FOOTHILLS EAR NOSE and THROAT, ALLERGY and HEARING CENTER

SUMMARY OF (HIPAA) PRIVACY PRACTICES

This summary of our privacy practices contains a condensed version of our Notice of Privacy Practices. Our full-length Notice is available upon request.

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.

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your protected health information is kept private.

How we will use and disclose your patient health information:

- For medical treatment
- To obtain payment for our services (insurance companies)
- Public Health Authorities
- Law Enforcement purposes
- Law Suits and Legal Proceedings
- Abuse or Neglect Reporting
- For appointment and patient recall reminders
- For workers' compensation programs
- Other Health Providers as deemed necessary

Individual Rights:

You have certain rights regarding the information we maintain about you.
These rights include:

- The right to inspect and copy records
- The right to request restrictions of the use of your health information as permitted by law
- The right to ask for an amendment to your records if you feel they are incorrect
- The right to a paper copy of this notice
- The right to an accounting of disclosures
- The right to request confidential communications

Complaints:

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our office manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Per Title Transparency Law T.C.A. § 63-1-109:

Robert E. Adham, Medical Doctor and Surgeon

Bond Almand, III, Medical Doctor and Surgeon

Bryan J. Tigner, Medical Doctor and Surgeon

DATE_____ PT ID#_____

FOOTHILLS EAR NOSE and THROAT, ALLERGY and HEARING CENTER

PATIENT INFORMATION

Last name_____ Social Security#_____

Legal First & Middle Name_____ Birthdate_____ Age_____ Sex_____

Home Address_____ Occupation _____

City, State_____ Zip_____ Employer_____

Home Phone#_____ Work Address_____

Cell Phone#_____ City, State_____ Zip_____

May we contact you on your cell? Yes____ No____ Work Phone#_____

Marital Status of Patient: ___Married ___Single ___Separated ___Divorced ___Widowed

Have we ever seen any other member of your family? Yes____ No____ If so, who? _____

Who referred you to our office? _____

Who is the patient's Primary Care physician? _____
(Must be Physician, **not** Dentist, P.A. or Nurse Practitioner)

Pharmacy Name: _____ City: _____

RESPONSIBLE PARTY (if different from patient)

Last name_____ Relationship to patient_____

Legal First & Middle Name_____ Occupation_____

Home Address_____ Employer _____

City, State_____ Zip_____ Work Address_____

Home Phone#_____ City, State_____ Zip_____

Cell Phone#_____ Work Phone#_____

Social Security#_____ May we contact you at work? Yes_____ No_____

Birthdate_____ Age_____ Sex_____

SPOUSE, OTHER PARENT OR EMERGENCY CONTACT

Last name_____ Occupation_____

Legal First & Middle Name_____ Employer _____

Home Address_____ Work Address_____

City, State_____ Zip_____ City, State_____ Zip_____

Home Phone#_____ Work Phone#_____

Cell Phone#_____ Birthdate_____ Age_____ Sex_____

Social Security#_____ May we contact you at work? Yes_____ No_____

Relationship to patient_____

Is this person also financially responsible for patient? Yes____ No_____

Is this visit work, auto or accident related? Yes____ No_____

*****ANY CO-PAYS, CO-INS, DEDUCTIBLE OR OUTSTANDING BALANCES ARE DUE UPON CHECK IN.*

WE ACCEPT CHECKS, CASH, VISA & MC AND CARECREDIT.

