4150 Deputy Bill Cantrell Memorial Road
Suite 260
Cumming, GA 30040

Fax: 770-292-3046
Office: 770-292-3045
www.naenta.com

NORTH ATLANTA ENT & ALLERGY

3180 North Point Parkway
Building 500, Suite 512
Alpharetta, GA 30005

Fax: 770-292-3046
Office: 678-679-5070
www.naenta.com

Personal Information / Demographics

Today's Date: _____

Person Completing the Form: ☐Patient ☐Parent/Guarantor ☐Other: _____

Primary Care Provider: _____ Referring Provider: _____

Last Name: _____ First Name: _____ Middle Name: _____

Date of Birth: _____ Social Security Number (billing purposes only): _____

E-Mail: _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed | Gender: ☐Male ☐Female ☐Transgender

Street (Mailing) Address: _____City: _____ State: _____ Zip Code: _____

Preferred Phone Number: (_____)-_____-_____ Secondary Phone Number: (_____)-_____-_____

Preferred Language(s): _____

Race/Ethnicity (check all that apply): ☐White ☐African American ☐Asian American ☐Indian/Alaska Native ☐Hawaiian/Pacific Islander ☐Hispanic/Latino ☐*not* Hispanic/Latino ☐Unknown/Other (specify): _____

Emergency Contact Name: _____ Emergency Contact Number: (_____)-_____-_____

Emergency Contact Name: _____ Emergency Contact Number: (_____)-_____-_____

Employer Name: _____ Employer Contact Number: (_____)-_____-_____

Insurance Information

Primary Insurance: _____	Secondary Insurance: _____
Phone Number (on back of card): _____	Phone Number (on back of card): _____
Subscriber Name: _____	Subscriber Name: _____
Subscriber Relationship to Patient: _____	Subscriber Relationship to Patient: _____
Subscriber Phone Number: _____	Subscriber Phone Number: _____
Subscriber Date of Birth: _____	Subscriber Date of Birth: _____
Member ID: _____	Member ID: _____
Group Number: _____	Group Number: _____

Pharmacy Information

Preferred Pharmacy: _____ Pharmacy Phone Number: (_____)-_____-_____

Pharmacy Street Address: _____ City: _____ State: _____ Zip Code: _____

NORTH ATLANTA ENT & ALLERGY

Patient Name:_____ DOB:_____

HEALTH HISTORY FORMS

IF YOU HAVE ALREADY COMPLETED PORTIONS OF YOUR NEW PATIENT HEALTH HISTORY FORMS ONLINE, YOU MAY LEAVE THOSE SECTIONS BLANK AND INFORM YOUR MEDICAL ASSISTANT

Reason for Appointment (please be as specific as possible):

Known Drug Allergies and Reactions: _____ ☐None

Current Medications (includes prescriptions, vitamins/supplements, and over-the-counter medications):

NAME	DOSE	NAME	DOSE

Past Medical History (check all that apply):

☐ Asthma	☐ COPD	☐ Emphysema	☐ Sarcoidosis	☐ Other lung disease
☐ Hay fever / Allergies	☐ Insect sting allergy	☐ Food allergy	☐ Latex allergy	☐ Angioedema/Anaphylaxis
☐ Eczema	☐ Hives	☐ Sinusitis	☐ Nosebleeds	☐ Sleep apnea
☐ Reflux/GERD	☐ Barrett's esophagitis	☐ Crohn's disease	☐ Ulcerative colitis	☐ Cardiovascular disease
☐ Thyroid disease	☐ Migraine headaches	☐ Type I diabetes	☐ Type II diabetes	☐ Blood clotting disorder
☐ Rheumatoid arthritis	☐ Lupus	☐ Immunodeficiency	☐ HIV / AIDS	☐ Other autoimmune disorder
☐ Hepatitis	☐ Other liver disease	☐ Hypertension	☐ High cholesterol	☐ Kidney disease
☐ Glaucoma	☐ Stroke	☐ Seizure/Epilepsy	☐ Anxiety/Depression	☐ Other psychiatric disorder
☐ Hearing Loss: ☐Left ☐Right ☐Bilateral Type (if known):		☐ Cancer (specify type):		

Other Past Medical History:

Surgeries/Hospitalizations:

DATE	SURGERY/HOSPITALIZATION	DATE	SURGERY/HOSPITALIZATION

NORTH ATLANTA ENT & ALLERGY

Patient Name:_____ DOB:_____

HEALTH HISTORY FORMS CONTINUED

Social History

Tobacco: Cigarettes: ☐Never ☐Former Smoker: Number of years: _____ Average packs per day: _____ Quit date: _____

Current Smoker: Number of Years: _____ Average packs per day: _____ Are you considering quitting? ☐Yes ☐No

Other Forms of Tobacco: ☐Never ☐Former ☐Current ☐Second hand smoke exposure

Alcohol Use: ☐None ☐Occasional/Social ☐Rare Number of drinks per day: _____ Per week: _____

Recreational Drug Use: ☐None ☐Marijuana ☐Other: _____

Housing: ☐House ☐Townhouse ☐Condo ☐Apartment ☐Mobile Home ☐Other: _____

Years in Georgia: _____ ☐Georgia Native | Years in current home: _____ Age of home: _____

Lives with: _____

Pets: ☐None ☐Cats: #_____ ☐Dogs: #_____ ☐Other: _____ Pets: ☐Inside ☐Outside

Occupation: _____ Type of Workplace: _____

Education: _____

Do you suspect any home or work/school exposures are triggering your symptoms? ☐Yes ☐No

Seat Belts: ☐Always ☐Sometimes ☐Never | Working smoke detectors in the home? ☐Yes ☐No

