James G. Houle, M.D. & Nancy J. Liu, M.D.
OTOLARYNGOLOGY- HEAD & NECK SURGERY
660 Glades Road, Suite 400
Boca Raton, FL 33431
561-750-2100 (Telephone) - 561-750-0889 (Fax)

Name (Please Print) _____

Local Address _____ Apt # _____

City, State: _____ **Zip:** _____

Telephone: _____ _____ _____
(Home) (Cell) (Work)

Birth Date: MM_____DD____YY_____ Marital Status: _____ **Sex:** _____

Social Security Number: _____ **Are you employed?:** _____

Employed By: _____ **Occupation:** _____

Spouse's Name: _____ **Occupation:** _____

Spouse's Employer: _____ **Phone:** _____

Emergency Contact (If other than spouse) _____ **Phone:** _____

Name of Primary Care Physician or Internist: _____

Who referred you to this office? _____

Has any member of your family ever been treated in this office? ( ) YES ( ) NO

Name of family member: _____

_____

Name of your insurance carrier: _____
Name of policy holder #1 _____
Policy holder's social security number: _____ Date of Birth: _____
Sex: _____ Employer: _____
Policy 1 number: _____ Group number: _____
Name of policyholder #2 _____
Policyholder Social Security number: _____ Date of Birth: _____
Sex: _____ Employer: _____
Policy 2 number: _____ Group number: _____

_____

Over Please

Assignment of benefits so that we may facilitate processing of any insurance claim for you, and payment credit agreement

1. I hereby assign to you, my health care provider, all medical and/or surgical benefits to which I am entitled, including Medicare, private insurance, and any other health insurance.
2. I hereby authorize said assignee to release all information to secure payment.
3. I understand that I am financially responsible for all charges, whether or not paid by said insurance, and the payments are due at the time services are rendered.
4. I understand and agree that, in the event that I fail to make payment for services rendered to me, my name and account may be turned over to an attorney or collection agency, and I agree to pay said collection agency's fees for collection, court costs, and/or reasonable attorney's fee that may be incurred in the collection of any outstanding balances.
5. This office reserves the right to charge interest on unpaid balances at the rate of 1.5% per month.

I hereby agree to the release of all medical information held by Dr. James Houle and/or Dr. Nancy Liu to any referring physician whom I have seen or will be seeing, to any insurance company to facilitate payment and to myself, upon my request, or to anyone else whom I may designate in writing.

If Dr. James Houle and/or Dr. Nancy Liu are not participating providers in my insurance carrier, I understand that I am fully responsible for any and all balances due for services rendered, and I agree to pay any balance as services are rendered.

I CERTIFY THAT I HAVE READ ALL OF THE ABOVE, FULLY UNDERSTAND, AND AGREE TO SAME:

SIGNED: _____ DATE: _____

James G. Houle, M.D.
JGH:12/03

New Patient Consent to the Use and Disclosure of Health Information
For Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, the office of Dr. Houle and Dr. Liu originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a ***Notice of Information Practices*** and the ***Patients Bill of Rights*** that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that the office of Dr. Houle and Dr. Liu reserves the right to change their notice and practices and, prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations, should the office of Dr. Houle and Dr. Liu change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:
_____
_____
_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept/decline the terms of this consent.

_____
Patient's Signature

_____
Date

==========

FOR OFFICE USE ONLY
[ ] Consent refused by patient, and treatment refused as permitted.
[ ] Consent added to the patient's medical record on _____.

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I, _____ **(please print)**, understand that as part of my health care, the office of Dr. Houle and Dr. Liu originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment as well as costs of examination and tests performed by Dr. Houle, Dr. Liu, Dr. Bai Rossi, Dr. Gross and/or the nursing staff.

I wish to give full access to the following person(s) regarding my **medical history/status:**

Name	Relationship to me
_____	_____
_____	_____
_____	_____
_____	_____

I wish to give full access to the following person(s) regarding my **account billing:**

Name	Relationship to me
_____	_____
_____	_____
_____	_____
_____	_____

_____
Patient's Signature

_____
Date

Name:_____

Review of Symptoms:

Please indicate below your history of any current problems with circling YES. If you have never encountered a problem with any of the problems below, indicate by circling NO.

GENERAL:

YES / NO Weight gain
YES / NO Weight loss
YES / NO Fever
YES / NO Chills
YES / NO Problems sleeping

HEAD, EYES, EARS, NOSE & THROAT

YES / NO Change in vision
YES / NO Ear infections or drainage
YES / NO Sinus infections
YES / NO Problems swallowing
YES / NO Glaucoma
YES / NO Cataracts
YES / NO Impaired hearing

CARDIOVASCULAR:

YES / NO Chest pain
YES / NO Shortness of breath with walking or laying down
YES / NO Heart murmur
YES / NO Difficulty walking 2 blocks
YES / NO Palpitations
YES / NO Dizziness
YES / NO Swelling in the feet
YES / NO Fainting

PULMONARY:

YES / NO Cough
YES / NO Shortness of breath
YES / NO Sputum production
YES / NO Emphysema/COPD
YES / NO Asthma
YES / NO Sleepiness during the day
YES / NO Snoring

GASTROINTESTINAL:

YES / NO Heartburn
YES / NO Change of appetite
YES / NO Frequent vomiting
YES / NO Change in bowel habits
YES / NO Black, tarry stool
YES / NO Rectal bleeding

CANCER : YES / NO

TYPE:_____

GENITOURINARY:

YES / NO Pain while urinating
YES / NO Burning while urinating
YES / NO Blood in urine
YES / NO Hesitancy in going
YES / NO Incontinence
YES / NO Night time urinating
# of times a night _____

MUSCULOSKELETAL:

YES/ NO Arthritis
YES / NO Muscle weakness
YES / NO Frequent fractures
YES / NO Osteoporosis
YES / NO Joint stiffness

NEUROLOGICAL:

YES / NO Mini strokes
YES / NO Strokes
YES / NO Seizures
YES / NO Fainting spells
YES / NO Depression

PSYCHIATRIC:

YES / NO Depression
YES / NO Anxiety
YES / NO Other psychotic diagnosis

ENDOCRINE:

YES / NO Hypothyroidism
YES / NO Hyperthyroidism
YES / NO Diabetes
____ insulin dependent
____ oral medication

SKIN:

YES / NO Rashes
YES / NO Jaundice
YES / NO Skin cancer – Type _____

OTHER:

_____

ALLERGIES:

_____

_____