PLEASE CONTINUE ON OTHER SIDE OF FORM ⇨⇨⇨⇨⇨⇨⇨⇨⇨⇨⇨⇨⇨

PATIENT MEDICAL HISTORY

Today's Date:_____

Patient's Name _____ **Date of Birth** _____ **Age**_____

CHIEF COMPLAINT

What is the main reason for today's visit? _____

When did the symptoms begin? _____

What Medications have you taken or are you taking for this problem? _____

PAST MEDICAL HISTORY

Please list any medical problems, illnesses, hospitalizations or surgeries that you have had in the past or that you currently have:

_____

_____

_____

* Do you have a history of any abnormal bruising or bleeding? _____Yes _____No

Do you take any medications/supplements on a routine basis? _____Yes _____No ; **If yes, please complete reverse side of this form.**

Are you allergic to any medications? _____Yes _____No If Yes, please list _____

Are you allergic to Latex? _____Yes _____No

FAMILY HISTORY

* Is there any family history of abnormal bruising or bleeding? _____Yes _____No

* Is there any family history of problems with general anesthesia? _____Yes _____No

Medical Problems of Mother or Father?_____

Medical Problems of Immediate Blood Relatives:_____

SOCIAL HISTORY

Have you ever smoked or chewed tobacco? _____Yes _____No If Yes, how many packs per day_____ For how many years? _____

Are you still smoking? _____ If not, how many years since you quit? _____

Are you now or have you ever been a heavy drinker? _____Yes _____No; Are you still drinking? _____Yes ____No

REVIEW OF SYSTEMS

HEIGHT:_____ **WEIGHT:**_____

Please check the following symptoms that you currently have or had:

ALLERGY
- ☐ Hay Fever
- ☐ Itchy Eyes or Throat
- ☐ Post Nasal Drip
- ☐ Asthma
- ☐ Blocked Nose

EARS
- ☐ Hearing Loss
- ☐ Ringing in Ears
- ☐ Dizziness
- ☐ Earache
- ☐ Ear Infections

NOSE AND SINUS
- ☐ Sinus Headaches
- ☐ Sinus Infections
- ☐ Stuffy Nose
- ☐ Snoring
- ☐ Nose Bleeds
- ☐ Recurrent Head Colds
- ☐ Facial Pain

THROAT / MOUTH
- ☐ Recurrent Sore Throats
- ☐ Enlarged Neck Glands
- ☐ Difficulty Swallowing
- ☐ Hoarseness
- ☐ Bad Breath
- ☐ Cough
- ☐ Oral Sores

MEDICAL
- ☐ Thyroid Disease
- ☐ Chest Pain
- ☐ Heart Murmur
- ☐ Tuberculosis
- ☐ Gastrointestinal Problems
- ☐ Diabetes
- ☐ Liver Disease
- ☐ Genitourinary Problems
- ☐ Neurologic Problems
- ☐ Seizures
- ☐ High Blood Pressure
- ☐ Heart Disease (Describe Below)
- ☐ Lung Disease (Describe Below)
- ☐ Fever / Chills
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Depression
- ☐ Cancer

Other medical problems, surgeries or illnesses not listed above (use back if needed):

_____

_____

Are you HIV positive? _____Yes _____No IV drug user/recreational drug user? ____Yes _____No

Have you taken aspirin, aspirin - containing, blood thinning or anti-inflammatory medications in the last two weeks? _____Yes _____No

If you are scheduled to have ANY surgery, you MUST be off all aspirin - containing products for two weeks prior to having surgery.

Ear, Nose and Throat Consultants of East Tennessee, PC

Foothills Ear Nose and Throat, Allergy and Hearing Center

Patient Financial Policy

Patient Name: _____ DOB: _____

Thank you for choosing **Foothills Ear Nose and Throat** for your ENT, allergy and audiology care!

We are committed to the success of your medical treatment and care. Please understand that a mutual financial understanding is part of our relationship.

We sincerely hope that by sharing our financial expectations we will strengthen the physician-patient relationship and keep the lines of communication open. This financial policy helps us provide quality care to our valued patients. If you have any questions or need clarification of any of the below policies, please feel free to ask a receptionist or contact us at 865-983-4090.

Payment is Due At the Time of Service

- We accept cash, checks, debit, credit cards and Care Credit.
- All Insurance co-payments, deductibles, co-insurance and fees for non-covered services are due at the time of service.
- Patient-responsible balances are due when you check in for your appointment.
- There is a $29.00 charge for checks returned to us for NSF.
- Outstanding balances not paid within 60 days of receiving your statement may be forwarded to an external collection agency and additional fees of **25%** will be added to your account. We also reserve the right to discontinue care.

