



WELCOME TO USF HEALTH

We appreciate you choosing USF Health for your healthcare needs. When you come to see a new healthcare provider, you may have questions about what to expect at your first visit. We hope this letter will prepare you.

USF Health has multiple locations throughout the Tampa Bay area so please reference the location for your appointment time. As a new patient, please plan on arriving at least 30 minutes prior to your appointment. All of our locations have handicap accessible parking available for vehicles that display the appropriate State issued handicap tag. All locations offer general patient parking as well as valet services available at the Morsani Center (for a nominal fee of \$2) and the South Tampa Center (provided by Tampa General Hospital for a fee of \$5). Additional information on our locations, including maps, may be found on our website: www.myhealthcare.usf.edu

At the time of your appointment, you may be asked for any of the following information: insurance card, physician referral, name and address of referring physician, completed health history form, copies of medical records, current prescription bottles and appropriate co-payment. Your name and insurance information will be verified at each subsequent office visit. As a result of Federal Law, we are required to ask for your race and ethnicity at the registration or check-in desk. Please note that you have the option of indicating “declined” if you so desire.

We are an academic institution where future healthcare providers are trained. We use a team approach for your best medical and surgical care so don’t hesitate to ask your caregivers their name or the role they have in your care. Although your Attending Physician is responsible for overseeing your healthcare team, the following explains the types of Providers that you might see during your visit:

- Attending Physician – has completed medical school, a residency program, and is fully licensed. The Attending Physician is directly responsible for your medical and surgical care and will answer questions about your diagnosis and treatment plan.
- Nurse Practitioner (NP), Physician Assistant (PA), or Certified Nurse Midwife (CNM) – is a fully licensed, advanced practice healthcare professional, trained to care for you in our clinic setting. • Fellow – has completed medical school, has completed residency training, and is now concentrating on his/her sub-specialty.
- Resident – is a physician who has completed medical school and is in training focusing on his/her specialty of interest.
- Medical Student – is in medical school learning how to care for patients under the direct supervision of USF Physicians.

Our team is devoted to providing you with the highest quality of care. Let us know if we do not meet your expectations so we can address your concerns promptly. If you think we can improve our care in any way, feel free to make suggestions in person, by phone, in writing, or via our patient satisfaction kiosks.

Thank you for choosing USF Health for all your healthcare needs.



Provider: _____

Appointment Date: _____

Appointment Time: _____

Location: Carol & Frank Morsani Center for Advanced Healthcare (*USF Campus, See attached map*)
13330 USF Laurel Dr. Tampa, FL 33612 – 3rd Floor
(813) 974-4683, option 1

To: All Patients
From: Carol & Frank Morsani Center for Advanced Healthcare
Re: Patient History Forms Attached

Thank you for choosing the Carol & Frank Morsani Center for Advanced Healthcare. For your convenience, we have enclosed a questionnaire and map to our facility; please bring it with you to your scheduled appointment.

It is recommended that you arrive 30 minutes prior to your appointment time. Patients who arrive 15 minutes after the scheduled time will be rescheduled. Patients who arrive at the wrong location will be rescheduled.

Please bring any medical records related to your care including hearing test, CD or films of X-rays, CT, MRI's.

If you require an interpreter, please bring an adult with you to provide translation between yourself, front desk staff, clinical staff and your physician.

****Note**** If the appointment is for a minor, a parent or legal guardian MUST accompany the child and sign the consent to treat a minor in front of a witness at the time of the appointment. HOWEVER, if accompanied by anyone other than a parent, we will need either the court order stating that you have legal custody or a notarized letter from the parent stating that you are authorized to accompany the minor and consent to treat, or the minor will not be seen by the physician. You must bring this paperwork to every office visit and present at the time of check-in.

Parking: We are pleased to offer valet services in front of our building or you can park in the garage in the assigned patients' parking. Valet charge is \$2.00, due at time of parking. No charge to park in the garage.

By completing your new patient forms and bringing them with you, you will help avoid delays upon your arrival for your scheduled appointment. The temperature in the clinic becomes chilly at times, please bring a jacket to make yourself more comfortable. If you are a diabetic, please bring a snack in case your blood sugar runs low.

Thank you in advance for your cooperation.

