TrimbleENT
Monty V. Trimble, MD
Jonathan S. Wu, MD
Christy Stewart, RN, MSN, FNP-BC
Erin Hattey, AuD

3455 LOCKE AVE., STE 210
FORT WORTH, TX 76107

361 W. SOUTHLAKE BLVD.
SOUTHLAKE, TX 76092

OFFICE 817.529.6200
FAX 817.529.6205
WWW.TRIMBLENT.COM

Welcome!

We are pleased you have chosen Trimble ENT for your otolaryngic needs. We would like to welcome you to our practice. This letter is to help answer any concerns you may have and to let you know what to expect during your initial visit. To ensure that you are ready for your appointment, we do ask that you arrive 15 to 30 minutes early to complete any necessary paperwork.

The initial visit involves a comprehensive evaluation focused on your major concerns. This will take between 30 and 60 minutes. Please bring any records that you have pertaining to your condition. If you have had any prior CT Scans performed pertaining to your condition, please bring the actual films or CD with you to the appointment. Every effort will be made to explain your condition, interpret test results, and give a tentative diagnosis and initial treatment plan during the first visit. Often, in cases of illness, injury, or chronic conditions, complete information may not be available until the follow up visit.

Often, CT Scans of the sinuses can be performed the same day after insurance approval is obtained. Additional diagnostic tests that cannot be performed will need to be scheduled at a future time. Referrals to outside providers and facilities are generated as soon as ordered by the ENT practitioner. If you have not received a call to schedule your appointment within 72 hours of the initial visit, please contact our referral coordinator for assistance.

The charge for the initial evaluation ranges from $150 to $350 or more depending on the complexity of the problem. Charges for audiometric (hearing tests), fiberoptic (endoscopic) examinations, sinus or ear CT examinations and minor procedures may be additional. You are ultimately responsible for the payment of your account balance, including charges that fall under your deductible or copayment. In all cases, you must provide us with a valid insurance card in order for us to verify your coverage at the time of service. You will need to provide the actual insurance card for your initial visit or if your insurance coverage changes during subsequent visits. An amount of $200 will be due upon arrival and any additional amounts at the conclusion of your visit, if you **do not have valid insurance**.

At the time of your visit, you will be expected to provide payment for any co-payment, deductible or co-insurance required by your insurance plan. Payments for any non-covered services will also be due at the time of your visit. Payments can be made with cash, check or credit card. If your insurance plan requires an insurance referral to see a specialist, please contact your Primary Care Physician to have this completed prior to your appointment to prevent any delays when you arrive to the clinic. The referral needs to be faxed to 817-529-6205 prior to your appointment. It is your responsibility to make sure the referral is complete. Failure to cancel and/or reschedule an appointment at least 24 hours in advance will result in a $50 cancellation fee.

You will receive a statement showing your account balance. You are responsible for any balances that remain after payment has been received from the insurance company unless your insurance contract specifically provided for an agreed upon negotiated rate for our services. Your prompt attention to this matter will help our office keep costs to a minimum, which also helps to keep our fees as low as possible. If there are any questions about fees, or if you need to make special arrangements, please let the staff know.

Please note some office procedures, (Flexible Laryngoscopy, Diagnostic Endoscopy, and Post-operative Sinus Debridement), are arbitrarily labeled as “surgery” by some insurance companies and may be applied to your deductible. If you have any questions regarding your explanation of benefits, you can contact your insurance carrier or my business office at 817-377-5223.

You can help in improving the delivery of your care by informing your employer of any problems you may encounter while dealing with your insurance carrier, (denial of care, delay in processing claims or denial of payment).

We understand that obtaining health care can be a complex process and that illness is always a difficult experience. Our commitment to you is to do everything possible to simplify that process while providing you with the best medical care available.

Trimble ENT Physicians and Staff

_____
(Patient’s Initials)

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PATIENT DEMOGRAPHIC INFORMATION

TODAY'S DATE: _____

PATIENT NAME: _____
(LAST NAME) (FIRST NAME) (M.I.)