Initial here

- If you make an overpayment on your account, we will issue a refund only if there are no other outstanding debts on your account to the same guarantor or financial responsible party that paid.

PLEASE REMEMBER- Your insurance is a contract between you and your insurance carrier. We, as healthcare providers, just execute that agreement for you. We are bound by the terms in your contract. As a result, it is your responsibility to understand your coverage and benefits. If your insurance requires a referral for "specialist" office visits, you need to contact your primary care physician to get that referral. We cannot see you without it, if it is required.

Filing Claims

- We will gladly submit claims for your services to your insurance company on your behalf. If your insurance company has not paid the claims within 60 days, the balance becomes patient responsibility. We try to resolve most claim issues, but it may become necessary for you to contact your insurance company to get the claim paid. **Be sure to keep your insurance information up-to-date with us with any changes.**

Referrals

- If you have a plan we are contracted with that requires a referral authorization for office visits (ie. AARP Medicare Complete, UHC Compass plan), you will need to obtain one from your primary care physician. If we have not received an authorization prior to your arrival at the office you will be asked to reschedule your appointment. Without an insurance required referral, the insurance company will deny payment for services.

No Show Policy

Initial here

- We request that at least a **two-business day** advance notice be given to the office if you will be unable to keep your scheduled appointment. This allows us to release your appointment time to another patient. We charge an administration fee of **$50 for no-shows or late cancellations**. Patients who repeatedly "no show", cancel or reschedule appointments may be discharged from the practice.

Arriving late for Appointment

- We understand that sometimes you may be running late. Unfortunately, we have patients scheduled throughout the day and may not be able to see you if you arrive late. We will try to accommodate you if possible. Otherwise, you will need to reschedule your appointment.

Children's Ear, Nose & Throat Specialists, PLLC

Phone Memo

Dr. Little *Dr. Belmont* *Dr. Ray* *Andy* *Audiology* *Nurse-L* *Nurse –B* *Nurse-R*
Janet *Surgery Deposits* *Medical Records* *Billing*

Patient's Name:_____ **Chart #:**_____

Date:_____ **Time:**_____ **Ins:**_____ **D.O.B.:**_____

Parent/Other:_____ **Phone:** ( )_____

_____ ( )_____

Reason for the call:

- Pt./Ref. Dr. requesting earlier appt:_____(symptoms)
- Need to schedule / reschedule surgery ~ Surgery scheduled for:_____
- Need lab/test results:_____(date and type of test)
- Need to order audiology supplies
- Need medication refill / authorization for_____
- Pharmacy name:_____ Pharmacy#:_____
- Illness: __Fever __D/C from ear __Ear/Throat pain __Nasal drainage __Cough __POP pain

Other: _____

_____

_____

_____

_____

_____

Doctor's Response:

_____

Assistant's Notes:

Front Desk conf. w/:_____ Date:_____ Time:_____

Appt. Date:_____ Time:_____

Children's Ear, Nose & Throat Specialists, PLLC

* John P. Little, M.D.
Board Certified
Fellowship Trained

Michael J. Belmont, M.D.
Board Certified
Fellowship Trained

R. Mark Ray, M.D.
Board Certified
Fellowship Trained

Kristie Johnston, Au.D.
CCC-A
Alison Whittle, Au.D.
CCC-A
Caroline Wind, M.S.
Pediatric Audiologists

Janet L. Harris
Office Manager

* Implant Surgeon,
Pediatric Cochlear
Implant Program
At Children's Hospital

Children's Hospital
Medical Office Building
2100 Clinch Avenue
Suite 410
Knoxville, TN 37916

865-521-6005
fax 865-521-6088

Specializing in Pediatric Otolaryngology providing Head and Neck medical and surgical care for children and adolescents (birth - 21 years)

School/Work Excuse

Date: _____

Please excuse _____ from school/work for the following date(s):

_____

_____

_____ has been under the medical and/or surgical care of Dr. John P. Little, Dr. Michael J. Belmont, or Dr. R. Mark Ray. He/She will be able to return to school/work on _____.

