RICHARD A. WANDZEL, D.O., P.C.

EAR, NOSE & THROAT
FACIAL PLASTIC - COSMETIC SURGERY

222 W. Highland Rd.
Highland, MI 48357
(248) 889-7600
Fax (248) 889-5876

820 Byron Rd., Suite 500
Howell, MI 48843
(517) 548-5900
Fax (517) 548-5982

PATIENT-SPECIALIST PHYSICIAN AGREEMENT

Dear Patients,

We are continuously working on ways to improve how we provide care to you. We are now a part of your Patient Centered Medical Home- Neighborhood, and will work closely with your Primary Care Physician in meeting your needs. We are asking you to improve your health care experience by taking an active role in your health care.

We Trust you, as our patients to:

- Keep your appointments and to know your insurance and what it covers. We expect you to pay your share of the visit when seen in the office.
- Tell us what you know about your Ear, Nose and Throat health and illnesses and what your needs and concerns are.
- Take an active part in planning your care and following that plan. Inform us if you are unable to do so.
- Tell us what medications you are taking and take your prescribed medications as directed. To ask for refills in a timely manner so there are no lapses in medication dosing.
- Keep us informed when you see other doctors and what medications they prescribe for you or if changes have been made.

We, as your Physician will:

- Provide care for the Ear, Nose and Throat condition you were referred to us for by your primary care physician or care for the Ear, Nose and Throat condition you arrived with upon self referral.
- We will communicate regularly with your primary care Physician to coordinate your care. A letter will be sent upon your first visit and any visits afterward that patient requests.
- Provide safe, quality care to you when needed, with respect to you and your privacy. We will not share your medical information without your permission, as designated on HIPPA form.
- Provide 24-hour access to our health care team.
- Discuss the most appropriate tests and procedures you need to meet your Ear, Nose and Throat goals and help coordinate your care among other health professionals.
- Tell you about your Ear, Nose and Throat health and illnesses in a way you can understand and provide care for short or long terms illnesses as indicated.

Signature: _____ Date: _____

Notice of Privacy Practices Summary

Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164. Rev. 2/2017

You have the right to:

- Get a copy of your paper or electronic medical record
- Amend your medical record if you believe it is incorrect or incomplete
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you (medical power of attorney or legal guardian)
- File a complaint with our practice, or the Secretary of the Department of Health and Human Services, if you believe your privacy rights have been violated

We may use and share your information as we:

- Provide medical treatment and coordination of your care with other health professionals
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government, insurance, employer requests
- Preventing or reducing a serious threat to anyone's health or safety

Our Responsibilities:

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing
- **For more information see:** www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

I authorize Dr. Richard A. Wandzel, D.O., P.C., and Huron Valley Hearing, Inc., to use and disclose the protected health information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct. This authorization shall be in force for six years, at which time this authorization expires. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient/legal guardian_____Date: _____

Name:_____

*PREVIOUS HOSPITALIZATIONS, SURGERIES and MEDICAL ILLNESS		
DATE (approx. year)	REASON	PLACE (hospital)

□ NO SIGNIFICANT HOSPITALIZATIONS, SURGERIES or MEDICAL ILLNESSES NOTED □ REFER TO LIST

Have you had any serious problems with anesthesia? If so, what?_____ YES NO

Is there any family history of problems with anesthesia?_____ YES NO

Are there any personal/religious reasons you would refuse blood transfusions?_____ YES NO

*LIST OF CURRENT MEDICATIONS		
NAME OF MEDICATION	DOSAGE	ROUTE (mouth,injection,inhaler)

□ CURRENTLY DOES NOT TAKE ANY MEDICATIONS □ REFER TO LIST

Pharmacy Name:_____ Location/Phone Number:_____

*ALLERGIES □ NO KNOWN DRUG ALLERGIES

ARE YOU ALLERGIC TO: If YES, describe reaction:

LATEX	YES	NO	_____
FOODS	YES	NO	_____
IODINE (on skin)	YES	NO	_____
ADHESIVE TAPE	YES	NO	_____
OTHER ALLERGIES:_____			_____

*LIST MEDICATION ALLERGIES:	
MEDICAL ALLERGY	REACTION

*Do you have Advance Directives and / or a Living Will? YES NO

Name:_____

*Height:_____ *Weight:_____

Occupation:_____

Employer:_____

*Family History

Has anyone in your family had any of the following?

