ENT Associates OF ROSEBURG

OTOLARYNGOLOGY - HEAD & NECK SURGERY | ALLERGY

Welcome to ENT Associates of Roseburg, LLC! Our mission is to provide quality, compassionate ear, nose and throat specialty care to our patients. We would like to take this opportunity to introduce you to our doctor, physician assistant and prepare you for your upcoming appointment.

Dr. James Yun is a board-certified Otolaryngologist- Head and Neck Surgeon. He completed his specialty training in Otolaryngology at the University of Florida in Gainesville and he performed his internship at the Naval Medical Center in San Diego, California. He is a 1996 graduate of Hahnemann University School of Medicine in Philadelphia. He has been practicing with our office since 2007.

Dr. Lennard is an otolaryngologist (Ear, Nose and Throat) and has been practicing in Roseburg since August 2022. She received her medical degree from Hahnemann University School of Medicine in Philadelphia, PA graduating Alpha Omega Alpha. She completed her Otolaryngology Residency at Walter Reed Army Medical Center in Washington, DC. She is board certified in Otolaryngology Head and Neck surgery.

Dr. Lennard has a passion for preventive care and well-being and believes the patient and provider relationship is a true partnership in care. "Presenting recommendations, options and choices is important to create a strong partnership with my patients. I have a special interest in treating pediatric patients and patients with allergy and sinus concerns." Outside of her practice time, she enjoys spending time outdoors, exploring the redwood forests, traveling, wine tasting and indulging in good cheese and ice cream.

Our office is located at 2423 NW Troost Street in Roseburg. Our contact phone number is 541-677-3400. Our office hours are Monday- Thursday from 8:00am to 5:00pm. Fridays we will be open from 8:30am to 12:00pm. Please note the lunch hour varies.

We ask that you arrive 10-15 minutes prior to your appointment time for check in. When you arrive for your appointment, please have the following information available:

1. **Insurance cards**
2. **Medication list**
3. **Allergy list**

Our staff will gladly bill your insurance for you but you will be responsible for any co-pays, deductibles or outstanding balances at the time of service. Please contact our billing office for any further questions or concerns you may have.

A $25.00 charge may be made to your account if your appointment is cancelled with less than 24hrs notice. Your cancellation notification allows the doctor to see another patient who needs to be cared for. We appreciate your understanding in this matter.

Our doctors and staff would like your visit with us to be a positive experience. If you have any questions, concerns or suggestions please feel free to discuss them with your doctor or the office manager.

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PATIENT INFORMATION

Patient's Name _____ [ ] Male [ ] Female
Last First Middle Int.

Mailing Address _____
Box/Street City State Zip

Date of Birth _____ SS# _____ Marital Status S / M / D / W / Other

Home Phone _____ Cell Phone _____

Employer _____ Work Phone _____

May we contact you at work? [ ] Yes [ ] No

RESPONSIBLE PARTY (if other than the patient)

Please circle one: Self/Spouse/ Parent/ Stepparent/ Legal Guardian/ Power of Attorney

Name _____Home Phone _____

Mailing address _____
Box/Street City State Zip

Employer _____Work Phone _____ Date of birth _____

PRIMARY INSURANCE

Please circle one: Self/Spouse/ Parent/ Stepparent/ Legal Guardian/ Power of Attorney

Insured/ Employee's Name _____

Insurance Name _____Group Name/Employer _____

Policy/ID # _____ Group # _____Effective date _____

Insured Date of Birth _____ Insured SS# _____

SECONDARY INSURANCE

Please circle one: Self/Spouse/ Parent/ Stepparent/ Legal Guardian/ Power of Attorney

Insured/ Employee's Name _____

Insurance Name _____Group Name/Employer _____

Policy/ID # _____ Group # _____Effective date _____

Insured Date of Birth _____ Insured SS# _____

Due to increased healthcare rules and regulations, we must have a list of people you wish to have knowledge of your healthcare status. Please provide a list of all the parties we may speak with or leave a message with regarding your healthcare, appointment scheduling or payment information.

Emergency Contact	Relationship	Phone #	Name	Relationship	Phone #
Name	Relationship	Phone #	Name	Relationship	Phone #

May we leave a message on your answering machine? [ ] Yes [ ]No

I understand this office participates in local and national health information exchanges (HIE) that permit health care provides to electronically exchange health information. Your health information may be shared with other providers and organizations when necessary and as appropriate for our and their treatment, payment, and health care operations purposes. This means ENT Associates of Roseburg, LLC will maintain my health information, including chart notes, prescription records, operative notes, radiographs and scans, lab results, and other health information in a secure shared record accessible to other participating healthcare providers. Other medical providers who participate in the HIE do the same thing, permitting all participating providers ready access to up to date information regarding my condition and care. Participating in this system allows my healthcare providers to give me better care with less hassle.

I understand that if I refuse to permit my health information to be included in the System, ENT Associates of Roseburg, LLC will refuse to treat me. I agree ENT Associates of Roseburg, LLC may from time to time take photographs of me and keep them with my medical records. I agree that all of my medical providers may use these photographs for identification purposes, to prevent fraud, and to assist with my medical care.

Terms of agreement

1. Authority is granted to ENT Associates of Roseburg, LLC to render treatment to the patient listed below.
2. I have read and understand the above, have had an opportunity to ask questions about this information, and I agree to the terms listed above and the charges that may become my responsibility in accordance with these terms.
3. I also attest that I have the legal right to consent for treatment and can be held financially responsible for services provided.
4. I hereby also release the provider(s) listed on this form to communicate with my insurance companies.
5. I authorize payment of medical benefits to James M. Yun, MD, PC and Randall B. Loch, MD, PC for services rendered.
6. I am also aware that delinquent accounts are subject to collection means at my own expense, including legal fees.
7. I understand that if I do not meet the requirements listed above that my relationship with the provider(s) may be terminated.

Patient Name: _____

Patient Signature: _____ Date: _____

If patient is under the age of 18, or unable to read or understand the above, this form must be signed by a competent adult responsible for the care of the patient. The responsible adult assumes all obligations above.

Responsible Adult: _____

Relationship to Patient: _____

Signature: _____ Date: _____

Patient name_____ Date of appointment_____

Date of birth_____ Age_____

Who referred you to this office?_____

Who is your primary provider (ie. Doctor, Nurse Practitioner, Physician Assistant)?_____

What are you here to see the doctor for today?_____

LIST YOUR PAST & CURRENT MEDICAL PROBLEMS: (Please give details if possible)

YES NO Heart problems:_____
YES NO Stroke_____
YES NO Diabetes _____
YES NO Asthma_____
YES NO Emphysema (COPD)_____
YES NO Cancer_____
YES NO Seasonal allergies_____
YES NO High blood pressure_____
YES NO Thyroid disease_____
YES NO Arthritis_____
Other_____
_____

Do you have any **drug allergies?**
YES NO **Please fill out completely.**
If yes, list specific drug and type of a allergic reaction: (rash, hives, shortness of breath, etc.)
_____
_____
_____

WOMEN: Are you pregnant? YES NO

FAMILY HISTORY: (Illnesses that run in the family)
YES NO Bleeding problems
YES NO Cancer (List who & what kind)
Other_____

PAST SURGICAL HISTORY: (Please give details and year if possible)

YES NO Appendix removed_____
YES NO Gall bladder removed_____
YES NO Tonsils/Adenoids removed_____
YES NO Gynecologic surgery_____
YES NO Ear surgery _____
YES NO Nose surgery_____
YES NO Neck surgery_____
YES NO Orthopedic surgery_____
YES NO Back surgery_____
YES NO Heart or lung surgery_____
YES NO Bowel surgery_____
Other_____
_____

SOCIAL HISTORY:
YES NO Smoking: If yes, number years?_____
Average packs per year?_____

YES NO Have you smoked in the past? If yes, how long ago did you quit? _____

YES NO Alcohol use: If yes, circle:
Daily Weekly Socially Rarely

OCCUPATION:_____
_____

HOBBIES:_____
_____

CURRENT MEDICATIONS: (Please list ALL medications and dosage or supply a list we can copy)

_____
_____
_____
_____
_____
_____
_____
_____

What pharmacy do you use?
_____
_____
_____

REVIEW OF SYSTEMS:

YES NO Shortness of breath_____
YES NO Headache_____
YES NO Blurred/double vision_____
YES NO Anxiety/depression_____
YES NO Hearing loss_____
YES NO Difficulty urinating_____
YES NO Fatigue/weight loss_____
YES NO Joint pain_____
YES NO Enlarged lymph nodes_____
YES NO Chest pain_____
YES NO Skin rash, itching_____
YES NO Hay fever_____
YES NO Fevers/chills_____
YES NO Nausea/abdominal pain_____

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PATIENT FINANCIAL RESPONSIBILITY CONSENT

- **Co-payments, deductibles and estimated co-insurance**: Due at time of service prior to seeing your physician.
- **Insurance**: We will bill your insurance as a *courtesy*. Deductibles, co-pays and estimated co-insurance are due at the time of service. Any remaining patient balance responsibility is due prior to the next appointment or within 30 days of receiving treatment. We accept cash, check, Visa, MasterCard, Discover and American Express. Please note it is ultimately the responsibility of the patient to know if their insurance is in network or out of network with our providers. Your out of pocket cost may be higher as a result.
- **Self-Pay**: Payment is due in full at the time of service. We do provide our uninsured patients a discount for services when paid in full at your appointment. If you are unable to provide payment at time of your appointment, please contact our office to arrange a payment agreement prior to coming to your scheduled appointment time.
- **Workers Compensation Claims/MVA Claims**: Patient must provide all billing information including mailing address, telephone number, claim number, and other pertinent information required to submit claim. You must have an attending physician assigned to your claim. We must be able to verify the condition you are requesting treatment for is an accepted condition on your claim and that our claim is in an open status. Regular health insurance information will be required, in addition to, regardless of claim status.
- **Returned Checks**: If a check is returned by your bank, you will be charged a $25.00 return check fee plus the original amount of the check. The total of these amounts must then be paid, within 5 days, by cash, cashier's check, or money order. Once a patient has had a check returned, no further checks will be accepted.
- **Late/Cancellation/Missed Appointments**: As a courtesy, we request a patient who needs to reschedule or cancel an appointment give 24 business hours' notice. If an appointment is missed or insufficient notice is given on a cancellation or reschedule, a fee of $25.00 may be charged. In addition, if a patient is more than 10 minutes late to their appointment they may be rescheduled and a charge may be applied.
- **Refunds**: After your insurance has processed your claim and if a refund is owed to you, we will process your refund within 30 days. We will not refund anyone who has a credit balance of $5.00 or less, unless requested. In return, we do not bill anyone who owes $5.00 or less.
- **Services from other Providers**: You may have addition medical services ordered by your provider, such as lab or pathology tests, x-rays or other radiology tests. You will receive a separate bill from that facility for their services. You are responsible for making your own payment arrangements with companies outside of our office.

I have read, understand, and agree to the above office payment and financial policy in accordance with the terms and conditions set forth in the policy of this office. I also hereby attest that I have given payment information to the best of my knowledge for complete and timely payment.

Patient Name: _____

Patient Signature:_____ Date:_____

If patient is under the age of 18, or unable to read or understand the above, this form must be signed by a competent adult responsible for the care of the patient. The responsible adult assumes all obligations above.

Responsible Adult:_____

Relationship to Patient: _____
Signature:_____ Date:_____

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ACKNOWLEDGEMENT AND CONSENT

I understand that ENT Associates of Roseburg, LLC (referred to below as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of this practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

By:_____ Date:_____
(Patient)

-OR-

By:_____ Date:_____
(Patient representative)

Description of Representative's Authority:_____

NOTICE OF PRIVACY PRACTICES
for ENT ASSOCIATES OF ROSEBURG, LLC

Revision Date: May 1, 2017

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.

