and check the reaction you experience:

Medication:	Breathing Difficulty	Rash	Other (nausea)
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐

Are you allergic to latex? ☐ Yes ☐ No

Otherallergies?_____

Please list your pharmacy: Name: _____

Phone: _____

Address: _____

Crossroads: _____

MAIL ORDER: ☐ Medco ☐ Caremark ☐ Express Scripts, Inc

☐ Pharmacare ☐ Other

NAME:_____ **Date of Birth:**_____/_____/_____

Family History: What medical problems run in your family?

Mother: _____

Father: _____

Other : _____

Social History:

Do you smoke? ☐ Yes ☐ No If yes, how many cigarettes a day? _____

Are you a former smoker? ☐ Yes ☐ No

If yes when did you quit. _____

Do you drink alcohol? ☐ Yes ☐ No

If yes how many drinks per day? ___

Have you had problems with alcoholism? ☐ Yes ☐ No

Have you had problems with drug abuse? ☐ Yes ☐ No

Do you drink caffeine? ☐ Yes ☐ No

How much salt do you eat daily? For example processed food is high in salt.

☐ High ☐ Average ☐ Low

Any information related to your medical care is confidential and will not be released without your permission. Michigan Ear Institute can give medical information related to your treatment to

_____.

Relationship: _____

Tests results and messages may be left by phone message at _____.

If you need to keep additional physicians updated on your visits, please provide the information on the back. A letter will be sent to your physician(s) from your MEI physician with updates UNLESS you specify that you DO NOT want one sent.

• I, the undersigned, do acknowledge that the information stated above is true. I authorize the Michigan Ear Institute to release medical information necessary to process my insurance claims. I authorize payments for medical benefits directly to the Michigan Ear Institute. For insurance purposes, I permit a copy of this authorization to be used in place of the original. I do hereby expressly guarantee payment in full of any and all charges in consideration for medical services rendered, or those to be rendered to me or to my dependents by the Michigan Ear Institute, regardless of my insurance coverage, including reasonable attorney's fees and costs of collection in the event of default. I further understand that if a payment becomes 90 days past due, delinquency at the lesser of the annual rate of 10%, or the maximum allowable rate, will be due on delinquent amounts from the date the payment was due. I understand that there will be a $25 charge for any returned checks. I also authorize the Michigan Ear Institute to release medical information to the above stated physicians. I consent to any medical, diagnostic, therapeutic, or minor surgical procedure rendered to the patient under the supervision of the physician.

SIGNATURE OF PATIENT/LEGAL GUARDIAN_____ **DATE:**_____

Valid for one year)

Relationship to patient: _____

NOTICE OF PRIVACY PRACTICES SUMMARY

To our patients: This notice describes how health information about you, as a patient of Michigan Ear Institute, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy: Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For workers compensation and similar programs.

Your rights regarding your health information:

1. Communications. You can 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. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care of the payment

for your care, such as family members or friends. We are not required to agree to your request; how ever, 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.

3. You have the right to inspect and obtain a copy of the health information 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 Michigan Ear Institute, Medical Records, 30055 Northwestern Hwy., #101, Farmington Hills, MI 48334 or fax request to 248-865-6161.

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and 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 Michigan Ear Institute, Medical Records, 30055 Northwestern Hwy., #101, Farmington Hills, MI 48334 or fax request to 248-865-6161.
   You must provide us with a reason that supports your request for amendment.

5. Right to a copy of this notice. You are entitled to receive a copy of this notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice via regular mail contact Michigan Ear Institute, Medical Records Department, 30055 Northwestern Hwy., #101, Farmington Hills, MI 48334 or fax request to 248-865-6161.

6. 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. To file a complaint with our practice, contact Michigan Ear Institute, Practice Administrator at 248-865-4444. You will not be penalized for filing a complaint. After contacting Michigan Ear Institute you will be asked to submit your complaint in writing.

7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy practices, please contact our administrator or clinical manager at 248-865-4444.

I hereby acknowledge that I have been presented with a copy of Michigan Ear Institutes' Notice of Privacy Practices on Pages 10-11.

