GREGORY A. HOGLE, D.O.
COLUMBINE OTOLARYNGOLOGY • HEAD AND NECK SURGERY

MELVIN & ELAINE WOLF SURGICAL BLDG.
4600 HALE PARKWAY, SUITE 450
DENVER, COLORADO 80220
PHONE 303.333.2119
FAX 303.333.2016

PATIENT REFERRAL WAIVER AGREEMENT

**** This may or may not apply to your insurance. It is your responsibility to know your insurance. ****

Because Dr. Hogle is a ***specialist***, some insurance policies require an authorization for your Primary Care Physician (PCP) to refer you. If your insurance policy requires authorized referrals, we need an authorization number and have a copy of the referral form mailed or faxed to this office prior to your appointment(s). If we do not have a copy of the referral form or you did not bring a copy with you, the following options are available:

1. You may call your insurance company to obtain the authorization number.
2. You may reschedule this appointment and bring your copy of the referral form or the authorization number with you to the next appointment.
3. You may keep this appointment today without either of the above but understand that your insurance company **MAY NOT PAY** for the charges related to your visit(s).
4. You understand that if you choose Option #3 and your insurance does not pay for your visit(s), you will be responsible for payment of **ALL CHARGES** related to that visit(s).

APPOINTMENT CANCELLATION POLICIES

OFFICE APPOINTMENTS:

It is important, not only to you but to our office and other patients, that you keep your appointments with us and are on time. If you are unable to keep an office appointment at any time, we ask that you kindly give us a 24-hour notice. We do understand that it is not always possible, and we do understand busy schedules. However, there will be a $50 fee to patients who do not call and cancel. *This fee is not billable to insurance.*

Patients who arrive late to an appointment may be asked to reschedule. Habitual late and/or missed appointments may result in discontinuation of Dr. Hogle's services.

SURGERY APPOINTMENTS:

Surgery scheduling is very time consuming for our staff. Patients who cancel scheduled surgeries within five (5) days of a scheduled surgery will be assessed a cancellation fee of 10% of Dr. Hogle's total surgical fee or $100, whichever is higher. Surgical fees vary depending on the extent and complexity of the surgery. *This fee is not billable to insurance. This fee will not apply if our office cancels your surgery for any reason.*

_____
Printed Name

_____ _____
Signature of Patient or Authorized Representative Date

Columbine Otolaryngology
Patient Information

Last Name	First Name	MI	Preferred Name

Date of Birth	Age	Birth Sex	Gender Identity	Preferred Pronouns	Sexual Orientation	Social Security # (for insurance verification)
___/___/___		☐ Male ☐ Female ☐ Intersex				

Home #	Mobile #	Work #
(_____)_____	(_____)	(_____)_____Ext_____

Street Address	Apt./Unit #	City	State	Zip

Mailing Address (if different)	Apt./Unit #	City	State	Zip

Relationship Status	Spouse(S)/Partner(P)/Significant Other(SO) Name	S/P/SO Birth Date	S/P/SO Phone #
			(_____)_____

Email Address (please print legibly)	Preferred Pharmacy (include street and city, or phone number)

Race
❑ African American/Black ❑ Caucasian/White ❑ Decline
❑ American Indian/Alaskan ❑ Other Race

Ethnicity
❑ Hispanic or Latino ❑ Decline
❑ Not Hispanic or Latino

Employment	Occupation	Who referred you to us?
❑ Employed Full Time ❑ Retired ❑ Employed Part Time ❑ Unemployed ❑ Student		❑ PCP ❑ Insurance ❑ Internet ❑ Family/Friend ❑ _____

Who is your Primary Care Physician (PCP)?	PCP Address & Phone	Preferred Method of Contact

May we leave a message or lab results (check each applicable #)? ❑ Home ❑ Mobile ❑ Work

❑ S/P/SO #:_____ ❑ Other Person: _____ Phone # (_____)_____

In case of emergency, notify

Name	Phone #	Relationship to Patient
	(_____)_____	

Minor Patients

Parent/Guardian Name	Date of Birth	Phone #
		(_____)_____

Payment

❑ I am a Self-Pay patient and I will pay cash/check/credit card at the time of service.

❑ I will have you bill my insurance and pay my co-pay at the time of service.