Additional comments: _____

_____

_____

_____

John P. Little, M.D.
Michael J. Belmont, M.D.
R. Mark Ray, M.D.

Children's Ear, Nose & Throat Specialists, PLLC

John P. Little, M.D. / Michael J. Belmont, M.D. / R. Mark Ray, M.D.

CONSULTATION REQUEST*

DATE: _____

TIME: _____

PATIENT'S NAME: _____ DOB: _____

PATIENT'S LOCATION (HOSPITAL / ROOM / BED #): _____

REQUESTING PHYSICIAN'S NAME: _____

REQUESTING PHYSICIAN'S BEEPER/CELL #: _____

IS REQUESTING PHYSICIAN THE PRIMARY CARE PHYSICIAN? YES NO
IF NOT, WHO IS? _____

PATIENT NEEDS TO BE SEEN:

____ NOW / URGENTLY**
____ TODAY
____ WITHIN 24 HOURS
____ COURTESY CONSULT

PATIENT'S PROBLEM:

_____

_____

_____

*Notify Dr. Little immediately of Consultation requests, prior to placing the request in his box

**All "NOW"/"URGENT" Consultation requests should be handled emergently (if they are not in the office, page Dr. Little and add a "*911" to the return call number)

CHECK OUR FILES TO SEE IF PATIENT HAS PREVIOUSLY BEEN SEEN BY US – IF SO, PLEASE PULL CHART AND PLACE CONSULT FORM ON IT

PHYSICIAN EXTENDER SURGERY SCHEDULING FORM

DATE:_____

PATIENT NAME:_____

CHART #: _____

PROCEDURE TO BE SCHEDULED:_____

PHYSICIAN TO BE SCHEDULED WITH: LITTLE BELMONT RAY

SPECIAL INSTRUCTIONS:_____

_____

_____

SURGERY DATE:_____ FACILITY:_____

NURSE NOTES:_____

_____

_____

_____

_____

_____

Photography Consent

_____give permission to Children's Ear, Nose and Throat Specialists to photograph _____ in order to seek medical advice and treatment.

COCHLEAR IMPLANT VACCINATION Recommendations

Date: _____

Re: _____

Dear _____

Your patient has a cochlear implant scheduled (or already inserted). Because of the implant, the child is at increased risk for meningitis and needs appropriate vaccination. Listed below are the vaccination requirements for different ages. Please make every effort to complete this vaccination schedule as soon as possible.

FAX us confirmation (865-521-6088) of completion of this vaccination schedule.

Highlights of the CDC Recommendations

The CDC has issued new pneumococcal vaccination recommendations for individuals with cochlear implants. These recommendations can be viewed in detail on the CDC website (http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5909a2.htm).

- **Children who have cochlear implants or are candidates for cochlear implants should receive PCV13.** PCV13 is now recommended routinely for all infants and children. (See Table 2 in the March 12, 2010, MMWR at the above website for the number of doses and dosing schedule.)

- **Older children with cochlear implants (from age 2 years through age 5) should receive two doses of PCV13 if they have not received any doses of PCV7 or PCV13 previously. If they have already completed the four-dose PCV7 series, they should receive one dose of PCV13 through age 71 months.**

- **Children 6 through 18 years of age with cochlear implants may receive a single dose of PCV13** regardless of whether they have previously received PCV7 or the pneumococcal polysaccharide vaccine (PPSV) (Pneumovax®).

- **In addition to receiving PCV13, children with cochlear implants should receive one dose of PPSV at age 2 years or older** and after completing all recommended doses of PCV13.

- Adult patients (19 years of age and older) who are candidates for a cochlear implant and those who have received a cochlear implant should be given a single dose of PPSV

For both children and adults, the vaccination schedule should be completed at least two weeks before surgery.

Thanks for your assistance in their care,
John P. Little, M.D.