PRINT NAME OF PATIENT: _____

PATIENT SIGNATURE: _____

DATE: _____

MEI PATIENT REPRESENTATIVE: _____

Michigan Ear Institute, P.L.L.C.

I authorize the Michigan Ear Institute to release medical information necessary to process my insurance claims. I authorize payments for medical benefits directly to the Michigan Ear Institute. For insurance purposes, I permit a copy of this authorization to be used in place of the original. I do hereby expressly guarantee payment in full of any and all charges in consideration for medical services rendered, or those to be rendered to me or to my dependents by the Michigan Ear Institute, regardless of my insurance coverage, including reasonable attorney's fees and costs of collection in the event of default. I further understand that if a payment becomes 90 days past due, delinquency at the lesser of the annual rate of 10% or the maximum allowable rate, will be due on delinquent amounts from the date the payment was due. I understand that there will be a $25 charge for any returned checks. I also authorize the Michigan Ear Institute to release medical information to any physician I have listed. I consent to any medical, diagnostic, therapeutic, or minor surgical procedure rendered to the patient under the supervision of the physician. I authorize Michigan Ear Institute to obtain medication history from electronic vendor.

For Research Purposes: We may use or disclose your protected health information for research when the use of disclosure for research has been approved by an institutional review board or privacy board that has reviewed the research proposal and research protocols to address the privacy of your protected health information.

SIGNATURE OF PATIENT / LEGAL GUARDIAN:_____

PRINT NAME OF PATIENT: _____

DOB:_____

DATE:_____

MICHIGAN EAR INSTITUTE REPRESENTATIVE:_____

Ascension Michigan
Notice of Privacy Practices
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. **WHO WILL FOLLOW THIS NOTICE OF PRIVACY PRACTICES.** All individuals who are providing services at Ascension Michigan facilities will follow this Notice. Ascension Michigan includes Ascension hospitals, ambulatory care centers, pharmacies, laboratories, outpatient physician practices (Ascension Medical Group/AMG practices), and other Ascension health care providers located in Michigan. Those following this Notice participate in an organized health care arrangement, which will share protected health information (PHI) with each other to carry out treatment, payment, or health care operations relating to the organized healthcare arrangement. Our privacy practices will be followed by:
   - any of our healthcare professionals who care for you at any one of our locations or sites;
   - all locations, departments and units that are part of Ascension Michigan and staffed by our workforce; and
   - all members of our workforce, including physicians and other healthcare professionals granted privileges to provide patient care in our facilities, employees, students and volunteers and our business associates.