If you have any questions about this notice, please contact the Privacy Officer of our office at (541) 677-3400.

WHO WILL FOLLOW THIS NOTICE. This notice describes our practices and that of (1) any healthcare professional authorized to enter information into your medical record that we maintain at this office; and (2) all employees, staff, and other healthcare personnel.

YOUR MEDICAL INFORMATION. We create a record of the care and services you receive at this office. We need this record to provide you with quality service and to comply with certain legal requirements. This notice applies to all of the records about you maintained by this office. Other physicians or healthcare providers that you use may have different policies or notices regarding the use and disclosure of your medical information. This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information. We are required by law to (1) make sure that medical information that identifies you is kept private; (2) give you this notice of our legal duties and privacy practices with respect to medical information about you; and (3) follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. "Use" is what we do with your information in this office. "Disclose" means sharing your information with others outside this office. All of our permitted uses and disclosures of information fall within one of the categories.

- **For Treatment**. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, office staff, or other personnel who are involved in your care.
- **For Payment**. We may use and disclose medical information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company, or a third party.
- **For Health Care Operations**. We may use and disclose medical information about you as reasonably necessary. These uses and disclosures are necessary to run the office and make sure that all of our patients receive quality care.
- **To the Department of Health and Human Services (HHS)**. We must disclose your medical information when requested by HHS when it is undertaking a compliance investigation, review, or enforcement action.
- **To You**. We must disclose your medical information to you when you request it as described below. We may disclose your medical information to you in other situations.
- **Opportunity to Agree or Object**. We may disclose your medical information in front of others with your informal permission when you are present. If you are not present or otherwise unable to give permission, we may disclose your medical information to others if, in a healthcare provider's professional judgment, disclosure is determined to be in your best interest. This includes telling family or friends involved in your care about your current medical condition.
- **For Appointment Reminders**. We may use medical information about you to remind you about appointments using phone calls, emails, or text messages. This also allows us to leave appointment reminders and messages with limited information on your voicemail and answering machine.
- **Incidental Use**. Although we try to limit communications of your medical information to the minimum necessary, we can disclose information that is incidental to an otherwise permissible use.
- **Valid Authorization**. We may disclose your medical information pursuant to your written authorization. For authorization to be valid, you must sign a form containing certain statements.
- **Public Interest and Benefit Activities**. We may disclose medical information about you for 12 national priority purposes, including when required by law, such as statute or court order; for public health activities, such as providing immunization records to a school with a parent's permission; to government agencies regarding victims of abuse; to health oversight agencies to carry out legally authorized audits and investigations; pursuant to court orders and subpoenas that meet certain requirements; to law enforcement as described below; to a coroner or medical examiner; as necessary to facilitate organ or tissue donation and transplantation; for research purposes under certain circumstances; to prevent a serious threat to your health and safety or the health and safety of the public or another person; for certain essential government functions; and for workers' compensation or similar programs.
- **Law Enforcement**. We may disclose your health information if asked to do so by a law enforcement official (1) in response to a court order, subpoena, warrant, summons, or similar process; (2) about a death we believe may be the result of criminal conduct; (3) about criminal conduct at the office; or (4) in emergency circumstances, in order to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.
- **Limited Data Set**. In certain situations we may disclose your medical information within a limited data set for research, healthcare operations, and public health purposes. A limited data set is medical information about you from which certain identifying information about you, your relatives, household members, and employers has been removed.

DISCLOSURES THAT REQUIRE AUTHORIZATION FROM YOU.