Home Address: _____ _____ _____
(CITY/STATE) (ZIP CODE)

_____ _____ _____
(HOME PHONE) (WORK PHONE) (CELL PHONE)

_____ _____ _____ _____ CHILD/S/M/D/W
(SOCIAL SECURITY #) (DATE OF BIRTH) (AGE) (GENDER) (MARITAL STATUS)

Email Address: _____ Pharmacy#:_____
(INCLUDE LOCATION)

Primary Care Physician Name & Number: _____

INSURANCE INFORMATION

PRIMARY Name of Insurance: _____

_____ _____ _____ _____
(NAME OF INSURED) (INSURED EMPLOYER) (INSURED'S DOB) (INSURED'S SOCIAL SECURITY#)

SECONDARY Name of Insurance: _____

_____ _____ _____ _____
(NAME OF INSURED) (INSURED EMPLOYER) (INSURED'S DOB) (INSURED'S SOCIAL SECURITY#)

COMPLETE ONLY IF PATIENT IS A MINOR

MOTHER'S NAME: _____
MOTHER'S DOB: _____
MOTHER'S ADDRESS: _____
MOTHER'S PHONE #: _____
SOCIAL SECURITY #: _____

FATHER'S NAME: _____
FATHER'S DOB: _____
FATHER'S ADDRESS: _____
FATHER'S PHONE #: _____
SOCIAL SECURITY #: _____

I hereby authorize Trimble ENT to release any medical information to my insurance company or my family physician. I understand that I am responsible for ALL charges. I authorize Dr. Trimble's office to file my insurance on my behalf. In the event that my insurance company does not pay for any services rendered, I am responsible for those charges. I understand that it's my responsibility to notify the office of any change, such as address, phone numbers, family doctor, and insurance plans. I understand that if my insurance requires a referral, then it's up to me to make sure this is done. I also understand that if I change insurance companies or family physician, then my current referral is VOIDED. I must contact my current family doctor to get a new referral. I understand if I fail to notify the office of any changes, I understand that I will be held accountable for those charges.

_____ _____
Signature Relationship to patient (if not patient signature)

PATIENT HEALTH HISTORY

Today's Date _____

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.** It is important for your doctor to know you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcome to a copy of the report if you wish.

Patient's Last Name _____ **First** _____ **MI** _____

Sex ☐ Male ☐ Female **Height** _____ft _____in **Weight** _____lbs **Date of Birth:** _____

Name of Primary Care Physician/other Physician(s): _____
Do you want physician to receive copy of visit ☐ Yes ☐ No
Pharmacy Preference (include location): _____
Do we see any other family members? ☐ Yes ☐ No Who_____
REASON FOR TODAY'S VISIT: _____

Whom may we thank for referring you to our office?_____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

Name of Medication	Dosage	How Often Taken

ARE YOU ALLERGIC TO ANY MEDICATION? ☐ **Yes** ☐ **No** If yes, please list below:

Name of Medication	Type of Reaction

SURGERIES AND HOSPITALIZATIONS.

Have you ever had any problems with anesthesia (being numbed or put to sleep)? ☐ Yes ☐ No
If yes, please list type of problems: _____

List any surgeries you have had (including dates): _____

_____

Have you ever been hospitalized for non-surgical reasons? ☐ Yes ☐ No _____

Are you HIV positive? ☐ Yes ☐ No Do you have any reason to suspect that you have been exposed to the HIV virus? ☐ Yes ☐ No

Hepatitis? If yes, check type: ☐ Type A ☐ Type B ☐ Type C ☐ Other ☐ Non-Specific type ☐ Don't Know

Diabetes? ☐ Yes ☐ No If yes, do you require insulin? ☐ Yes ☐ No

WOMEN: Are you currently pregnant? ☐ Yes ☐ No Expected Delivery Date _____

Do you have any disease, condition or problem not previously listed that you feel we should know about? _____

_____

_____

CURRENT OR MOST RECENT OCCUPATION: _____

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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.

This Notice of Privacy Practices (this "Notice") tells you about the ways we may use and disclose your medical information. This Notice applies to the practice of Trimble ENT, including its professionals, employees and contractors (the "Practice," "us," or "we").

I. OUR OBLIGATIONS. We are required by law to:

- Make sure that the medical information we have about you is kept private, to the extent required by state and federal law;
- Give you this Notice explaining our legal duties and privacy practices with respect to medical information about you;
- Inform you that the Practice may create and/or receive medical information about you and such medical information may be subject to further disclosure to authorized parties in an electronic format;
- Accommodate your request (unless required by law to make a disclosure) that we not disclose to a health plan your medical information related solely to services provided by the Practice, if you have paid for services out of pocket in full;
- Notify you of any breach of your unsecured protected health information; and
- Abide by the terms of this Notice.

II. HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe the different reasons that we typically use and disclose your medical information. These categories are intended to be generic descriptions only, and not a list of every instance in which we may use or disclose your medical information. Please understand that for these categories, the law generally does not require us to get your consent in order for us to release your medical information.

A. For Treatment. We may use medical information about you to provide you with medical treatment and services, and we may disclose medical information about you to doctors, nurses, technicians, medical students, or hospital personnel who are providing medical care to you. For example, physicians and nursing staff will have access to your medical record in order to provide treatment to you.

