

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 CAREFULLY.

Uses and Disclosures:

Treatment – Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment – Your health information may be used to seek payment from your health plan, from other sources of coverage such as automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of services, the services provided, and the medical condition being treated.

Health Care Operations – Your health information may be used as necessary to support the day-to-day activities and management of Cape Fear Otolaryngology. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement – Your health information may be disclosed to public health agencies, without permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

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.

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 of disclosure of information that occurred before you notified us of your decision.

Additional uses of information (Require your Authorization):

Appointment Reminders – Your health information will be used by our staff to send you appointment reminders. We will also contact you by phone to remind you of your upcoming appointment. Our policy regarding a reminder call that is answered by voice mail or machine, we will leave a message stating the name of our office, our telephone number and the date and time of the upcoming appointment.

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

Individual Rights:

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

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

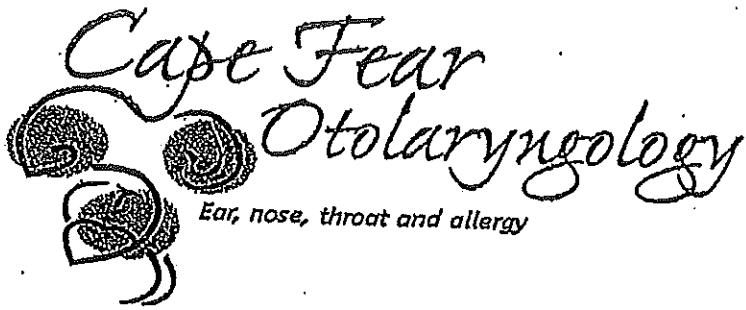
Cape Fear Otolaryngology Duties:

We are required to abide by 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 practices or policies. These changes in our policies and practices may be required by changes in federal and state laws/regulations. Whatever the reason for these revisions, we will provide you with a revised policy upon your next office visit. The revised practices and policies will be applied to all protected health information.

2053 Valleygate Drive, Suite 101 – Fayetteville, NC 28304
Phone (910) 323-9222 Fax (910) 221-9220 www.capefearoto.com



2053 Valleygate Drive, Ste. 101, Fayetteville, NC 28304
(910) 323-9222 Telephone, (910) 221-9220 Fax

September 3, 2009
No-Show Policy

A pattern of repeated "no-shows" for appointments will result in dismissal from this medical practice. A "no-show" is defined as a missed appointment in which the individual does not call to cancel or reschedule the appointment prior to the appointment time.

Your signature below indicates that you have read and understand this policy. Should you have any questions, please direct them to a staff member.

We appreciate in advance your cooperation.

Sincerely,

A handwritten signature in cursive script that reads "Eric L. Mansfield".

Eric L. Mansfield, M.D.
Medical Director

Patient/ Responsible Party signature

Date



Notice of Privacy Practices

Requests to Inspect Protected Health Information:

As permitted by federal regulations, we require that requests to inspect or copy your protected health information be submitted in writing. To get copies of your records or to request that they be sent to another party, you may obtain a records release form from our staff at the front desk. Once this signed authorization has been received, we reserve the right to allow our office personnel to copy your records and send them to requesting party within 7 business days.

Contacts for More Information and/or Complaints:

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to the contact listed below:

Cape Fear Otolaryngology
2053 Valleygate Drive, Suite 101
Fayetteville, NC 28304
ATTN: Practice Administrator

If you believe your privacy rights have been violated, you should call attention to the matter 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.

Please read both pages of this form then return the signed form to our front desk staff.

THIS NOTICE IS EFFECTIVE ON AND AFTER JANUARY 1, 2003.

Consent to Use Disclosure of Protected Health Information

Notice of Privacy Practices:

You should review the Notice of Privacy Practices above for a complete description of how your protected health information may be used or disclosed. Please review this notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information:

You may request a restriction on the use or disclosure of your protected health information.

Cape Fear Otolaryngology may or may not agree to restrict the use or disclosure of your protected health information.

If Cape Fear Otolaryngology agrees to your request, the restriction will be binding on the practice. Use of disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent:

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices:

Cape Fear Otolaryngology reserves the right to modify the privacy practices outlined in this notice.

Signature:

I have reviewed this consent form and give my permission to Cape Fear Otolaryngology to use and disclose my health information in accordance.

Printed Patient's Name _____

Patient Signature _____

CFO Witness _____

Date _____

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Revised 12.2007



Financial Agreement

We are committed to providing you with the best possible care. Our staff works as a team to provide medical expertise as well as old-fashioned courtesy and compassion. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for services is due at the time services are rendered. We accept cash, check, MasterCard and Visa.