- **Psychotherapy Notes, Marketing, and Sales of Protected Health Information**. Most uses and disclosures of psychotherapy notes, protected health information for marketing purposes, and that constitute a sale of protected health information require authorization.
- **Other**. Other uses and disclosures not described in this notice will be made only with your authorization.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU. You have the following rights regarding medical information we maintain about you:

- **Right to Inspect and Copy**. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes prescriptions and billing records. To inspect and copy medical information that may be used to make decisions about you, you may be required to submit your request in writing to the Privacy Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.
  We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. We will select a licensed healthcare professional to review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
- **Right to Amend**. If you feel that 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 or for this office.
  To request an amendment, complete and submit an AMENDMENT REQUEST form to the Privacy Officer.
  We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (1) was not created by us, unless the person or entity that created the information is no longer available to make the amendment; (2) is not part of the medical information kept by or for the office; (3) is not part of the information which you would be permitted to inspect and copy; or (4) is accurate and complete.
- **Right to an Accounting of Disclosures**. You have the right to request an "accounting of disclosures." This is a list of certain disclosures we made of medical information about you.
  To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. Your request must state a time period which may not be longer than six years. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at the time before any costs are incurred.
- **Right to Request Restrictions**. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. 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 unless (1) the disclosure is for the purposes of carrying out payment or healthcare operations, and (2) the protected health information pertains to an item or service which you, or another person other than your health insurance, have paid for in full. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.
  To request restrictions, you may complete and submit the REQUEST FOR LIMITATION AND RESTRICTION OF PROTECTED HEALTH INFORMATION to the Privacy Officer. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted.
- **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.
  To request confidential communications, you may complete and submit the PATIENT'S REQUEST TO LIMIT CONFIDENTIAL COMMUNICATIONS to the Privacy Officer. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted.
- **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. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, contact the Privacy Officer.
- **Right to Receive Notice of Breach**. You will receive notification of breaches of your unsecured protected health information unless we determine there is a low probability your PHI was compromised.

CHANGES TO THIS NOTICE. We reserve the right to change this notice. 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 summary of the current notice in the office. The summary will contain, in the top right-hand corner the effective date. You are entitled to a copy of the current notice in effect.

COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with the office, contact the Privacy Officer. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, 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.

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AUTHORIZATION TO EMAIL HEALTH INFORMATION

I authorize and direct ENT Associates of Roseburg, LLC (Practice), to send me my medical records—including, but not limited to, chart notes, scans, and billing-related information—and other protected health information via **unsecured** email at _____ (email address). I understand the email is unsecure while in transit between Practice and me. Practice does not and cannot ensure the information will not be lost, compromised, or hacked while in transit, and I knowingly accept this risk.

I have reviewed and I understand this Authorization. I also understand that the information emailed pursuant to this Authorization may no longer be protected under federal law if lost, compromised, or hacked in transit. Unless revoked earlier, this Authorization shall remain in effect until my death.

OPT OUT: _____ I do **not** authorize Practice to send me email.

_____ Dated _____, 20___

(Signature)

_____ Date of Birth: _____/_____/_____

(Print name)

ENT ASSOCIATES OF ROSEBURG, LLC

AUTHORIZATION TO SEND TEXT MESSAGES CONTAINING HEALTH INFORMATION

I authorize and direct ENT Associates of Roseburg, LLC (Practice), to communicate with me via **unsecured** text messaging for the purpose of sending appointment reminders at _____ (cellular phone number). I understand the text messages are unsecure while in transit between Practice and me. Practice does not and cannot ensure the information will not be lost, compromised, or hacked while in transit, and I knowingly accept this risk.

I understand that standard text messaging rates will apply to any messages received from Practice. I also understand that I may revoke this permission in writing at any time.

I have reviewed and I understand this Authorization. I also understand that the information communicated pursuant to this Authorization may no longer be protected under federal law if lost, compromised, or hacked in transit. Unless revoked earlier, this Authorization shall remain in effect until my death.

OPT OUT: _____ I do **not** authorize Practice to send me text messages.

_____ Dated _____, 20___

(Signature)

_____ Date of Birth: _____/_____/_____

(Print name)

Practice will not condition our provision of services or treatment to you on the receipt of this signed authorization.