ear medical group
otology/neurotology

WELCOME

Ear Medical Group would like to welcome you to our unique practice. We have two board certified Otologists / Neurotologists, three physician assistants, and Allergy Department, a full-service Hearing and Balance Center, and a Hearing Aid Center.

Your First Visit

Enclosed you will find our New Patient paperwork. Please fill this out in its entirety and bring it with you on the day of your appointment. We kindly ask that you do not mail your paper work back to our office. You may use blue or black ink to complete this packet.

Please bring your insurance card and your picture ID to your appointment, as we will need a copy for insurance verification. Our friendly office staff will ask your permission to take a photo of you for our medical records. This helps us to identify patients when they do not respond to their name being called.

Due to the highly specialized nature of our practice, you may experience a longer than normal wait time when visiting our office. Depending on your symptoms, various tests may need to be performed prior to your visit with the physician. Sometimes, to ease with patient flow, we perform these tests after you have seen the doctor. Because the balance nerve is located in the ear, a hearing test will be performed if you are feeling imbalance or dizziness (even if you do not feel you have problems with your hearing). If you have had any similar hearing or balance testing within the recent months, please bring copies of your results with you. However, you may need to have the testing repeated as we perform in-depth testing using state-of-the-art equipment.

Additionally, it is very important to have a companion or a loved one with a familiar voice attend the appointment with you. This is someone what you are used to communicating with on a regular basis. You will receive a lot of information and it is good to have a loved on there to help absorb some of that information.

It is also recommended to bring a sweater to our office as the temperatures can vary and may be cooler for some patients.

Your Follow-up Visit

To help eliminate your wait time and avoid frustration, please do not arrive earlier than the time you were given. Each department sees patients by appointment time. If you are going to be late, please call the office to notify us as soon as possible.

As a courtesy, we provide an appointment reminder call one to two days prior to your appointment. This will also be in the form of a text message if a cell phone number is on file.

If you have any questions before or after your visit, please feel free to contact us at **(210) 614-6070.**

Race and ethnicity categories in the U.S. are defined by the Office Management and Budget (OMB). The minimum race categories and the exact wording of the OMB standards for collection date on race and ethnicity are:

The minimum race categories are:

1. American Indian or Alaska Native
2. Asian
3. Black or African American
4. Native Hawaiian or Other Pacific Islander
5. White

The minimum ethnicity categories are:

1. Hispanic or Latino
2. Not Hispanic or Latino

Ear Medical Group has decided to go above the minimum for collecting data on race, which is as follows:

1. **Asian**
2. **Caucasian / White**
3. **Black / African American**
4. **American Indian or Alaska Native**
5. **Native American**
6. **Other**

We will continue to use the minimum standards for collecting data on ethnicity:

1. **Hispanic or Latino**
2. **Not Hispanic or Latino**

****Please refer to this for Ear Medical Group's *Patient Registration and Medical Questionnaire***

PATIENT REGISTRATION & MEDICAL QUESTIONNAIRE

Date:_____/_____/_____

Name:_____ Social Security # _____-_____-_____

Sex:_____ Age:_____ Date of Birth:_____/_____/_____ Marital Status:_____

Address: _____ City, State, Zip:_____

Primary Phone # (_____)_____ (HM, WK, Cell) Secondary # (_____)_____ (HM, WK, Cell)

E-mail Address: _____ Race and Ethnicity:_____

Preferred Language:_____ Occupation / Employer:_____

Spouse (Parent / Guardian if under 18) _____ D.O.B.:_____/_____/_____ WK#_____

EMERGENCY CONTACT

Name:_____ Relation: _____ Phone #:_____

Reason for Visit:_____

Referred By:_____ Is referral from a physician? ☐ YES ☐ NO
(FIRST NAME AND LAST NAME)

Address / Phone of referral source:_____

Family Doctor:_____ Address / Phone#:_____

Pharmacy information:_____

Allergies to Medications	Type of Reaction (ex: hives, anaphylaxis, etc.)	Severity (Critical, Severe, Moderate or Mild

Current Medications	Dose	Frequency

CT/MRI of Head	Location	Date	Name of Physician

Flu Vaccination ☐ YES ☐ No Date Received: _____

Pneumonia Vaccination ☐ YES ☐ No Date Received: _____

SUBSCRIBER INFORMATION

PRIMARY INSURANCE:_____

Subscriber's Name:_____ Relation to patient:_____

Subscriber's Address:_____ Phone #_____

Subscriber's Employer:_____ Phone #_____

Date of birth of subscriber:_____ Group #_____ ID#_____

SS# of subscriber:_____

SECONDARY INSURANCE:

Subscriber's Name:_____ Relation to patient:_____

Subscriber's Address:_____ Phone #_____

Subscriber's Employer:_____ Phone #_____

Date of birth of subscriber:_____ Group #_____ ID#_____

SS# of subscriber:_____

RESPONSIBLE PARTY:_____

Address:_____

Home Phone Number:_____Work Phone Number:_____

SS#:_____ Date of Birth:_____

PLEASE NOTE

PAYMENT IS REQUIRED AT TIME OF SERVICE. THERE WILL BE A $25.00 FEE FOR RETURNED CHECKS. FOR YOUR CONVENIENCE, WE ACCEPT ALL MAJOR CREDIT CARDS.

I understand that I am financially responsible for all charges and guarantee payment of this account.

I hereby authorize Ear Medical Group to release any information required in the course of my examination or treatment for insurance claims. Furthermore, I authorize payment directly to Ear Medical Group for medical and / or surgical benefits, which may otherwise be payable to me for their services.

I authorize any physician, hospital, laboratory, or x-ray facility to release to any physician of EAR MEDICAL GROUP any and all medical information, hospital records, laboratory studies or x-rays that may be requested. A copy of this authorization is as binding as the original..

Patient / Parent / Guardian Name (Please Print):_____

Date:_____ Signature:_____

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Please Print **Last Name:**_____

Please Print **First Name:**_____

Date of Birth:_____

Medical History Form

Please describe your overall health:	☐ Excellent ☐ Very Good	☐ Good ☐ Fair	☐ Poor	
If this visit is for a minor, are the child's immunizations up to date?	☐ N/A	☐ Yes	☐ No	
Are you allergic to latex?	☐ Yes	☐ No		
Are you or could you be pregnant?	☐ Yes	☐ No		

Social History / Risk Factors

Tobacco Use

How would you describe your cigarette smoking?	☐ Current	☐ Previous	☐ Never
If you answered **"Current"** or **"Previous"**, please provide the year you started smoking. (YYYY)			
If you answered **"Previous"**, please provide the year you quit smoking. (YYYY)			
How many cigarettes a day do you smoke (or did smoke)?			
Do you smoke cigars?	☐ Yes	☐ No	
Do you use smokeless/chewing tobacco?	☐ Yes	☐ No	
Any passive (second hand) smoke exposure?	☐ Yes	☐ No	

Alcohol Use

Do you drink alcohol?	☐ Yes	☐ No		
If **"Yes"**, about how many drinks per day?				
What type(s) of alcohol?	☐ Beer	☐ Wine	☐ Liquor	☐ Other

Drug Use

Do you use recreational drugs?	☐ Yes	☐ No		
If **"Yes"**, which ones?	☐ Marijuana	☐ Cocaine	☐ Heroin	☐ Amphetamines
	☐ Barbiturates	☐ Hallucinogens	☐ Other	

HIV

HIV high risk behavior? *(HIV Risk Factors: IV drug use, more than one sexual partner, sex with a prostitute, unprotected sexual contact, contact with contaminated injection equipment.)*	☐ Yes	☐ No

Habits

How many caffeine drinks do you drink per day? (Coffee, Tea, soda(s), etc.)			
Do you exercise regularly?	☐ Yes	☐ No	
Sun Exposure:	☐ Rarely	☐ Occasionally	☐ Frequently

Please indicate if you have a history of any of the following:

☐	**NONE**	☐	Head & Neck Cancer
☐	Allergic Rhinitis	☐	Hearing Loss
☐	Anemia	☐	Hemochromatosis
☐	Anesthesia Complications	☐	Hepatitis A
☐	Aneurysm	☐	Hepatitis B
☐	Anxiety	☐	Hepatitis C
☐	Asthma	☐	High Cholesterol
☐	Atrial Fibrillation	☐	High Blood Pressure
☐	Autoimmune Disorder	☐	Hypothyroidism
☐	Balance Disorder	☐	Kidney Disease
☐	Blood Transfusions	☐	Liver Disease
☐	Brain Tumor	☐	Heart Attack
☐	Breast Cancer	☐	Methicillin Resistant Staphylococcus Aureus Infection
☐	Breast Disease	☐	Neurological Disorder (include Headaches)
☐	Cervical Cancer	☐	Osteoarthritis
☐	Crohn's Disease	☐	Osteoporosis
☐	Cirrhosis	☐	Rheumatoid Arthritis
☐	Colon Cancer	☐	Sarcoidosis
☐	CVA / Stroke	☐	Seizure Disorder
☐	COPD	☐	Sinusitis
☐	Coronary Heart Disease	☐	Sleep Apnea
☐	Depression	☐	Thyroid Disorder
☐	Diabetes	☐	TMJ
☐	DVT	☐	Tuberculosis
☐	Eczema	☐	Peptic Ulcers
☐	GERD	☐	Valvular Heart Disease
☐	GI Bleed	☐	Varicose Veins / Phlebitis
☐	Glaucoma	☐	Vascular Disease
	OTHER:_____		_____

Please indicate if you have had any of the following surgeries:

☐	**NONE**	☐	Drainage of Neck Abscess
☐	Abdominal Surgery	☐	Neck Surgery
☐	Removal of Adenoids	☐	Oral Cavity Surgery
☐	Removal of Appendix	☐	Repair of Ear Bones
☐	Removal of Neck Cyst	☐	Outer Ear Surgery
☐	Heart Surgery	☐	Palate Surgery
☐	Carotid Artery Surgery	☐	Parathyroid Gland Removal
☐	Carpal Tunnel Repair	☐	Peritonsillar Abscess Drainage
☐	Removal of Gall Bladder	☐	Angioplasty of Heart Blood Vessels
☐	Cosmetic Surgery	☐	Rotator Cuff Repair
☐	Corrective Surgery for Swallowing	☐	Sinus Surgery
☐	Ear Tubes	☐	Spine Surgery
☐	Facial Fracture Repair	☐	Submandibular Gland Removal
☐	Hip Replacement	☐	Cesarean Section
☐	Hysterectomy	☐	Hysterectomy with Ovary Removal
☐	Knee Arthroscopy	☐	Thyroglossal Duct Cyst Removal
☐	Knee Joint Replacement	☐	Tonsils Removal
☐	Removal of Larynx	☐	Ear Drum Repair
☐	Mastoid Ear Surgery	☐	Zenker's Diverticulum Removal
☐	Repair Nasal Fracture	☐	Sleep Apnea / Snoring Surgery
☐	Straighten Nasal Septum	☐	Pacemaker
	OTHER:_____		_____

Please indicate if you have a family history of any of the following: (family includes parents, grandparents, and siblings)

☐	Family History Unknown	☐	Diabetes
☐	Alcoholism	☐	Hearing Loss
☐	Allergy	☐	Heart Disease
☐	Anesthesia Problems	☐	High Cholesterol
☐	Arthritis	☐	Kidney / Renal Disease
☐	Asthma / Respiratory Disease	☐	Migraine
☐	Bleeding Disorder	☐	Seizures
☐	Breast Cancer	☐	Skin Cancer
☐	Other Cancer	☐	Suicide

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Authorization From for Release of Protected Health Information with Family or Friends

Patient Name: _____ **Date of Birth**: _____

I grant permission for my healthcare provider and their representative of Ear Medical Group to discuss my care using this disclosure from to **share relevant information about my healthcare or discuss financial information for payment on my account with family or friends**

☐ I **DO NOT** want any of my information shared with family or friends.

Release my protected health information to the following person(s) / entity:

Name: _____ Phone: _____ Relationship:_____

Name: _____ Phone: _____ Relationship:_____

Name: _____ Phone: _____ Relationship:_____

The information you may release subject to this authorization are the following:

Appointment date and time	☐ **YES** ☐ **NO**
Explanation of diagnosis and/or procedures	☐ **YES** ☐ **NO**
Lab Reports	☐ **YES** ☐ **NO**
Billing Information	☐ **YES** ☐ **NO**

I understand that my health information at **Ear Medical Group** is protected. I have the **Notice of Health Information Practice Acknowledgment Form** and this document will be on record with **Ear Medical Group.**

_____

Patient Signature Date

This consent will be considered **valid until such time that I revoke it**. I reserve the right to revoke it at any time. I understand that to revoke this consent, I **must provide written notice** to **Ear Medical Group**.

ATTENTION ALL PATIENTS WITH AN HMO PLAN

PLEASE BE AWARE OF THE FOLLOWING:

PATIENT ARE RESPONSIBLE FOR OBTAINING A REFERRAL FROM THEIR PRIMARY PHYSICIAN. IF NO REFERRAL IS ON FILE, THE PATIENT WILL BE RESPONSIBLE FOR THE BILL AT THE TIME OF OFFICE VISIT.

Susan Marenda King, M.D., F.A.C.S.
M. Geraldine Zuniga Manrique, M.D.

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APPOINTMENT CONFIRMATIONS

Ear Medical Group confirms appointments via text or voice message **3 business days prior** to the visit date and sends a reminder text message **2 business days prior**. Due to increased in visit demand, if we have not received your **confirmation by 3:00pm 2 business days prior** to your appointment, the appointment will be **rescheduled**.

Thank you for your cooperation and understanding.

21 Spurs Lane, Suite 245
San Antonio, Texas 78240
Tel: 210.614-6070 Fax: 210.615.6814
www.earmedicalgroup.com

Revised 04/18/2023

Dr. Susan Meranda King, M.D., F.A.C.S
M. Geraldine Zuniga, M.D.

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A NOTE TO OUR VALUED PATIENTS

Please be advised that it is Ear Medical Group (EMG) policy to refer patients to their primary care physician (PCP) for completion of any forms. This is part of integrated care and coordination with you and your PCP.

Here are some examples of the most commonly requested forms:

- Family Medical Leave Act (FMLA)
- Short-Term or Long-Term Disability
- Social Security Disability
- Attending Physicians Statement
- Any type of Disability or Leave Form

We will ensure that copies of your office notes will be forwarded to your PCP for their records. The office note will include your diagnosis and treatment plan.

SURGICAL PATIENTS: EMG physicians will complete FMLA paperwork for patients who are scheduled for surgery for a fee of **$50.00**. We ask for this to be paid prior to completion. Please allow **2 Weeks** for the completion of any forms.

LETTERS: Letters of any type will require pre-payment of **$50.00** as well. Please allow **2 weeks** for the completion of any letters.

Revised 04/12/2023

BILLING AND INSURANCE

Financial Policy

"Self Pay" – Patients are responsible for payment of all charges at the time of service. We may require you to post a deposit on your account prior to being seen by a provider. The Group accepts cash, checks, credit cards and money orders.

We do offer a discount program for uninsured patients on a cash pay basis, and will be happy top discuss any special consideration in the handling of your account.

Insurance – We have the ability to verify your healthcare insurance coverage to include online methods with different insurance carriers. If you do not produce an insurance card or if your coverage is not active at the time of your visit, you will have the option to **either reschedule your appointment, or to pay a "good faith estimate"** of charges for all expected services before you will be seen by the physicians / providers.

Most insurance policies have a timely filing period of **60 or 90 days** after which claims cannot be submitted for payment. You must insure that you have provided our office with the correct insurance information at the time of services. **Any claims denied due to incorrectly provided insurance will be your responsibility.**

Insurance is a contract between you and your insurance company. We are **not** a party to this contract. However, we are preferred providers for most major health insurance plans and for you convenience, we will be happy to electronically file your primary and secondary insurance claims directly from this office. Most insurance policies have a timely filing period of **60 or 90 days** after which claims cannot be submitted for payment. You must insure that you have provided our office with the correct insurance information at the time of service. **Any claims denied due to incorrectly provided insurance will be your responsibility.**

Co-Payments, fees and deductibles are due at the time of service. Failure to pay your co-payment at the time of service will result in an additional **$20.00** charge to your account. You are responsible for any charges not covered or reimbursed by your insurance policy. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc. other than to supply factual information as necessary. **You are responsible for the timely payment of your portion of your account with Ear Medical Group.**

Outstanding Balances – All past due balances are expected to be paid in full prior to any future appointments unless you have a previously established payment plan. **Ear Medical Group will not get involved in disputes** between family members regrading responsibility for payment on an outstanding balance.

Billing Statements – Ear Medical Group mails patient account statements monthly. We greatly appreciate your timely attention to those statements. If you believe that there is an error on your account or if you believe that another insurance company should be responsible for payment, it is your responsibility to notify us as soon as possible. **We will not be able to assist you once the "timely filing" period of your insurance has expired.**

Returned Checks – A fee of **$25.00** may be charged to your account for any / all / each returned check. All future payments must be made by way of cash or credit card.

Cancellation Policy – We require **24-hours notice** for any appointment cancellation. Repeated cancellations or no shows for appointments could result in discharge from the practice.

Referrals – In order to expedite your care, Ear Medical Group has referral coordinators to assist you.

Other Fees - $50.00 for any correspondence request not covered by your insurance policy.

Please contact our Revenue Cycle Manager and billing office during normal business hours if you have any questions about your Patient Accounts policies.

Thank you for your understanding.

Signature: _____ **Date:**_____

GUARANTEE OF PAYMENT

_____ I understand that I am totally responsible for payment of all fees and services rendered, irrespective of insurance coverage or other responsibilities.

NOTE: The guarantor of each account is ultimately responsible for payment in full of the account. You are expected to provide timely and accurate information regarding guarantor and insurance coverage.

_____ I understand that if I am participating in my HMO plan, my primary care physician (PCP) must authorize the services that I requested and received today. I have been advised that if I did not notify my PCP in advance for a referral authorization, my HMO plan may deny payment for services and thus, I will become responsible for payment of all services.

_____ I have been provided with an overview of billing process and have read the copy of the "Understanding Your Financial Responsibility" handout.

ASSIGNMENT

_____ I request that payment of authorized Medicare benefits be made on my behalf to Ear Medical Group for any services furnished to me by these providers.

_____ The signature below authorizes payment of mandated medigap benefits to Ear Medical Group.

Medigap - _____ Policy Number - _____Group Number - _____

_____ I assign the benefits from my insurance carriers to this clinic for the medical / surgical benefits I am entitled.

RELEASE OF INFORMATION

_____ I authorize the Ear Medical Group to release to my insurance carrier(s) any information needed to determine benefits or benefits payable for related services.

_____ I have read and agree with understanding my financial responsibilities and the payment policy, assignment and release of information paragraph stated which apply to me.

_____ _____

Patient Signature Date

_____ _____

Person signing on behalf of patient Relationship to patient

CANCELLATION / NO-SHOW POLICY

PLEASE READ CAREFULLY.
THIS POLICY IS STRICTLY ENFORCED!

Our goal is to provide quality medical care in a timely manner. In order to do so, we have had to implement a **no-show / cancellation policy**. This policy enables us to better utilize available appointments for our patients in need of medical care.

Cancellation of an Appointment:

In order to be respectful of medical needs of other patients, please be courteous and call Ear Medical Group at **(210) 614-6070** promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call ***at least 24 hours in advance***. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

Late Cancellations:

Late cancellations will be considered as a **"no-show"**.