2. **HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION.** We may use and disclose your PHI for many different reasons. Below, we describe the different uses and disclosures and give you some examples of each.
   - **2.1 Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations.** We may use and disclose your PHI for the following reasons without your authorization.
     - **2.1.1 For Treatment.** We may use or disclose your PHI to provide treatment to you or coordinate care. Your PHI may be used by or disclosed to physicians, nurses, medical students, and other health care professionals who provide you with health care services or are involved in your care. For example, if you're being treated for a knee injury, we may disclose your PHI to the physical therapy department or to a pharmacy when we send a prescription to be filled for you.
     - **2.1.2. To Obtain Payment for Treatment.** We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. For example, we may disclose your PHI to your health plan to get paid for the health care services we provided to you or to find out whether a proposed treatment is covered. We may also disclose your PHI to our business associates, such as billing companies, claims processing companies, and others that process our health care claims.
     - **2.1.3 For Our Health Care Operations.** We may use or disclose your PHI for health care operation purposes, in other words, in order to run our business. For example, we may use your PHI in order to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided services to you. We may also disclose your PHI to our accountants, attorneys, and consultants who perform services on our behalf.
   - **2.2 Other Uses and Disclosures** The following categories describe additional ways that we may use and disclose, or be required to use and disclose, your PHI without your authorization. We may have to meet certain conditions in the law before we can share your information for these reasons.
     - **2.2.1. Disclosures Required by Federal, State, or Local Law, Judicial or Administrative Proceedings, or Law Enforcement.** For example, we may make disclosures when a law requires we report information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence, when dealing with gunshot or other wounds from violent crimes, or as ordered by a court or in an administrative proceeding. We may also disclose PHI, if necessary, to identify or locate a suspect or missing person, for concerns of criminal conduct at an Ascension Michigan facility, for concerns of a victim of a crime under certain circumstances, and in certain emergency situations.
     - **2.2.2 Public Health and Safety.** We may disclose your PHI for public health and safety purposes. For example, we disclose information about births, deaths, immunizations and various conditions (such as HIV/AIDS and cancer) to government officials or registries. We may also disclose PHI to manufacturers of drugs, biologics, devices and other products regulated by the Food and Drug Administration on quality, safety, and effectiveness. PHI may also be disclosed to certain people exposed to communicable diseases or to employers in connection with occupational health and safety or worker's compensation matters.
     - **2.2.3 Coroners, Medical Examiners, and Funeral Directors.** We may disclose your PHI to a coroner or medical director for the purpose of identifying a deceased person, determining cause of death, or other duties authorized by law. We may also disclose your PHI to a funeral director, consistent with law, to permit the funeral director to carry out his or her duties.
     - **2.2.4 Health Oversight Activities.** We may disclose your PHI to a health oversight agency for health oversight activities authorized by law. These activities include audits, investigations, licensure and disciplinary actions, and related activities which are necessary to monitor the health care system, governmental benefit programs and compliance with civil rights laws. For example, we may disclose information to assist the government when it conducts an investigation or inspection of a healthcare professional or organization.
     - **2.2.5 Purposes of Organ Donation.** We may disclose your PHI to organ, eye, or tissue procurement organizations and others engaged in procurement, banking, and transplantation to assist them in donations and transplants.
     - **2.2.6 Research Purposes.** Under certain circumstances, we may use or disclose your PHI for research purposes. For example, a research project may involve comparing the health and recovery of all individuals who receive one medication to those who receive another. All research projects are approved using a special process that reviews protections for patients, including privacy.
     - **2.2.7 Specific Government Functions.** We may disclose PHI of military personnel and veterans in certain situations. We may also disclose PHI for national security purposes, such as protecting the President of the United States or conducting intelligence operations.
     - **2.2.8. Workers' Compensation Purposes.** We may disclose PHI as authorized by and to the extent necessary to comply with workers' compensation laws or laws relating to similar programs.
   - **2.3. Uses and Disclosures to Which You Have an Opportunity to Object**
     - **2.3.1 Patient Directories.** We may include your name, location in the facility, and general condition in our patient directory and disclose it to individuals who ask for you by name, unless you object. We also may include your religious affiliation (if any) in the facility directory and disclose facility directory information to clergy members, unless you object.
     - **2.3.2 Disclosure to Family, Friends, or Others.** We may provide your PHI to a family member, friend, or other person to the extent that person is involved in your care or the payment for your health care, unless you object in whole or in part. If you are unable to object, our healthcare professionals will use their best judgment in communicating with your family and others.
     - **2.3.3 Special Legal Restrictions.** Michigan law and/or federal regulations may require specific authorization for the disclosure of PHI for patients receiving treatment for mental health, substance abuse, or HIV/AIDS conditions, as well as certain genetic information. We abide by all state and federal laws.

2.4 **Uses and Disclosures to Which You Have the Opportunity to Opt Out.** We may use or disclose PHI for fundraising activities for our organization, including through a foundation owned by or affiliated with an Ascension Michigan facility. The money raised through these activities is used to expand and support the health care services and educational programs we provide to the community. If you do not wish to be contacted as part of our fundraising efforts, please contact the Ascension Michigan HIPAA Privacy Officer listed in Section 6 of this Notice.

2.5 **Uses and Disclosures That Require Your Authorization.** If you choose to sign an authorization to disclose your PHI, you can later revoke that authorization,in writing, at any time. Your revocation will stop any future uses and disclosures (to the extent that we have not taken any action relying on the authorization).

2.5.1. **Psychotherapy Notes.** We must obtain your written authorization before we may use or disclose your psychotherapy notes for most purposes, except we are permitted to use or disclose your psychotherapy notes for the following reasons without obtaining your authorization: use by the originator of the psychotherapy notes for treatment; for our own training programs; or to defend ourselves in a legal action or other proceeding.

2.5.2. **Marketing.** We must obtain your authorization before we may use or disclose your PHI for marketing purposes.