I/we hereby authorize payment directly to Dr. Hogle's office of the group benefits otherwise payable by me. The estimate provided by this office is considered as a guideline until the insurance payment has been received. I understand that this office can make no guarantee of the insurance payment as estimated and that I am responsible for all costs of medical treatment. I also understand that if this office is not paid by my insurance company by the 61st day after treatment, or if I provide incorrect insurance information, I will be billed in full.

Privacy Notice

I have been given a copy of the Notice of Privacy Practices in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Collection/NSF Checks

- There will be a $25.00 handling fee for any returned checks.
- In the case of default of payment (90+ days past due), an additional fee of $75 will be added to the account balance.

I have read, understand, and agree to all of the above information.

_____ Date_____

Patient Signature (Parent or Guardian if minor patient)

Columbine Otolaryngology
Patient History Form
(Please complete each line)

Name _____ DOB _____Date_____

Height _____ Weight _____ Age _____

Reason for today's visit?_____

Date of injury or accident _____ Worker's Comp _____ Auto _____

Other _____

Have you had any other treatment for this problem? ❑ Yes ❑ No If yes, please explain

_____

_____

Last flu vaccine (mo./yr.) _____/_____ Last pneumonia vaccine (mo./yr.) _____/_____

Advanced Care Plan: If age 65+, I have an Advanced Care Plan ❑ Yes ❑ No
If Yes, name of surrogate decision maker: _____

Past/Current Medical History (please check all that apply)

Cardiovascular ❒ None

❑ heart attack
❑ coronary artery disease
❑ blood clot
❑ stroke
❑ TIA (transient ischemic attack)
❑ high blood pressure
❑ brain aneurysm
❑ aortic aneurysm
❑ valve disease: mitral
❑ valve disease: aortic
❑ cardiac septal defect
❑ high cholesterol
❑ other: _____

Blood Disease ❒ None

❑ anemia
❑ low white blood cells
❑ low blood platelets
❑ abnormal red blood cell: thalassemia
❑ abnormal red blood cell: sickle cell
❑ bleeding problems
❑ clotting disorder
❑ other _____

Chest ❒ None

❑ pneumonia
❑ asthma
❑ emphysema
❑ COPD
❑ chronic bronchitis
❑ bronchospasm
❑ sarcoid
❑ pulmonary embolism (clot in lung)
❑ tuberculosis
❑ other: _____

Gastrointestinal/Abdominal Disease ❒ None

❑ heartburn
❑ GERD
❑ stomach ulcers
❑ esophagitis
❑ colitis, Crohn's disease
❑ bowel obstruction
❑ irritable bowel syndrome
❑ hepatitis A
❑ hepatitis B
❑ hepatitis C
❑ cirrhosis
❑ gall stones
❑ gastric bleeding
❑ intestinal bleeding
❑ kidney stones
❑ renal insufficiency
❑ renal failure
❑ pancreatitis
❑ liver insufficiency
❑ liver failure
❑ other _____

Connective Tissue/Rheumatology Disorder

❒ None

❒ osteoarthritis
❒ rheumatoid arthritis
❑ lupus
❑ neurofibromatosis
❑ scleroderma
❑ other: _____

Neurologic Disease

❒ None

❑ seizure disorder / convulsions
❑ multiple sclerosis
❑ brain aneurysm
❑ migraine
❑ Alzheimer's disease
❑ ALS (Lou Gehrig's disease)
❑ Depression or mental health issues_____
❑ other _____

Malignant Disease (cancer)

❒ None

❑ skin: basal cell (common skin cancer)
❑ skin: squamous cell
❑ skin: melanoma_____
❑ lung _____
❑ laryngeal
❑ thyroid
❑ salivary gland
❑ other head/neck cancer: _____
❑ breast
❑ ovarian, uterine, cervical
❑ esophagus
❑ other _____
❑ stomach
❑ colon
❑ rectal
❑ brain _____
❑ renal: kidney
❑ renal: bladder
❑ lymphoma _____
❑ prostate
❑ leukemia____

Infectious Disease

❒ None

❑ meningitis
❑ malaria
❑ HIV
❑ immune deficiency
❑ other _____
❑ sexually transmitted disease (STD):
  ❑ herpes
  ❑ HPV
  ❑ other _____