Laura Pearce

Business Administrator, Department of Otolaryngology-Head and Neck Surgery

APPOINTMENT REMINDERS

As a service to our patients, we have implemented an appointment reminder system, HouseCalls, to provide you with a reminder of your next scheduled appointment. HouseCalls will either call, text, or email you two days prior to your next appointment to give you the date and time of your appointment. If you are unavailable when the call is made and have voicemail or an answering machine, the system will leave a brief message.

When you receive your appointment reminder phone call, it is very important to either confirm or cancel your appointment. Simply use your telephone keypad and press the following keys anytime during the message: Press the 1 Key to confirm your appointment

Press the 2 Key to replay the message

Press the 3 Key to cancel your appointment

CANCELLATIONS AND MISSED APPOINTMENTS

Within a 3 month period, two cancellations (cancel with less than 24 hours notice) or missed appointments will result in warning letters. Third recurrence patient will receive a discharge letter which will restrict patient from scheduling future appointments with our department.

PLEASE READ

The faculty and staff of the USF Department of Otolaryngology – Head and Neck Surgery make the effort to make your experience with us as pleasant as possible. To that end, you can assist us by familiarizing yourself with the following:

You must have a valid insurance card and a picture ID with you at the time of service. Without these you will not be seen.

It is your responsibility to know your insurance benefits. It is not the responsibility of this office to verify medical eligibility.

It is your responsibility to be sure that the faculty of Otolaryngology are providers for your insurance company prior to making an appointment.

It is your responsibility to obtain a referral or authorization for the office visit and/or procedure. You must either verify that our office has received your referral/authorization or you must bring it with you to your scheduled appointment. If you do not have a referral or an authorization at the time of service, you will not be seen.

Co-payments, co-insurance, deductibles not met, and all past due balances will be collected prior to your visit. If you fail to pay in accordance with your insurance company's contract, you will not be seen.

If needed, it is your responsibility to bring a translator with you to all appointments. A minor child is not acceptable; you must bring an adult family member or friend.

ATTENTION FOSTER PARENTS OR LEGAL GUARDIANS

Foster Parents – you must bring a copy of the court order stating that you have legal custody or the minor will not be seen. You must bring this to every office visit and present at the time of check-in.

Legal Guardians – you must bring a NOTARIZED note from the parent stating that you are authorized to accompany the minor and consent to treatment. Unless otherwise stated in the note, a new note will be required for every visit, or the minor will not be seen.

PATIENT HEALTH QUESTIONNAIRE: Otolaryngology - Head and Neck Surgery

Patient Name: _____
Last First MI
Email address: _____
Age: _____ **Sex:** Male Female

Medical Record #: _____
Phone #: _____
Date of Birth: _____

Type of visit: Consultation requested by another Physician Self-referred Second Opinion

PHYSICIAN INFORMATION

Primary Care MD: _____ Specialty: _____

Address: _____

Phone: _____ Fax: _____

Referring Physician: _____ Specialty: _____

Address: _____

Phone: _____ Fax: _____

Would you like your records to go to any other physician? Yes No

Other Physician: _____ Specialty: _____

Address: _____

Phone: _____ Fax: _____

PERSONAL HISTORY

Married Widowed Divorced Single

Occupation: _____ How long? _____

Currently Employed? Yes No

Do you live? With spouse/family Alone With others Do you have

a living will or advance directive? Yes No

PLEASE NOTE THE REASON FOR YOUR VISIT TODAY:

C. ALLERGIES (*Specify drug and reaction*)

D. MEDICATIONS/ DOSE/ FREQUENCY (*Include over the counter medications, herbal products, supplements and vitamins*)

**Include cancer, diabetes, heart attacks, high blood pressure, strokes, tuberculosis, and other major illnesses.*

I. REVIEW OF SYSTEMS: *Check all responses that apply.*

General

- | | | |
|--------------------------------------|--------------------------|--------------------------|
| | Yes | No |
| Weight gain/loss | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty falling asleep | <input type="checkbox"/> | <input type="checkbox"/> |
| Need to cut down alcohol consumption | <input type="checkbox"/> | <input type="checkbox"/> |
| Fever | <input type="checkbox"/> | <input type="checkbox"/> |
| Change in appetite | <input type="checkbox"/> | <input type="checkbox"/> |

Skin

- | | | |
|-----------------------------------|--------------------------|--------------------------|
| | Yes | No |
| Rash, sore, or excessive bruising | <input type="checkbox"/> | <input type="checkbox"/> |
| Lump or growth on skin | <input type="checkbox"/> | <input type="checkbox"/> |