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, unless those uses can be reasonably inferred from the intended uses above. If you have provided us with your 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 you.

PATIENT RIGHTS

THIS SECTION DESCRIBES YOUR RIGHTS AND THE OBLIGATIONS OF THIS PRACTICE REGARDING THE USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION.

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. This includes your own medical and billing records, but does not include psychotherapy notes. Upon proof of an appropriate legal relationship, records of others related to you or under your care (guardian or custodial) may also be disclosed.

  To inspect and copy your medical record, you must submit your request in writing to our Compliance Officer. Ask the front desk person for the name of the Compliance Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies (tapes, discs, etc.) 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 our Compliance Committee review the denial. Another licensed health care professional chosen by the Practice will 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 and recommendations from that review.

- Right to Amend: If you feel that the medical information we have about you in your record is incorrect or incomplete, then you may ask us to amend the information, following the procedure below. You have the right to request an amendment for as long as the Practice maintains your medical record.

  To request an amendment, your request must be submitted in writing, along with your intended amendment and a reason that supports your request to amend. The amendment must be dated and signed by you and notarized.

  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:

  - was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
  - is not part of the medical information kept by or for the Practice;
  - is not part of the information which you would be permitted to inspect and copy;
  - 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 the disclosures we made of medical information about you, to others.

  To request this list, you must submit your request in writing. Your request must state a time period not longer than six (6) years back and may not include dates before *April 1, 2003*. Your request should indicate in what form you want the list (for example, on paper or electronically). 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.

- 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 (a family member or friend). For example, you could ask that we not use or disclose information about a particular treatment you received.

  We are not required to agree to your request and we may not be able to comply with your request. If we do agree, we will comply with your request except that we shall not comply, even with a written request, if the information is exempted from the consent requirement or we are otherwise required to disclose the information by law.

  To request restrictions, you must make your request in writing. In your request, you must indicate:

  - what information you want to limit;
  - whether you want to limit our use, disclosure, or both;
  - to whom you want the limits to apply (e.g. disclosures to your children, parents, spouse, etc.).

- 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 only contact you at work or by mail, that we not leave voice mail or e-mail, or the like.

  To request confidential communications, you must make your request in writing. We will not ask you the reason for your request. We will accommodate all *reasonable* requests. Your request must specify how or where you wish us to contact you.

- 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.

PEDIATRICS PRACTICE

Date of Last Revision: **April 14, 2003**
Effective Date: **April 14, 2003**

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 describes our Practice's policies, which extend to:

- any health care professional authorized to enter information into your chart (including physicians, medical assistants, medical students, RNs, etc.);
- all areas of the Practice (front desk, administration, billing and collection, etc.);
- all employees, staff, and other personnel that work for or with our Practice;
- our business associates (including billing service, or facilities to which we refer patients), on-call physicians, and so on.

The Practice provides this notice to comply with the Privacy Regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

OUR THOUGHTS ABOUT YOUR PROTECTED HEALTH INFORMATION

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create paper and electronic medical records about your health, our care for you, and the services and/or items we provide to you as our patient. We need this record to provide for your care and to comply with certain legal requirements.

We are required by law to:

- make sure that the protected health information about you is kept private;
- provide you with a notice of our Privacy Practices and your legal rights with respect to protected health information about you;
- follow the conditions 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 protected health information that we have and share with others. Each category or uses of disclosures provides a general explanation and provides some examples of uses. Not every use or disclosure in a category is either listed or actually in place. The explanation is provided for your general information only.

- Medical Treatment: We use previously given medical information about you to provide you with current or prospective medical treatment or services. Therefore we may, and most likely will, disclose medical information about you to doctors, nurses, technicians, medical students, or hospital personnel who are involved in taking care of you. For example, a doctor to whom we refer you for ongoing or further care may need your medical record.

ETCH PREOPERATIVE: SURGICAL BOOKING ORDER

East Tennessee Children's Hospital

FOR RESERVATIONS CALL 865-541-8128 **AND** FAX ORDER TO 865-541-8289

SURGERY DATE: _____ **POST OP:** ◯ OBSERVATION ◯ INPATIENT ◯ PICU ◯ OPS

SURGEON: _____ **PCP:** _____

SURGICAL DIAGNOSIS *(ICD 10 CONSISTENT DESCRIPTION)*: _____

_____

_____

SURGICAL PROCEDURE: _____

SPECIAL EQUIPMENT REQUEST:

- **IMPLANTS:** _____
- **XRAY:** ◯ C-ARM ◯ DISC ◯ PORTABLE ◯ O- ARM
- **LASER:** ◯ PULSE DYE ◯ OMNIGUIDE ◯ C02 ◯ HOLMIUM
- **NAVIGATION SYSTEM:** ◯ ENT ◯ NEURO

ANCILLARY LAB REQUEST: ◯ FROZEN SECTION ◯ FRESH ◯ BONE MARROW ◯ BLOOD GAS

PATIENT INFORMATION:

LEGAL NAME: _____ **GENDER:** _____ **DOB:** _____

PLEASE LIST TWO PHONE NUMBERS BELOW: **SS#:** _____

PRIMARY PHONE #: _____ **SECONDARY PHONE #:** _____

ADDRESS: _____

NAME LEGAL GUARDIAN: _____ *(MOM/DAD OR OTHER)*

PRIMARY INSURANCE: _____ **ID#** _____

POLICY HOLDER NAME: _____ **DOB:** _____

SS#: _____

PRECERTIFICATION #: _____ *(SEND AS SOON AS POSSIBLE)*

SECONDARY INSURANCE: _____

ID#: _____ **PRECERTIFICATION #:** _____

Children's West Surgery Center

Phone (865) 560-0303 Fax (865) 670-9082

Surgery Date _____ **Length of Procedure** _____

Surgeon _____ Procedure Code(s) _____

Procedure(s) _____

Needs Interpreter _____ Language _____

Instructions/Equipment/Instrumentation _____

Patient Name _____ **Sex M F DOB** _____

Address _____ SS # _____

City _____ State _____ Zip _____

Primary Contact

Name: _____ ☐ **Parent** ☐ **Guardian**

Home Phone: _____ **May we leave a message? Yes No**

Cell Phone: _____ **May we leave a message? Yes No**

Work Phone: _____ **May we leave a message? Yes No**

Other Phone: _____ Relationship: _____ May we leave a message? Yes No

Email: _____

Emergency Contact Number: _____ Relationship _____

Insurance Information

Primary Ins _____ **Policy #** _____ Grp # _____

Phone Number (Provider Benefits) _____ Precert # _____

Subscriber _____ DOB _____ Relationship _____

Secondary Ins _____ **Policy #** _____ Grp # _____

Phone Number (Provider Benefits) _____ Precert # _____

Subscriber _____ DOB _____ Relationship _____

Children's Ear, Nose & Throat Specialists, PLLC

John P. Little, M.D. / Michael J. Belmont, M.D. / R. Mark Ray, M.D.
Children's Hospital Medical Office Building
2100 Clinch Avenue, Suite 410
Knoxville, TN 37916
865-521-6005 / 865-521-6088(fax)

SURGERY SCHEDULING FORM

Patient Name: _____ **Age:** _____

Date of Surgery: _____

Surgeon: John P. Little, M.D. / Michael J. Belmont, M.D. / R. Mark Ray, M.D.

Signature: _____

Procedure(s) to be performed:

BMT

Patient Diagnosis:

Recurrent acute otitis media / Chronic otitis media w/ effusion /
Eustachian Tube dysfunction / Tympanic membrane atelectasis

Time for Procedure: 15mins (approximate)

Notes for Anesthesia:

***Special Instrument / Equipment Requests:**

*If not specified, please refer to Dr. Little's preference cards/sheets

Pre-operative Labs:

CBC PT/PTT Other: _____
(order only if circled)

Children's Ear, Nose & Throat Specialists, PLLC

John P. Little, M.D. / Michael J. Belmont, M.D. / R. Mark Ray, M.D.