2.5.3. **Sale of PHI.** We must obtain your written authorization before we sell your PHI.

2.5.4. Any other uses or disclosures not covered by this Notice or the laws that apply to us will be made only with your authorization.

3. **YOUR RIGHTS** You have the following rights with respect to your PHI:

3.1. **The Right to Request Limits on Uses and Disclosures of Your PHI.** You have the right to ask that we limit how we use and disclose your PHI. This request must be made in writing. We will consider your request, but we are not required to accept it (except if you pay in full out-of-pocket for a particular service and you request that we not disclose any information to your health plan about that service, we must grant that request unless we are legally required to share the information). If we agree to your request, we will put any requested limits in writing and abide by them, except in emergency situations.

3.2 **The Right to Request Confidential Communications.** You have the right to ask that we send PHI to you at an alternate address (for example, to your work address rather than your home address) or by alternate means (for example, encrypted email instead of regular mail). We will agree to all reasonable requests.

3.3 **The Right to See and Get Copies of Your PHI.** In most cases, you have the right to look at or get copies of your PHI that we have. If we do not have your PHI, but we know who does, we will tell you where to direct your request. We will respond to you within 30 days after receiving your written request. We will also transmit a copy of your PHI to another person designated by you in writing. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed. If you request copies of your PHI, we may charge you a reasonable fee as permitted by law.

3.4 **The Right to Get a List of the Disclosures We Have Made.** You have the right to request an accounting (a list) of times we disclosed your PHI. The list will not include any of the uses or disclosures for treatment, payment, and health care operations purposes, as well as some other types of disclosures we are permitted to make. We will respond within 60 days of receiving your request. The list we will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide the list to you at no charge, but if you make more than one request in the same year, we will charge you a reasonable, cost-based fee for each additional request.

3.5 **The Right to Amend Your PHI.** If you believe that there is a mistake in your PHI, or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. We will respond within 60 days of receiving your request.

3.6 **The Right to Receive a Copy of this Notice.** You have the right to receive a copy of this Notice and we will give you a copy in the format you request (paper or electronic). If you agree to receive this Notice via email, you still have the right to request a paper copy of this Notice.

3.7 **The Right to Complain About Our Privacy Practices.** You may file a written complaint with the Ascension Michigan HIPAA Privacy Officer at 28000 Dequindre Road, Warren, Michigan 48092 or via email to: compliance.michigan@ascension.org or with the Secretary of Health and Human Services, Office for Civil Rights, 200 Independence Avenue, S.W., Washington, D.C. 20201. We will not retaliate against you for filing a complaint.

4. **HEALTH INFORMATION EXCHANGES.** In an effort to provide the best care to you, Ascension Michigan and its care delivery sites may participate in arrangements between health care organizations that facilitate access to healthcare information relevant to your care. We may disclose your PHI to other health care providers, health plans, other health care entities or the government, as permitted by law, through a Health Information Exchange ("HIE") in which we participate. If you have questions about how to opt out of the HIE so that your PHI is not disclosed to other health care providers through the HIE, please contact the Ascension Michigan HIPAA Privacy Officer listed under Section 6. Please be aware that even if your PHI is no longer disclosed to other health care providers through the HIE, your PHI may still be disclosed through the HIE for other purposes permitted or required by law.

5. **ASCENSION MICHIGAN is dedicated to protecting the privacy and security of your medical information. We are required by law to:**
   - Protect the privacy and security of your medical information or, what we call "protected health information" or "PHI".
   - Provide you with this Notice about our legal duties and privacy practices with respect to PHI. This Notice explains how, when, and why we use and disclose your PHI. We are legally required to follow the practices described in this Notice.
   - Notify you if a breach of your unsecured PHI occurs.

6. **CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.** If you have any questions regarding this Notice or how to exercise your rights listed in this Notice, you may contact the Ascension Michigan HIPAA Privacy Officer by telephone at (586) 753-1171, by sending a letter to 28000 Dequindre Road, Warren, Michigan 48092 or by email at: compliance.michigan@ascension.org.

7. **EFFECTIVE DATE OF THIS NOTICE:** April 29, 2021