Eyes

- | | | |
|------------------|--------------------------|--------------------------|
| | Yes | No |
| Wear glasses | <input type="checkbox"/> | <input type="checkbox"/> |
| Decreased vision | <input type="checkbox"/> | <input type="checkbox"/> |
| Pain in eyes | <input type="checkbox"/> | <input type="checkbox"/> |

Ears, Nose, Throat, Mouth

- | | | |
|----------------------------------|--------------------------|--------------------------|
| | Yes | No |
| Difficulty or changes in hearing | <input type="checkbox"/> | <input type="checkbox"/> |
| Earaches | <input type="checkbox"/> | <input type="checkbox"/> |
| Discharge from ears | <input type="checkbox"/> | <input type="checkbox"/> |
| Buzzing or ringing in ears | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequent sneezing | <input type="checkbox"/> | <input type="checkbox"/> |
| Nose stuffiness or running | <input type="checkbox"/> | <input type="checkbox"/> |
| Recurrent sore throat | <input type="checkbox"/> | <input type="checkbox"/> |
| Persistent hoarseness | <input type="checkbox"/> | <input type="checkbox"/> |
| Dental problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Sinus problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Lymph glands or nodes | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequent nose bleeds | <input type="checkbox"/> | <input type="checkbox"/> |

Genitourinary

- | | | |
|-----------------------------|--------------------------|--------------------------|
| | Yes | No |
| Painful urination | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequent urination | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood in urine | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty emptying bladder | <input type="checkbox"/> | <input type="checkbox"/> |

Musculoskeletal

- | | | |
|-------------------------|--------------------------|--------------------------|
| | Yes | No |
| Painful joints | <input type="checkbox"/> | <input type="checkbox"/> |
| Sore muscles | <input type="checkbox"/> | <input type="checkbox"/> |
| Back pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Pain in calves of legs | <input type="checkbox"/> | <input type="checkbox"/> |
| Weakness in extremities | <input type="checkbox"/> | <input type="checkbox"/> |
| Numbness in extremities | <input type="checkbox"/> | <input type="checkbox"/> |

Neuropsychiatric

- | | | |
|--|------------|-----------|
| | Yes | No |
|--|------------|-----------|

- | | | |
|----------------------------------|--------------------------|--------------------------|
| Anxiety | <input type="checkbox"/> | <input type="checkbox"/> |
| Depression | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequent or severe headaches | <input type="checkbox"/> | <input type="checkbox"/> |
| Dizziness or faintness | <input type="checkbox"/> | <input type="checkbox"/> |
| More nervous than average person | <input type="checkbox"/> | <input type="checkbox"/> |

Cardiovascular

- | | | |
|--------------------------------|--------------------------|--------------------------|
| | Yes | No |
| No Chest pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Shortness of breath | <input type="checkbox"/> | <input type="checkbox"/> |
| Abnormal swelling in legs/feet | <input type="checkbox"/> | <input type="checkbox"/> |
| Fatigue or tire easily | <input type="checkbox"/> | <input type="checkbox"/> |

Respiratory

- | | | |
|-----------------|--------------------------|--------------------------|
| | Yes | No |
| Cough | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood in sputum | <input type="checkbox"/> | <input type="checkbox"/> |
| Wheezing | <input type="checkbox"/> | <input type="checkbox"/> |

Endocrine

- | | | |
|------------------------------------|--------------------------|--------------------------|
| | Yes | No |
| Excessive thirst or urination | <input type="checkbox"/> | <input type="checkbox"/> |
| Change in sexual drive/performance | <input type="checkbox"/> | <input type="checkbox"/> |
| Change in heat or cold tolerance | <input type="checkbox"/> | <input type="checkbox"/> |

Gastrointestinal

- | | | |
|--------------------------------|--------------------------|--------------------------|
| | Yes | No |
| Frequent heartburn/indigestion | <input type="checkbox"/> | <input type="checkbox"/> |
| Nausea or vomiting | <input type="checkbox"/> | <input type="checkbox"/> |
| Diarrhea | <input type="checkbox"/> | <input type="checkbox"/> |
| Constipation | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood in stool | <input type="checkbox"/> | <input type="checkbox"/> |
| Ulcers | <input type="checkbox"/> | <input type="checkbox"/> |