B. For Payment. We may use and disclose medical information about you so that we may bill and collect from you, an insurance company, or a third party for the services we provide. This may also include the disclosure of medical information to obtain prior authorization for treatment and procedures from your insurance plan. For example, we may send a claim for payment to your insurance company, and that claim may have a code on it that describes the services that have been rendered to you. The Practice is required to restrict disclosure of your medical information to a health plan or third-party payor if the disclosure is for payment or health care operations and pertains to a health care item or service that you paid for in full out-of-pocket.

C. For Health Care Operations. We may use and disclose medical information about you for our health care operations. These uses and disclosures are necessary to operate our practice appropriately and make sure all of our patients receive quality care. For example, we may need to use or disclose your medical information in order to conduct certain cost-management practices, or to provide information to our insurance carriers.

D. Business Associates. We may use business associates to perform certain functions on behalf of the Practice (such as billing services), and the business associate may need access to your medical information to perform these services. To protect your medical information, the Practice enters into an agreement with the business associate, which requires the business associate to appropriately safeguard your information.

E. Quality Assurance. We may need to use or disclose your medical information for our internal processes to determine that we are providing appropriate care to our patients.

F. Utilization Review. We may need to use or disclose your medical information to perform a review of the services we provide to ensure that the proper level of service is received by our patients.

G. Peer Review. We may need to use or disclose medical information about you in order for us to review the credentials and actions of our health care personnel to ensure they meet our qualifications and standards.

H. Treatment Alternatives. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that we believe may be of interest to you.

I. Health Related Benefits and Services. We may use and disclose medical information about you to tell you about health-related benefits or services that we believe may be of interest to you.

J. Individuals Involved in Your Care or Payment for Your Care. We may release medical information about you to a friend or family member who is involved in your medical care, or to someone who helps pay for your care, but we will do so only as allowed by state or federal law, or in accordance with your prior authorization.

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K. **As Required By Law.** We will disclose medical information about you when required by applicable law, in response to a court order, subpoena, discovery request, or other lawful process, or any other legal proceeding for which we may be required or authorized to use or disclose your medical information. We may disclose your medical information if we are asked to do so by law enforcement officials or federal officials for intelligence, counterintelligence, or other national security activities.

L. **To Avert a Serious Threat to Health or Safety.** We may use or disclose medical information about you when necessary to prevent or decrease a serious and imminent threat to your health or safety or the health and safety of the public or another person. Such disclosure would only be to someone able to help prevent the threat, or to appropriate law enforcement officials.

M. **Organ and Tissue Donation.** If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.

N. **Research.** We may use or disclose your medical information to an Institutional Review Board or other authorized research body if your consent has been obtained as required by law, or if the information we provide them is "de-identified."

O. **Military and Veterans.** If you are or were a member of the armed forces, we may release medical information about you as required by the appropriate military authorities.

P. **Workers' Compensation.** We may release medical information about you for your employer's workers' compensation or similar program. These programs provide benefits for work-related injuries. For example, if you have injuries that resulted from your employment, workers' compensation insurance or a state workers' compensation program may be responsible for payment for your care, in which case we might be required to provide information to the insurer or program.

Q. **Public Health Risks.** We may disclose medical information about you to public health authorities for public health activities. As a general rule, we are required by law to disclose certain types of information to public health authorities, such as the Texas Department of State Health.

R. **Health Oversight Activities.** We may disclose medical information about you to a health oversight agency for activities authorized by law. These oversight activities include audits, civil, administrative, or criminal investigations and proceedings, inspections, licensure and disciplinary actions, and other activities necessary for the government to monitor the health care system, certain governmental benefit programs, and certain entities' compliance with government regulations related to health information and civil rights laws.

S. **Coroners, Medical Examiners and Funeral Home Directors.** We may disclose your medical information to a coroner or medical examiner. We may also release medical information about our patients to funeral home directors as necessary to carry out their duties.

T. **Inmates.** If you are an inmate of a correctional institution or under custody of a law enforcement official, we may disclose medical information about you to the correctional institution or the law enforcement official.

III. **OTHER USES OF MEDICAL INFORMATION.** There are times we may need or want to use or disclose your medical information other than for the reasons listed above, but to do so, we will need your prior permission. Disclosures that require your authorization include: (i) release of psychotherapy notes, (ii) uses and disclosures of protected health information for marketing purposes, (iii) sale of protected health information, and (iv) other uses and disclosures not outlined in this Notice. If you provide us permission to use or disclose medical information about you for such other purposes, you may revoke that permission in writing at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

IV. **YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.** Federal and state laws provide you with certain rights regarding the medical information we have about you. The following are a summary of those rights.

A. **Right to Inspect and Copy**. Under most circumstances, you have the right to inspect and/or copy your medical information that we have in our possession, which generally includes your medical and billing records. To inspect or copy your medical information, you must submit your request in writing to the Practice's Compliance Officer the address listed in Section VI below.

B. **Right to Request an Amendment.** If you feel the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by the Practice. To request an amendment, you must provide a reason why you want the amendment in writing and submit it to the Compliance Officer at the address listed in Section VI below. We will notify you in writing whether we accept or deny your request.

C. **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures" of your medical information. This is a list of the disclosures we have made for up to six years prior to the date of your request of your medical information, but does not include disclosures for Treatment, Payment, or Health Care Operations (as described in Sections II A, B, and C of this Notice), or disclosures made pursuant to your specific authorization (as described in Section III of this Notice), or certain other disclosures. To

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request this accounting, you must submit your request in writing to the Practice's Compliance Officer at the address set forth in Section VI below. Your request must state a time period the accounting should cover. The first request for an accounting within a twelve-month period will be free. However, the Practice may charge a reasonable fee for each additional accounting provided at your request during the same twelve-month period. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. To the extent the Practice maintains any electronic health records, the Practice will account for disclosures made of the electronic information even if made for treatment, payment, or health care operations. If you request an electronic accounting, the accounting by law is only required to cover the three years prior to the date of your request for an accounting. Depending upon how long the Practice has had an electronic health record in place, the Practice may not be able to provide an electronic accounting for the years prior to the full implementation of its electronic health record.

D. **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you in various situations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. In addition, there are certain situations where we won't be able to agree to your request, such as when we are required by law to use or disclose your medical information. To request restrictions, you must make your request in writing to the Practice's Compliance Officer at the address listed in Section VI below. In your request, you must specifically tell us what information you want to limit, whether you want us to limit our use, disclose, or both, and to whom you want the limits to apply.

E. **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we contact you at home and not at work or vice versa. To request such confidential communications, you must make your request in writing to the Practice's Compliance Officer at the address listed in Section VI below.

F. **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this Notice, you must make your request in writing to the Practice's Compliance Officer at the address set forth in Section VI below.

V. **CHANGES TO THIS NOTICE.** We reserve the right to change this Notice at any time, along with our privacy policies and practices. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice, along with an announcement that changes have been made, as applicable, in our office. When changes have been made to the Notice, you may obtain a revised copy by sending a letter to the Practice's Compliance Officer at the address listed in Section VI below or by asking the office receptionist for a current copy of the Notice.

VI. **COMPLAINTS.** If you believe that your privacy rights as described in this notice have been violated, you may file a complaint with the Practice at the following address or phone number:

Trimble ENT
Attn: Compliance Officer
3455 Locke Ave., Ste 210
Fort Worth, Texas 76107
Telephone: (817) 529-6200

To file a complaint, you may either call or send a written letter. The Practice will not retaliate against any individual who files a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services. In addition, if you have any questions about this Notice, please contact the Practice's Compliance Officer at the address or phone number listed above.

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Name of person(s) authorized to use or receive medical information:

1) _____ **2)** _____

3) _____ **4)** _____

Would you like to request any restrictions or limitations on the medical information we may use or disclose to the individuals listed above?

_____

_____

I hereby acknowledge that I have received a copy of the Trimble ENT's Notice of Privacy Practices. I understand that I may address any questions or concerns I may have about the Notice to the Practice's Compliance Officer.

_____
Signature of Patient

_____
Signature of Guardian/ Representative
(if executing on behalf of patient)

_____
Patient's Printed Name

_____
Guardian/ Representative's Printed Name

_____
Date

_____
Date

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DISCLOSURE OF PHYSICIAN'S OWNERSHIP INTEREST

Due to your physician's concern over improving the quality of healthcare and reducing cost of medical procedures, along with a number of other physicians, Dr. Monty Trimble is an owner of USMD Hospital at Fort Worth located at 5900 Altamesa Blvd, Fort Worth, TX.

After meeting with your physician, if surgery is necessary, your physician may schedule your surgery at this facility. Your physician's ownership interest means that your physician may benefit from choosing to perform surgical procedures at USMD Hospital at Fort Worth. Because of this, your physician hereby advices you that you have the right to choose to be treated at a different facility, should you desire, and he will make such arrangements, if possible.

Please note that USMD Hospital at Fort Worth is a separate legal entity from Monty V. Trimble, MD PA.

_____

Print Patient Name

_____ _____

Signature of Patient/Parent/Legal Representative Date