No-Show Policy:

A "no-show" is someone who misses an appointment without cancellation in an adequate manner. "No-shows" inconvenience those individuals who need access to medical care in a timely manner. A failure to present at the time of a scheduled appointment will be recorded in the patient's chart as a "no-show". **The following are Ear Medical Group's "No-Show" Fees:**

1. Office Visit No-Show - **$25.00**
2. Vestibular Testing No-Show – **$100.00 (48 hour notice)**
3. Allergy SLIT No-Show - **$170.00**
4. Allergy Testing No-Show - **$50.00**
5. Surgery Cancellations - **$250.00 (72 hour notice)**

The "no-show" fees will not be covered by your insurance or workman's compensation, but will have to be paid by you personally before you will be able to schedule another appointment.

In the event you have **three "no-shows" / cancellations,** all remaining appointments may be canceled and you will be referred back to your primary care / referring physician for future medical care.

Patient Signature:_____ Date:_____

Staff Signature:_____ Date:_____

Notice of Health Information 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 see the receptionist to request a copy.

Understanding Your Health Record / Information

Each time you visit a hospital, physician or other healthcare providers, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. This information often referred to as your health or medical record, serves as a

- basis for planning your care and treatment
- means of communication among the many health professionals who contribute to your care
- legal document describing the care you received
- tool to educating health professionals
- source of data for medical research
- source of information for public health officials charged with improving the health of the nation.
- Source of data for facility planning and marketing
- tool with which we can assess and continually work to improved the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used to help you to:

- ensure its accuracy
- better understand who, what, when, where and why others may access your health information
- make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522. Requests for restriction on disclosures to your health plan for health care items or services paid out of pocket must be accepted
- obtain a paper copy of the notice of information practices upon request
- inspect and obtain a copy of your health record as provided for in 45CFR 164.524 and HB 300 (paper electronic)
- amend your health record as provided in 45 CFR 164.528
- obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- request communication of your health information by alternative means or at alternative locations
- revoke your authorization to use or disclose health information except to the extent that action has already been take
- receive a notice of a breach of "unsecured" protected health information

Our Responsibilities

This organization is required to:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction
- accommodate reasonable request you may have to communicate health information by alternative means or at alternative locations
- notify you of a breach of "unsecured" protected health information

We reserve the right to change our practices and to make the new provisions effective for all protected health information (PHI) we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us.

We will not use, disclose, or sell your health information without your written authorization, except as described in this notice.

To Report a Problem

If you have questions and would like additional information, you may contact the Privacy Officer at this office.

If you believe your privacy rights have been violated, you can file a complaint with this office or with the secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Examples of Disclosures for Treatment, Payment and Health Operations

Treatment: Information obtained by a nurse, physician or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectation of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way, the physician will know ho you are responding to treatment. We will also provide subsequent healthcare providers with copies of various reports that should assist them in treating your.

Payments: A bill may be sent to you or third-party payer. This information on or accompanying the bill may include information that identifies you, as well as your diagnoses, procedures, and supplies used.

Health Operation:

Risk Management – Members of the medical staff or the risk or quality improvement staff may use information in you health record to assess the care and outcomes in your case and other like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business Associates – There are some services provided in our organization through contacts with business associates. Examples include radiology, laboratory, copy services, transcription services, billing services, etc. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Notification – We may use or disclose information to notify or assist in notifying a family member, personal representative or anther person responsible for your care, of your location and general condition.

Communication With Family – Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research – We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral Directors – We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ Procurement Organizations – Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant.

Marketing – We may contact you to provide appointment reminders or face-to-face information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Food and Drug Administration (FDA) – We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, recall, repairs, or replacement.

Worker's Compensation – We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Public Health – As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Law Enforcement – We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Schools – We may disclose childhood immunization records to schools.

Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering on or more patients, workers or the public.

This Notice is effective as of _04-25-2023_ and will remain in effect until revised.

NOTICE OF HEALTH INFORMATION PRACTICES ACKNOWLEDGMENT FROM

EAR MEDICAL GROUP

(*Practice Name*)

The attached notice describes ow medical information about you may be used and disclosed and how you can get access to this information. Please sign this cover sheet acknowledging receipt of the policy and return it to the receptionist. Review the policy carefully and let us know if you have any questions or requests.

By my signature below, I acknowledge that I have received the Notice of Health Information Practices of **EAR MEDICAL GROUP**. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

_____

Name of Patients

_____

Signature of Patients

_____

Date