For Women only

- | | | |
|---------------------------------|--------------------------|--------------------------|
| | Yes | No |
| Irregular periods | <input type="checkbox"/> | <input type="checkbox"/> |
| Bleeding between periods | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you pregnant | <input type="checkbox"/> | <input type="checkbox"/> |
| Date of last menstrual period | ___/___/___ | |
| Ever have an abnormal Pap smear | <input type="checkbox"/> | <input type="checkbox"/> |
| Lump or growth on breast | <input type="checkbox"/> | <input type="checkbox"/> |

Allergic/Immunologic

- | | | |
|------------------|--------------------------|--------------------------|
| Hayfever | <input type="checkbox"/> | <input type="checkbox"/> |
| Hives | <input type="checkbox"/> | <input type="checkbox"/> |
| Immunodeficiency | <input type="checkbox"/> | <input type="checkbox"/> |

Hematologic/Lymphatic Anemia

	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Bleeding or Bruising	<input type="checkbox"/>	<input type="checkbox"/>
Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>

_____ LPN/MA/RN _____ Date

Reviewed by:

_____ MD _____ Date
 Department of Otolaryngology – Head & Neck Surgery
 Tampa, Florida



ATTENTION ENT PATIENTS

IT IS OFTEN NECESSARY FOR A SCOPING PROCEDURE TO BE PERFORMED DURING YOUR OFFICE VISIT SO THAT AN ACCURATE DIAGNOSIS CAN BE MADE BY YOUR PROVIDER. A SCOPING PROCEDURE MAY ALSO BE NECESSARY TO MONITOR YOUR PROGRESS FOLLOWING SURGERY OR OTHER TREATMENT PLAN PROGRESS.

MANY INSURANCE COMPANIES NOW CONSIDER THIS PROCEDURE TO BE SEPARATE FROM YOUR OFFICE VISIT AND HAVE IMPLEMENTED A CO-PAY OR DEDUCTIBLE REQUIREMENT THAT IS IN ADDITION TO THE CO-PAY OR DEDUCTIBLE REQUIRED FOR YOUR OFFICE VISIT. PLEASE NOTE THAT THIS IS A CHANGE MADE BY YOUR INSURANCE COMPANY TO YOUR BENEFIT PLAN NOT A CHANGE MADE BY YOUR PROVIDER OR THE USFPG. IF YOU SHOULD CHOOSE NOT TO BE SCOPED PLEASE UNDERSTAND WE MAY NOT BE ABLE TO PROVIDE YOU WITH CONTINUED CARE.

IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE COVERAGE AND LIMITS OF YOUR BENEFIT PLAN HOWEVER, WE WILL ASSIST YOU IN ANY WAY POSSIBLE.

Thank you for your attention to this matter.

Laura Pearce
 Business Administrator
 Department of Otolaryngology - Head & Neck Surgery

 Print Patient Name

 Patient Signature

 Date

Procedure codes (*if applicable*):

31231 – nasal scopes

31575 – laryngoscope

31576 – flex with bx laryngoscope

31237 – nasal scope with sinus debridement

Affix Label Here

Mailing Address (all locations): 12901 Bruce B. Downs Blvd. MDC 73 Tampa, FL 33612

<http://health.usf.edu/medicine/ent>

Department of Otolaryngology – Head & Neck Surgery
Tampa, Florida



USFPG
Consent for E-Mail Communication

USFPG offers patients the ability to communicate with providers via electronic mail (e-mail) for non-urgent matters if, the arrangement is agreed to by both parties.

Privacy and Security of the E-Mail:

Do not use e-mail to send or request very sensitive information. USFPG cannot and does not guarantee the privacy or security of any messages being sent over the Internet. There is potential that e-mail sent over the Internet can be intercepted, and read by others. If this is of concern to you, you should not communicate with your provider through e-mail.

I have been informed of and understand the risks and procedures involved with using e-mail. I agree to the terms listed above and I hereby voluntarily request the use of e-mail as one form of communication with my physician or other health care provider.

Email address: _____

Print Patient Name

Patient Signature

Date

Affix Label Here

Mailing Address (all locations): 12901 Bruce B. Downs Blvd. MDC 73 Tampa, FL 33612 <http://health.usf.edu/medicine/ent>