Endocrine Disease

❒ None

❑ hyperthyroid
❑ hypothyroid
❑ hyperparathyroid
❑ hypoparathyroid
❑ other _____
❑ pituitary disorder
❑ adrenal disorder
❑ diabetes, Type I
❑ diabetes, Type II

Head & Neck

❒ None

- ❒ chronic ear infection
- ❒ chronic mastoid infection
- ❒ chronic sinusitis
- ❒ nasal/sinus polyps
- ❒ seasonal allergic rhinitis
- ❒ salivary gland tumor
- ❒ congenital cyst of neck/in front of ear
- ❒ obstructive sleep apnea (OSA)
- ❒ vocal fold nodule /polyp
- ❒ vocal fold paralysis
- ❒ thyroid nodule(s)
- ❒ other: _____

Past Surgical History

❒ None

Surgery Type	Surgery Description	Year
❒ ear, mastoid		
❒ nasal		
❒ sinus		
❒ removal of tonsils & adenoids		
❒ tonsillectomy only		
❒ adenoidectomy only		
❒ palate surgery		
❒ larynx (voice box)		
❒ tracheostomy		
❒ eye		
❒ lung		
❒ heart		
❒ vascular		
❒ GI, bowel, appendix		
❒ hysterectomy, removal ovary(ies)		
❒ prostate		
❒ kidney		
❒ spine/disc		
❒ bone, joint		
❒ brain		
❒ other		

Current Medications

❒ None

Please include all medications which you take regularly and occasionally (include vitamins, supplements, herbs, pain medications, birth control)

Medication	Dose	Frequency		For Treatment of:
		# Times	daily/weekly	

Are you pregnant? ❑ Yes ❑ No ❑ N/A Are you trying to get pregnant? ❑ Yes ❑ No ❑ N/A

Social History

Do you currently smoke cigarettes? ❑ Yes ❑ No ❑ Never smoked
How many packs a day? _____
Age started? _____

Have you quit smoking cigarettes? When? _____ (**Congratulations !)**
How many packs a day? _____
Age started? _____
Age stopped? _____

Have you chewed tobacco? ❑ Yes ❑ No
❑ Never
❑ Former
❑ Current
How many cans per day?_____
Age started? _____
Age stopped? _____

Do you drink alcoholic beverages? ❑ Former ❑ Yes ❑ No
Average drinks per week _____

Have you used "street" drugs? ❑ Yes ❑ No
Type _____
Quantity:_____
Age started:_____
Age stopped:_____

Have you ever taken steroids? ❑ Yes ❑ No
When?_____
Reason _____

Family History:

❒ None

Medical problems of parents/brothers/sisters, such as cancer, heart disease, arthritis, high blood pressure, diabetes, bleeding problems, trouble with anesthesia, alzheimers, stroke, mental illness:

Relative (mother, father, etc.)	**Medical Problem**	**Onset Age**

Drug/Food Allergies (please circle ALL reactions that apply)

❒ None

DRUGS:

❑ Penicillin/Amoxicillin: (itching, rash/hives, breathing difficulty, facial swelling, nausea/GI upset)
❑ Sulfa: (itching, rash/hives, breathing difficulty, facial swelling, nausea/GI upset)
❑ Iodine: (itching, rash/hives, breathing difficulty, facial swelling, nausea/GI upset)
❑ Codeine: (itching, rash/hives, breathing difficulty, facial swelling, nausea/GI upset)
❑ _____ (itching, rash/hives, breathing difficulty, facial swelling, nausea/GI upset)
❑ _____ (itching, rash/hives, breathing difficulty, facial swelling, nausea/GI upset)

FOODS:

❑ Milk/dairy: (itching, rash/hives, breathing difficulty, facial swelling, nausea/GI upset)
❑ Gluten (itching, rash/hives, breathing difficulty, facial swelling, nausea/GI upset)
❑ _____ (itching, rash/hives, breathing difficulty, facial swelling, nausea/GI upset)
❑ _____ (itching, rash/hives, breathing difficulty, facial swelling, nausea/GI upset)

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Notice of 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 REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment: Gregory A. Hogle, D.O. endorses, supports, and participates in electronic Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. However, you may choose to opt-out of participation in the CORHIO HIE, or cancel an opt-out choice, at any time. Your health information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of tests and procedures will be available in your medical record to all healthcare professionals who may provide treatment or who may be consulted by staff members. We might disclose your health information to a pharmacy when ordering a prescription for you.

Payment: Your health information may be used to seek payment from your health insurance carrier, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health insurance carrier may request and receive information on dates of service provided and the medical condition being treated. We may contact your health insurance carrier to certify that you are eligible for benefits (and what range of benefits). We may release health information for worker's compensation and similar programs.

Healthcare Operations: Your health information may be used as necessary to support the day-to-day activities and management of this office. For example, information on the services you received may be used to support budgeting and financial reporting and activities to evaluate and promote quality of care.

Law Enforcement: Your health information may be disclosed to law enforcement agencies, without your permission, to support government mandated reporting (such as reporting child abuse or neglect). We may have to respond to a court or administrative order, if you are involved in a law suit or similar proceedings (subpoena, discovery request or other lawful process.)

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Release of Information to Family: Our practice may release your health information to family members involved in your care, or who assist in taking care of you. For example, a parent or guardian may ask that a babysitter bring a child to the office for treatment. In this example, the babysitter may have access to the child's medical information.

Military: Our practice may disclose your health information if you are a member of the United States military forces and if requested by the appropriate authorities.

Other Uses and Disclosures Require Your Authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosures of information that occurred before you notified us of your decision. We reserve the right to require annual updates to information and authorizations.

Additional Uses of Information—Appointment Reminders: Your health information may be used by our staff to call/leave appointment reminders.

Information About Treatment: Your health information may be used to send your information on the treatment and management of your medical condition that we may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

Deceased Patients: We may release your health information to a medical examiner or coroner to identify a deceased person or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

Organ and Tissue Donation: We may release your health information to organizations that handle organs, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate the donation and transportation if you are an organ donor.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to receive confidential communications concerning your medical condition and treatment. For example, your request to be called at home, rather than at work (unless an emergency situation arises).
- The right to inspect and obtain a copy of your protected health information. You must submit your request in writing to Gregory A. Hogle, D.O. We have forms available at the front desk. We will charge a fee for the cost of copying, mailing, labor and supplies associated with your request. We may deny your request to inspect and/or obtain a copy in certain circumstances (such as a court restraining order); however, you may request a review of our denial. Custodial and non-custodial birth parents have the same rights, unless we receive a copy of a signed/notarized court order directing us not to release the record.
- The right to ask us to amend or submit corrections to your protected health information if you believe it is incorrect or incomplete. To request an amendment, your request must be in writing and submitted to Gregory A. Hogle, D.O. You must provide a reason that supports your request (supporting reason) in writing.

  We may deny your request if you ask for us to amend information that is, in our opinion: accurate and complete; not part of the health information kept by or for the practice; not part of the health information which you would be permitted to inspect and obtain copy of, such as psychotherapy notes; not created by our practice.
- The right to request a restriction in our use or disclosure of your health information for treatment, payment or healthcare operations. We are not required to agree to your request. In order to request a restriction, you must make your request in writing to Gregory A. Hogle, D.O.
- The right to receive an accounting of how and to whom you protected health information has been disclosed. Use of your health information as part of the routine patient care in our practice is not required to be documented. For example, the billing department using your information to file your insurance claim. To obtain an accounting of disclosures you must submit your request in writing to Gregory A. Hogle, D.O.. All requests for an "accounting of disclosures" must state a time period, which may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but we will charge for additional lists within the same 12-month period. We will notify you of the cost involved with additional requests and you may withdraw your request before you incur any costs.
- The right to receive a printed copy of this notice. To obtain a copy of this notice, please ask the receptionist.

Duty of Gregory A. Hogle, D.O.

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we may maintain.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you may do so by sending a letter outlining your concerns to the office's HIPAA Compliance Officer:

Caly Means
4600 Hale Parkway, Suite 450
Denver, CO 80220

If you believe your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

If you have contacted the Compliance Officer with your concerns and feel that you need further assistance, you may contact:

Department of Health and Human Services
Office of Civil Rights
https://www.hhs.gov/hipaa/index.html
200 Independence Avenue, S.W.
Washington, D.C. 20201
Toll Free Call Center: 1-800-368-1019
TTD Number: 1-800-537-7697

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