As a courtesy to our patients, we will file and accept payment directly from your insurance company. Since most insurance companies do not pay 100%, you are responsible for your portion at the time of service. Our office will estimate your financial responsibility. Please keep in mind this only an estimate based on the information provided by your insurance company.

Returned checks (return check fee of \$25 will be assessed), and balances older than 90 days will be subject to additional collection fees and interest charge of 1% per month. Charges may also be made for broken appointments and appointments cancelled without 24 hour advance notice.

While filing of insurance claims is a courtesy that we extend to our patients, you must realize:

1. Your insurance is a contract between you, your employer and the insurance company.
2. Insurance may pay all, some or none of your bill. Your portion is due prior to and at the time of service. If your insurance does not make payment within 30 days you will be billed for the unpaid balance.
3. Not all services are a covered benefit. Some companies arbitrarily select certain services they will not cover. Please familiarize yourself with your insurance coverage. Benefits vary.

We must emphasize that as a health care provider, our relationship is with you, not your insurance company. We realize that temporary financial problems may affect timely payment of your account. If such problems arise, don't ignore our bills. Instead, contact us promptly for assistance in managing your account.

If you have questions about information, or if you are uncertain of your insurance coverage, please do not hesitate to ask our staff. We are here to help!

► I hereby authorize payment of medical benefits to *Cape Fear Otolaryngology* for services rendered, as well as the authority to submit claims and accept assignment of benefits on behalf _____
& _____ Insurance Company (ies). I have authorized a release of information related to my claims.

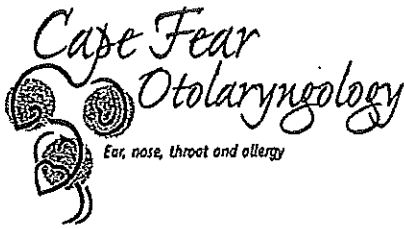
Patient/Guarantor Signature

Date

CFO Witness

Date

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Eric L. Mansfield, M.D.
Sabina P. Francis, M.D.
Robert R. Friedrichs, M.D.
Purvi M. Mehta, PA-C
Jenny Blanco-Doe, Au.D.
Heather Honeycutt, Au.D.
Ericka Hallis, Au.D.

MEDICAL HISTORY QUESTIONNAIRE

Patient's Name: _____ DOB: _____

Patient's Pharmacy Name: _____ Location: _____

Medical Health History: Please check the box if you have any of the below listed conditions

Illnesses:

- Asthma
- Anemia
- Diabetes
- High Blood Pressure
- Cancer
- Epilepsy
- Heart Problems
- Thyroid Problems
- Other _____

Previous Surgeries:

- Ear Tubes
- Tonsillectomy
- Nose or Sinus Surgery
- Gallbladder
- Appendectomy
- Hysterectomy
- Heart or Bypass Surgery
- Cancer Surgery
- Other _____

Family members with significant medical problems: _____

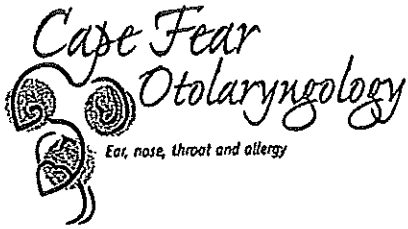
Are you taking any medication? ____ Yes ____ No List Meds: _____

Are you allergic to any medication? ____ Yes ____ No List meds allergic to: _____

Do you smoke? ____ Yes ____ No If yes, how long & how much? _____

Do you drink alcohol? ____ Yes ____ No If yes, how long & how much? _____

Do you take any recreational drugs? ____ Yes ____ No Which ones? _____



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PATIENT REGISTRATION

Date _____

PATIENT INFORMATION:

 Last Name First Name Middle Name S.S.#

 Address City State Zip

 Date of Birth Home Phone # Cell Phone #

 _____ Male _____ Female

Work Phone # _____

REFERRING PHYSICIAN/PRACTICE NAME OR PRIMARY CARE PHYSICIAN: _____

EMERGENCY CONTACT INFORMATION:

 Emergency Contact Name Date of Birth Phone #

GUARANTOR INFORMATION:

 Guarantor Name Date of Birth S.S. # _____ Male _____ Female

 Address City State Zip Phone #

SUBSCRIBER/INSURANCE INFORMATION:(please present insurance card for verification)

Primary Insurance:	Secondary Insurance:
ID #:	ID #:
Group Number:	Group Number:
Group Name:	Group Name:
Subscriber Name:	Subscriber Name:
Subscribers Address:	Subscribers Address:
Subscribers DOB:	Subscribers DOB: