**Courtney W. Garrett, M.D.** 

**Jeremy D. Lough, M.D.**

**Leah Hauser, M.D.**

**Andrew Tomlinson, M.D.**

Drs. Courtney W. Garrett, Jeremy D. Lough, Leah Hauser, Andrew Tomlinson and staff welcome you to our office. Our job is to serve your ears, nose and throat needs in a professional and caring manner.

Enclosed please find your patient paperwork to fill out prior to your appointment with Dr. Courtney W. Garrett, Dr. Jeremy D. Lough, Dr. Leah Hauser or Dr. Andrew Tomlinson. Please complete all forms and bring them to your appointment along with a picture ID and insurance card(s) and/or you can FAX the paperwork to (775) 323-0749. ​Please arrive 15 minutes before your appointment time​ so that we can copy your insurance card(s) and ID and process the information. You will have an opportunity to review a copy of our privacy practices, a notice that tells you the efforts we take to protect patient confidentiality. This notice is in compliance with federal regulations. If you cannot come at your scheduled time, please call our office 48 hours before your scheduled time at (775) 323-2157.

As a courtesy to you, we will bill all contracted insurance health plans. It is ​your​ responsibility to determine whether or not your insurance carrier is contracted with our office. It is our policy to collect all co-pays, co-insurance and deductibles at the time of each visit. If you have any questions regarding our billing procedures, our billing coordinator or business office would be happy to assist you at (775) 323-3139.

The map above will help you find our office. There is free parking directly south of the 900 Ryland Street building. We look forward to seeing you!

Basic Driving Directions to 900 Ryland Street, Reno, NV 89502

|  |  |  |
| --- | --- | --- |
| Driving on I-80 West1. Take Exit 14, Wells Avenue2. Turn left onto N. Wells Avenue 3. Turn left onto Ryland Street4. 900 Ryland Street is on the right, just past Locust Street. | Driving on I-80 East1. Take Exit 14, Wells Avenue2. Turn right onto N. Wells Avenue 3. Turn left onto Ryland Street4. 900 Ryland Street is on the right, just past Locust Street.  | Driving on I-580 N/US-395 N1. Take I-580 N/US-395 N toward Reno/Sparks.2. Take Exit 66, Mill Street3. Turn left onto Mill Street4. Turn slight left onto Ryland St. 5. 900 Ryland Street is on the left. |

 Phone: 775.323.2157

900 Ryland St Buss: 775.323.3139

Reno, Nevada 89502 www.RenoENTSpecialists.com Fax: 775.323.0749

**Courtney W. Garrett, M.D., Jeremy D. Lough, M.D. Leah Hauser, M.D. and Andrew Tomlinson, MD**

**Courtney W Garrett, M.D.**

**Jeremy D. Lough, M.D.**

**Leah J. Hauser M.D.**

**Andrew Tomlinson, M.D.**

**Welcome to Reno Ear Nose & Throat Specialists**

**In an effort to serve you better, it is important that you understand that it is your responsibility:**

**• To know your insurance,**

**• To know if Reno Ear Nose & Throat Specialists is a contracted provider for your insurance,**

**• To know if you need prior authorization for procedures or office visits,**

**• To know if procedures such as injections, CT scans, scopes, debridements, etc. are covered under your insurance,**

**• To know if you have a copayment, coinsurance, and/or a deductible**

**• To know how much of your deductible has been met.**

**There are hundreds of insurance companies and plans within those companies, and it is not possible for our staff to know the specific requirements of each policy.**

**Please help us better serve you.**

**Patient's Name (please print}**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of patient or guarantor Date**

**900 Ryland Street**

**Reno, NV 89502**

**Phone:775.323.2157**

**Busi: 775.323.3139**

**Fax: 775.323.0749**

WE APPRECIATE THE OPPORTUNITY OF SERVING YOU

WE PLEDGE TO GIVE YOU OUR VERY BEST MEDICAL CARE

**OFFICE POLICY ON PAYMENT**:

Patients are responsible for all co-pays, services applied to your deductibles and any procedures or services denied as not medically necessary by your insurance. The cost of services not covered by insurance will be paid at the time of service. Patients without insurance card information or insurance required referral authorizations will be required to pay for all charges of visit.

Three charges beyond that of your medical care may be incurred:

1. $25 per returned check
2. If your account is sent to collection your balance may increase as much as 40%.
3. $20 for completion of each form for FMLA, disability or work leave of absence due at the time of service and not billable to insurance

**INSURANCE POLICY**:

Insurance provides for reimbursement to your physician on allowed medical charges. We will submit claims to your insurance carriers if you have provided us with all pertinent information to process the claim. You are responsible for all deductibles and charges not covered by insurance. It is your responsibility to follow-up with your insurance carrier when payment has not been made to your physician in a timely manner. We do not bill third insurance companies.

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION:**

I authorize my physician to release any medical information in my office records. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal or other purposes necessary to ensure the best medical care on my behalf.

I have read the above and accept financial responsibility for my account and give authorization for release of my medical information.

 Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Patient, Parent or Guardian

**PATIENT CONSENT FORM**:

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

* Conduct, plan and direct my treatment, follow-up treatment and follow-up to the multiple healthcare providers who may be involved in that treatment directly or indirectly.
* Obtain payment from third-party payers.
* Conduct normal healthcare operations such as quality assessments and physician certifications.

**ACKNOWLEDGMENT**

I, hereby, acknowledge that I have been given the right to review the 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: 900 Ryland Street, Reno, Nevada 89502 to obtain a current copy of this notice.

PRINT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Patient, Parent or Guardian

**ACKNOWLEDGMENT REFUSED**

On this date, the undersigned patient refused or failed to acknowledge receipt of the Notice of Privacy Practices.

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NAME OF PATIENT:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REASON FOR REFUSAL/FAILURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYEE SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Courtney W. Garrett, M.D. 900 Ryland St**

**Jeremy D. Lough, M.D. Reno, Nevada 89502**

**Leah Hauser, M.D. 775.323.2157**

**Andrew Tomlinson, M.D.**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CHIEF COMPLAINT/HISTORY OF ILLNESS**

**1. What is the reason for today’s visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**2. How long have you had this problem?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**3. How severe is this problem? (Circle) mild 1 2 3 4 5 6 7 8 9 10 Severe**

**4. How often does this problem occur? Constant\_\_\_\_\_\_ Comes and Goes\_\_\_\_\_\_\_\_\_\_\_\_\_**

**5. What makes it better?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**6. What makes it worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**7. What other symptoms are you having?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**8. What medication have you tried?**

 **Prescription: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Over the Counter: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Doctor’s Notes:**

**Dr.’s Initials:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**OFFICES OF**

**Courtney W. Garrett, M.D., Jeremy D. Lough, M.D., Leah Hauser, M.D. and Andrew Tomlinson, M.D.**

**Courtney W. Garrett, M.D., Jeremy D. Lough, M.D., Leah Hauser, M.D. and Andrew Tomlinson, M.D.**

**PAST MEDICAL HISTORY**: (please check any illnesses you have had):

 \_\_\_High Blood Pressure \_\_\_Blood Clots \_\_\_Hepatitis/Liver \_\_\_Peptic Ulcer Others \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Kidney Diseases \_\_\_Asthma \_\_\_Sleep Apnea \_\_\_Thyroid Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Diabetes \_\_\_Stroke, TIA \_\_\_Rheumatic Fever \_\_\_Bleeding Disorder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Neck/Back Disease \_\_\_Heart Disease \_\_\_Emphysema \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAST SURGICAL HISTORY** (Please check any surgeries you have had):

\_\_\_Heart Bypass/Valve \_\_\_Lung Surgery \_\_\_Prostate Removal \_\_\_Thyroid \_\_\_Nose

\_\_\_Coronary Angioplasty \_\_\_Joint Replacement \_\_\_Colon removal \_\_\_Cosmetic \_\_\_Sinus

\_\_\_Carotid Artery Surgery \_\_\_Back Surgery \_\_\_Appendectomy \_\_\_Ear Surgery \_\_\_Other

\_\_\_Vascular Bypass \_\_\_Other Orthopedic \_\_\_Female Surgery \_\_\_Ear Tubes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Mastectomy/Biopsy \_\_\_Brain Surgery \_\_\_Gall Bladder \_\_\_Tonsils/Adenoids

**MEDICATIONS** (List all of your current medications including vitamins and any over-the-counter medicines):

Medication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take Aspirin, Motrin, Ibuprofen or other anti-inflammatories? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take Warfarin (Coumadin) or Plavix? Yes / No

Have you taken steroids (cortisone) in the last three months? Yes / No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALLERGIES**  (List medications you are allergic to and what happens when you take them): Medication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY** (Check all Illnesses that have occurred in your family):

\_\_\_Hearing Loss \_\_\_Alcoholism \_\_\_Heart Attack/Disease Others:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_High Blood Pressure \_\_\_Bleeding Problems \_\_\_Anesthesia Reaction \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Poor Circulation \_\_\_Cancer \_\_\_Sickle Cell Anemia \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Thyroid \_\_\_Diabetes \_\_\_Stroke \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL HISTORY**

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever smoked? \_\_\_Yes \_\_\_No

How much and for how long have you smoked? \_\_\_\_\_\_ packs per day for \_\_\_\_\_\_ years. Quit? \_\_\_Yes \_\_\_No When? \_\_\_\_\_\_\_\_\_\_

How much alcohol do you drink each day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any street drugs you currently use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any drug addictions? \_\_\_Yes \_\_\_No

Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dr.’s Initials: \_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

**REVIEW OF SYSTEMS**  (Check all symptoms you have had either now or in the past):

**CONSTITUTIONAL**

\_\_\_Weight loss \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_pounds in the past \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_weeks

\_\_\_Fever \_\_\_Chills \_\_\_Sweats \_\_\_Swollen Glands \_\_\_Excessive Thirst \_\_\_Unusual Fatigue