PRE-OP / ADMISSION ORDERS

1) Admit to Dr. Little / Dr. Belmont / Dr. Ray

2) NPO after midnight

3) Labs – _____

4) Procedure(s):

_____ BMT _____

_____

_____

Signature: _____

BRIEF OP NOTE

PRE/POST-OP Diagnosis:

_____

_____

_____

Procedure:

_____

_____

_____

Surgeon: LITTLE / BELMONT / RAY

Assistant: None

Specimens: _____

EBL: _____

Findings: _____

_____

_____

_____

Signature: _____

POST-OP ORDERS

1) To PACU, then OPS

2) VS per PACU / OPS protocol; Record I/Os

3) Elevate HOB > 20-30°

4) Diet: Clear liquids; advance as tolerated

5) Fluids per anesthesia
INT if taking Pos well
D/C i.v. upon discharge

6) Medications:

Tylenol 15 mg/kg PO/PR q 4° prn pain
or T > 100°; (max dose 650 mg)

_____ Otic _____ gtts. A.U. BID x ____ days

_____

_____

_____

_____

7) D/C Home when awake, alert, and stable

8) Return for F/U in office in 6 weeks

Signature: _____

Children's Ear, Nose & Throat Specialists, PLLC

John P. Little, M.D. / Michael J. Belmont, M.D. / R. Mark Ray, M.D.
Children's Hospital Medical Office Building
2100 Clinch Avenue, Suite 410
Knoxville, TN 37916
865-521-6005 / 865-521-6088fax

INFORMED CONSENT

Patient Name: _____ Date of Surgery: _____

1) I hereby request and authorize Dr. Little, Dr. Belmont, or Dr. Ray to treat the conditions that appear below:
RECURRENT ACUTE OTITIS MEDIA,
CHRONIC OTITIS MEDIA WITH EFFUSION

2) The following procedure(s) to be performed has been explained to me and I understand the nature of the procedure: **BILATERAL MYRINGOTOMIES WITH TYMPANOSTOMY TUBE PLACEMENT**
Procedure (common terms): **Placing Ventilating Tubes in the Eardrums**

3) It has been explained to me that, during the course of the operation, unforeseen conditions may require additional surgery immediately. If I need such additional surgery during my operation, I permit the doctor to perform such medical and surgical procedures as are necessary.

4) Dr. Little, Dr. Belmont or Dr. Ray have discussed and explained to me the following:

   a. the indication, nature, and purpose of the procedure;
   b. the possibility that complications may develop;
   c. significant risks;
   d. alternative methods of treatment; and
   e. prognosis if no treatment is received.

Risks for this procedure include, but are not limited to, the following:
Chronic Hole in Eardrum(s), Recurrent or Persistent Ear Infections / Drainage,
Eardrum Scarring, Hearing Loss, Bleeding,
Need for Further Surgery, Anesthesia Risks

5) I understand that results are uncertain and no warranty or guarantee has been made to me. I also understand that I will be responsible for any payment amount which insurance does not cover.

6) I consent to the examination and disposal of any tissue or parts which may be removed or recovered by staff of the hospital at which the surgery is performed.

7) I certify that I have read and fully understand this form, and that all of my questions have been answered in a satisfactory manner.

Parent / Guardian signature: _____

Printed name: _____

Date: _____

Witness: _____

Date: _____

Physician signature: _____

Children's Ear, Nose & Throat Specialists, PLLC

John P. Little, M.D. / Michael J. Belmont, M.D. / R. Mark Ray, M.D.

PROCEDURE NOTE

Patient Name: _____ Chart#: _____

Date: _____

Diagnosis: Dysphagia, congenital anomaly of superior lip

Procedure: Frenulotomy (incision of superior labial frenulum)

Surgeon: John P. Little, M.D.

