Thomas H. Rhee, MD
Manassas Hearing Center
Adult and Pediatric Otolaryngology
8703 Stonewall Road, Suite 1B, Manassas, Va 20110
703 369 3500 Fax 703 369 1551

Patient Information

Patient Legal Name:_____Date of Birth_____

Social Security number: _____ Sex: Male / Female _____

Mailing address:_____City_____ Sate/zipcode_____

Home Phone:_____ Cell Phone:_____

Email: _____Referred by Dr:_____

Emergency Contact Name: _____ Phone: _____

Pharmacy Name and Location Zip Code: _____

Guarantor Information (Person Responsible for the Bill)

Name:_____ DOB :_____ Male / Female

Address:_____ SSN: _____

Phone Number: _____ Email: _____

Primary Insurance_____Policy ID#:_____

Policy Holder Name:_____ DOB: _____

Secondary Insurance_____ Policy ID#:_____

Policy Holder Name:_____ DOB: _____

Payment Policy: Your office visit copayment, deductible or coinsurance will be collected at the time of the visit. Any charges in conjunction with your visit will be submitted to your insurance and may generate an additional bill to you. There is a $30.00 bank fee for returned checks. If your account is turned over for collection activity due to non-payment of your account, you are responsible for all attorney fees and court costs. Please call 24 hours in advance if you are unable to keep your scheduled appointment. There is a $30.00 fee for missed appointments not canceled. I authorize the release of any medical benefits to this provider. I authorize release of all pertinent medical records to Dr. Thomas H. Rhee as necessary.

Patient Signature: _____ **Date:** _____

PATIENT CONSENT FORM/ HIPPA

THOMAS H. RHEE, M.D., P.C.
8703 Stonewall Rd #1B
Manassas, Va 20110

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 that treatment directly and indirectly.

: Obtain payment form third-party payers.

: Conduct normal healthcare operations such as quality assessments and physician certificates.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. 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 at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my practice information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken, again relying on this consent.

I understand that I may advise you of the individuals you are to release my PHI to.

****These are the individuals you may advise of my PHI:**

_____

Signature of Patient or Responsible Party: _____Date: _____

Printed Name of Patient or Responsible Party:

_____

Relationship to Patient: _____

Patient Medical History

Patient Name:_____ DOB:_____ Date:_____

Reason for your visit?_____

Is this an injury? Yes / No Date of Injury? _____

Circle all Medical Problems you have:

High Blood Pressure Heart Disease Cancer Diabetes None

Have you had any Surgical Procedures in the past 5 years ? Please list:

_____

Does anyone in your immediate family have any of the following?

High Blood Pressure Heart Disease Cancer Diabetes Unknown Adopted None

Are you a smoker? Never Smoker Former Smoker Current Smoker
Alcohol use? Do not drink Daily Frequently Occasionally

Review of symptoms. Please circle all that apply

Constitutional: Fever
Eyes: Reading glasses
Respiratory: Cough, Wheezing, Asthma
Digestive: Abdominal pain, Heartburn
Urinary female: Difficulty urinating
Neurological: Seizures, Strokes
Hematologic/Lymphatic: Easy bleeding
Head: Frequent headaches
Ears/Nose/Mouth: Loss of hearing, Ringing in ears, Sinus pressure, Stuffiness, Nasal drainage, Hoarseness, Difficulty swallowing, Throat pain, Snoring
Heart: Elevated cholesterol
Muscles/bones: Degenerative disease
Skin: Skin cancer
Endocrine/glands: Diabetes
Allergies: Hay fever, Environmental

Currently taking any medications? Please list: _____

_____

Are you **allergic to any medication?** _____

Patient Height: _____ Patient Weight: _____ Patient/Guardian **Signature**: _____