**EYES** **ENT**

\_\_\_Double Vision \_\_\_Hearing loss \_\_\_Nose Drainage \_\_\_Difficulty Swallowing \_\_\_Poor Sleep \_\_\_Loss of Vision \_\_\_Ringing in Ears \_\_\_Nasal Congestion \_\_\_Throat Clearing \_\_\_Daytime Drowsiness \_\_\_Itching \_\_\_Dizziness \_\_\_Sneezing \_\_\_Hoarseness \_\_\_Loss of Sense of Smell \_\_\_Tearing \_\_\_Ear Pain \_\_\_Headaches \_\_\_Snoring \_\_\_Facial Pain

 \_\_\_Ear Drainage \_\_\_Sore Throat/Mouth \_\_\_Cough

**CARDIOVASCULAR**

\_\_\_Chest Pain \_\_\_Heart Attack \_\_\_Irregular Heartbeat \_\_\_Angina

\_\_\_Poor Circulation \_\_\_Ankle Feet Swelling \_\_\_Leg Pain while Walking

**PULMONARY**

\_\_\_Wheezing \_\_\_Shortness of Breath \_\_\_Cough \_\_\_Coughing up Blood \_\_\_Pain When Breathing

**GASTROINTESTINAL**

\_\_\_Ulcers \_\_\_Nausea/Vomiting \_\_\_Diarrhea \_\_\_Blood in Stools

\_\_\_Heartburn \_\_\_Trouble Swallowing \_\_\_Abdominal Pain \_\_\_Jaundice

**KIDNEY/BLADDER**

\_\_\_Blood in Urine \_\_\_Pain During Urination \_\_\_Difficulty Making Urine \_\_\_Bladder Leaking \_\_\_Frequent Urination

**MUSCULOSKELETAL**

\_\_\_Neck Pain \_\_\_Shoulder Pain \_\_\_Back Pain \_\_\_Swollen or Painful Joints \_\_\_Muscle Pain

**NEUROLOGICAL**

\_\_\_Stroke/Mini Stroke \_\_\_Loss of Sensation \_\_\_Paralysis \_\_\_Facial Weakness \_\_\_Headache \_\_\_Migraine

 \_\_\_Temporary Loss of Vision or Speech Control

**SKIN**

\_\_\_Skin Cancers \_\_\_Rash with Tape, Iodine or Latex \_\_\_Eczema \_\_\_Other Rashes

**PSYCHIATRIC**

\_\_\_Clinical Depression \_\_\_Anxiety \_\_\_Bipolar \_\_\_Schizophrenia \_\_\_Hallucinations

**INFECTIOUS DISEASE**

\_\_\_Hepatitis \_\_\_HIV/AIDS \_\_\_Mononucleosis \_\_\_Immune Deficiency \_\_\_TB

**REPRODUCTIVE**

\_\_\_Irregular Periods \_\_\_Heavy Bleeding \_\_\_Pregnant \_\_\_Last Menstrual Period \_\_\_Menopause

Patient’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have personally reviewed this history and review of systems.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician’s Signature





**Reno** Ear Nose &Throat

Specialists

Courtney W. Garrett, M.D.
Jeremy D. Lough, M.D.
Leak J. Rouser, M.D.

Andrew R. Tomlinson, M.D.

FINANCIAL CONTRACT/AGREEMENT

COURTNEY W. GARRETT, M.D.
JEREMY D. LOUGH, M.D.
LEAH J. HAUSER, M.D.
ANDREW TOMLINSON, M.D.

I understand that if I do not pay my account with Dr. Garrett, Dr. Lough, Dr. Hauser or Dr. Tomlinson in full, my account may be assigned to a collection agency for collection.

I understand that if my account is assigned to a collection agency, the collection agency will charge a
commission or fee to Dr. Garrett, Dr. Lough, Dr. Hauser or Dr. Tomlinson. I agree that if my account is assigned to a collection agency, Dr. Garrett, Dr. Lough, Dr. Hauser or Dr. Tomlinson will add a charge in the amount of $25.00 to my account.

I agree that if my account is assigned to a collection agency, I will pay the sum of $25.00 which is in addition to my unpaid balance for professional services provided to me.

I understand and agree that in the event legal action is commenced to enforce my obligations hereunder, I will pay court costs and reasonable attorney fees.

We schedule our appointments so that each patient receives the right amount of time to be seen by our
physicians. That is why it is very important that you keep your scheduled appointment with us and arrive
on time. If your schedule changes and you cannot keep your appointment, please contact us so we may
reschedule you and accommodate those patients who are waiting for an appointment. If you do not cancel
or reschedule your appointment with at least 24 hours notice, we may assess a $50.00 "no-show" service
charge to your account. This "no-show charge" is not reimbursable by your insurance company. You will
be billed directly for it. After three consecutive no-shows to your appointment, our practice may decide
to terminate its relationship with you. I understand that I must cancel or reschedule any appointment at
least 24 hours in advance in order to avoid a potential "no-show” charge.

Signature of patient or guarantor Date