Heart Disease	YES	NO
Stroke	YES	NO
Cancer	YES	NO
Bleeding Disorder	YES	NO
Diabetes	YES	NO
Hearing Loss	YES	NO
Hypertension	YES	NO

*Social History

Do you use tobacco?	YES	NO
If YES, how many Packs/Day and #yrs:_____		
Year Quit:_____		
Do you drink alcohol?	YES	NO
If YES, what type and amt. per wk.:_____		
Do you consume caffeine?	YES	NO
If YES, how many cups per day:_____		
Do you/have you had a problem with chemical dependency or recreational drug use?	YES	NO
Have you had a recent pneumonia vaccine?	YES	NO
Are you pregnant?	YES	NO
Any History of Cancer?	YES	NO
If YES, please describe:_____		
Do you exercise regularly? Yes No How often?_____		

*REVIEW OF SYSTEMS:

GENERAL	EYES	EAR,NOSE,THROAT	CARDIAC	RESPIRATORY
□ *None*	□ *None*	□ *None*	□ *None*	□ *None*
□ Weakness	□ Blurred Vision	□ Hearing Loss	□ Irregular Heartbeat	□ Cough
□ Fatigue	□ Itchy/Irritated Eyes	□ Ear Infections	□ Poor Circulation	□ Asthma
□ Fever/Chills	□ Eye Pain	□ Nose Bleeds	□ High Blood Pressure	□ Shortness of Breath
□ Headaches	□ Tearing	□ Sore Throat	□ Cardiac Disease	□ Difficulty Breathing
□ Dizziness	□ Cataracts	□ Snoring/Sleep Apnea	□ History of heart attacks	□ Wheezing
□ Night Sweats	□ Glaucoma	□ Vertigo	□ High Cholesterol	□ Pneumonia
□ Other:	□ Other:	□ Tinnitus	□ Other:	□ Pulmonary Disease
		□ Other:		□ Other:

GASTROINTESTINAL	GENITOURINARY	MUSCULOSKELETAL	SKIN	NEUROLOGICAL
□ *None*	□ *None*	□ *None*	□ *None*	□ *None*
□ Reflux/GERD	□ Difficulty with Urination	□ Joint Swelling/Pain	□ Skin color change	□ Tremors
□ Heart Burn	□ Kidney Disease	□ Muscle Aches	□ Skin Rashes	□ Epilepsy/Seizers
□ Nausea/Vomiting	□ Pain/Burning	□ Back Pain	□ Itchy Skin	□ Memory Loss
□ Poor Appetite	□ Blood in Urine	□ Arthritis	□ Skin Sores	□ Stroke/TIA
□ Abdominal Pain	□ Infections	□ Other:	□ Head/Facial Lesions	□ Other:
□ Other:	□ Other:		□ Skin Cancer	
			□ Other:	

PSYCHIATRIC	ENDOCRINE	HEMATOLOGY	IMMUNOLOGY	ORAL
□ *None*	□ *None*	□ *None*	□ *None*	□ *None*
□ Depression	□ Diabetes	□ Anemia	□ Sneezing	□ Bleeding Gums
□ Anxiety	□ Thyroid Disease	□ Clotting Disorder	□ Runny Nose	□ Dental Problems
□ Insomnia	□ Weight Loss	□ Bruises Easily	□ Skin Sensitivity	□ Ulcers/Blisters/Sores
□ Other:	□ Weight Gain	□ Aspirin Use	□ Allergies	□ Loss of Taste
	□ Hypoglycemia	□ Blood thinner Use	□ AIDS/HIV	□ Bad Breath
	□ Other:	□ Other:	□ Autoimmune Disease	□ Other:
			□ Other:	

Reason for Visit Today: _____

Physician's Signature: _____

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PATIENT INFORMATION:

Name: _____ **Male/Female**

Date of Birth _____ Age: _____ **Preferred Language**_____

Race_____ **Ethnicity:** __ Non Hispanic/Latino __Hispanic/Latino __Other

Marital Status: Single/Married/Widowed/Divorced **Social Security#:**_____

Mailing Address: _____City: _____Zip Code: _____

Home Phone:_____ Cell Phone: _____ Work phone: _____

Authorization to leave a message? Yes No Email:_____

Preferred method of contact: (circle one) Home Phone / Cell Phone / Email / Other

Emergency Contact: _____ Relationship: _____ Phone: _____

Referring Doctor or Primary Care Physician: _____ Phone: _____

INSURANCE INFORMATION: **Primary Insurance:**

_____

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Relationship to Patient Insured: (Circle one) Self / Spouse / Child / Other (explain) _____

Secondary Insurance: _____

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Relationship to Patient Insured: (Circle one) Self / Spouse / Child / Other (explain) _____

Workmen's Compensation: Yes No **Auto Accident: Yes No**

I authorize the release of information needed to process claims to the insurance company and assign all benefits to Dr. Richard A. Wandzel, D.O.. I understand and agree that I am responsible for the balance on my account. It is important for you to understand that your health insurance coverage is an agreement between you and your insurance company, not you and your provider. I certify that this information is true and correct to the best of my knowledge. I will notify the office of Dr. Richard A. Wandzel, D.O. of any changes in my health status or insurance information.

X_____ **Date:** _____
PATIENT SIGNATURE or RESPONSIBLE PARTY

www.wandzel.com