Anesthesia: Topical (2% Pontocaine) and 1% lidocaine with epinephrine 1:100,000

PROCEDURE:

The patient was brought to the procedure room with parent(s) in attendance on the above listed date. The sublabial mucosa was topically anesthetized with 2% Pontocaine on a non-saturated cotton-tipped applicator. After a short period of time, to allow for adequate anesthesia, the patient was gently placed in the papoose. Less than ½ cc of 1% lidocaine with 1/100,000 units of epinephrine was injected into the operative site.

Iris scissors were then used to transect the sublabial frenulum. Silver nitrate was used to ensure hemostasis. This being done the procedure was completed. The patient was returned to the arms of the attending parent in stable condition. There were no complications.

Children's Ear, Nose & Throat Specialists, PLLC

John P. Little, M.D. / Michael J. Belmont, M.D. / R. Mark Ray, M.D.

PROCEDURE NOTE

Patient Name: _____ Chart#: _____

Date: _____

Diagnosis: Ankyloglossia

Procedure: Sublingual Frenulysis

Surgeon: John P. Little, M.D.

Anesthesia: Topical (2% Pontocaine)

PROCEDURE:

The patient was brought to the procedure room with parent(s) in attendance on the above listed date. The sublingual mucosa was topically anesthetized with 2% Pontocaine on a non-saturated cotton-tipped applicator. After a short period of time, to allow for adequate anesthesia, the patient was gently placed in the papoose.

The grooved director was used to elevate the tongue and a hemostat was used to clamp the sublingual frenulum. Iris scissors were then used to transect the thinnest portion of the sublingual frenulum down to the junction of the tongue base and floor of mouth. Silver nitrate was used to assist with hemostasis with the excess removed with moist cotton-tipped applicators and 4x4 gauze. This being done the procedure was completed. The patient was returned to the arms of the attending parent in stable condition. There were no complications.

Children's Ear, Nose & Throat Specialists, PLLC

John P. Little, M.D. / Michael J. Belmont, M.D. / R. Mark Ray, M.D.

PROCEDURE NOTE

Patient Name: _____ Chart#: _____

Date: _____

Diagnosis: Ankyloglossia

Procedure: Sublingual Frenulysis

Surgeon: Michael J. Belmont, M.D.

Anesthesia: Topical (2% Pontocaine)

PROCEDURE:

The patient was brought to the procedure room with parent(s) in attendance on the above listed date. The sublingual mucosa was topically anesthetized with 2% Pontocaine on a non-saturated cotton-tipped applicator. After a short period of time, to allow for adequate anesthesia, the patient was gently placed in the papoose.

The grooved director was used to elevate the tongue and a hemostat was used to clamp the sublingual frenulum. Iris scissors were then used to transect the thinnest portion of the sublingual frenulum down to the junction of the tongue base and floor of mouth. Silver nitrate was used to assist with hemostasis with the excess removed with moist cotton-tipped applicators and 4x4 gauze. This being done the procedure was completed. The patient was returned to the arms of the attending parent in stable condition. There were no complications.

Children's Ear, Nose & Throat Specialists, PLLC

John P. Little, M.D. / Michael J. Belmont, M.D. / R. Mark Ray, M.D.

PROCEDURE NOTE

Patient Name: _____ Chart#: _____

Date: _____

Diagnosis: Dysphagia, congenital anomaly of superior lip

Procedure: Frenulotomy (incision of superior labial frenulum)

Surgeon: Michael J. Belmont, M.D.

Anesthesia: Topical (2% Pontocaine)

PROCEDURE:

The patient was brought to the procedure room with parent(s) in attendance on the above listed date. The sublabial mucosa was topically anesthetized with 2% Pontocaine on a non-saturated cotton-tipped applicator. After a short period of time, to allow for adequate anesthesia, the patient was gently placed in the papoose. Less than ½ cc of ½% lidocaine with 1/100,000 units of epinephrine was injected into the operative site.

Iris scissors were then used to transect the sublabial frenulum. This being done the procedure was completed. The patient was returned to the arms of the attending parent in stable condition. There were no complications.