Exercise: ☐None ☐Occasional ☐1-2 times per week ☐3-4 times per week ☐5-6 times per week ☐Daily

Caffeine Intake: ☐None ☐Occasional ☐Rare ☐1-2 cups per day ☐3-4 cups per day ☐5+ cups per day

Travel outside of the United States: _____

Review of Systems (check all that apply):

General: ☐fatigue ☐fever ☐night sweats ☐chills ☐weight loss ☐weight gain ☐sleep disturbance ☐changes in appetite ☐changes in activity level

Eyes: ☐itching ☐redness ☐watery eyes ☐dry eyes ☐eye pain ☐discharge ☐blurred vision ☐changes in vision

ENT: ☐ear pain ☐blocked ears ☐ear fullness/pressure ☐decreased hearing ☐ringing in the ears ☐sinus pain/pressure ☐facial pain/pressure ☐nasal congestion ☐rhinorrhea ☐post nasal drip ☐history of nasal fracture ☐changes in taste ☐decreased sense of smell ☐sore throat ☐difficulties swallowing ☐dry mouth ☐globus sensation ☐frequent throat clearing

Respiratory: ☐cough ☐wheezing ☐shortness of breath ☐hemoptysis ☐pain with inspiration ☐history of pneumonia

Cardiac: ☐chest pain ☐palpitations ☐dyspnea on exertion ☐lower extremity edema ☐claudication ☐irregular heartbeat ☐heart murmur

Hematology: ☐swollen glands ☐prolonged bleeding ☐bleeding problems ☐anemia ☐easy bruising

Endocrinology: ☐cold intolerance ☐heat intolerance ☐hot flashes ☐hair loss ☐excessive thirst

Neurologic: ☐headaches ☐dizziness ☐lightheadedness ☐balance difficulty ☐gait abnormality ☐memory loss ☐tremor ☐difficulty speaking ☐numbness or tingling ☐fainting ☐seizures

Psychiatric: ☐anxiety ☐depressed mood ☐changes in behavior

Other:

NORTH ATLANTA ENT & ALLERGY

Patient Name:_____ DOB:_____

HEALTH HISTORY FORMS CONTINUED

Family History (check all that apply):	
Mother Living / Deceased	☐cancer ☐heart disease ☐diabetes ☐hypertension ☐high cholesterol ☐anemia ☐asthma ☐hearing loss ☐chronic otitis media ☐sleep apnea ☐sinusitis ☐reflux ☐obesity ☐anxiety ☐depression ☐Other:
Father Living/Deceased	☐cancer ☐heart disease ☐diabetes ☐hypertension ☐high cholesterol ☐anemia ☐asthma ☐hearing loss ☐chronic otitis media ☐sleep apnea ☐sinusitis ☐reflux ☐obesity ☐anxiety ☐depression ☐Other:
Siblings #Living _____ #Deceased _____	☐cancer ☐heart disease ☐diabetes ☐hypertension ☐high cholesterol ☐anemia ☐asthma ☐hearing loss ☐chronic otitis media ☐sleep apnea ☐sinusitis ☐reflux ☐obesity ☐anxiety ☐depression ☐Other:
Children #Living _____ #Deceased _____	☐cancer ☐heart disease ☐diabetes ☐hypertension ☐high cholesterol ☐anemia ☐asthma ☐hearing loss ☐chronic otitis media ☐sleep apnea ☐sinusitis ☐reflux ☐obesity ☐anxiety ☐depression ☐Other:
Maternal Grandmother Living / Deceased	☐cancer ☐heart disease ☐diabetes ☐hypertension ☐high cholesterol ☐anemia ☐asthma ☐hearing loss ☐chronic otitis media ☐sleep apnea ☐sinusitis ☐reflux ☐obesity ☐anxiety ☐depression ☐Other:
Maternal Grandfather Living / Deceased	☐cancer ☐heart disease ☐diabetes ☐hypertension ☐high cholesterol ☐anemia ☐asthma ☐hearing loss ☐chronic otitis media ☐sleep apnea ☐sinusitis ☐reflux ☐obesity ☐anxiety ☐depression ☐Other:
Paternal Grandmother Living / Deceased	☐cancer ☐heart disease ☐diabetes ☐hypertension ☐high cholesterol ☐anemia ☐asthma ☐hearing loss ☐chronic otitis media ☐sleep apnea ☐sinusitis ☐reflux ☐obesity ☐anxiety ☐depression ☐Other:
Paternal Grandfather Living / Deceased	☐cancer ☐heart disease ☐diabetes ☐hypertension ☐high cholesterol ☐anemia ☐asthma ☐hearing loss ☐chronic otitis media ☐sleep apnea ☐sinusitis ☐reflux ☐obesity ☐anxiety ☐depression ☐Other:
Maternal Aunt Living / Deceased	☐cancer ☐heart disease ☐diabetes ☐hypertension ☐high cholesterol ☐anemia ☐asthma ☐hearing loss ☐chronic otitis media ☐sleep apnea ☐sinusitis ☐reflux ☐obesity ☐anxiety ☐depression ☐Other:
Maternal Uncle Living / Deceased	☐cancer ☐heart disease ☐diabetes ☐hypertension ☐high cholesterol ☐anemia ☐asthma ☐hearing loss ☐chronic otitis media ☐sleep apnea ☐sinusitis ☐reflux ☐obesity ☐anxiety ☐depression ☐Other:
Paternal Aunt Living / Deceased	☐cancer ☐heart disease ☐diabetes ☐hypertension ☐high cholesterol ☐anemia ☐asthma ☐hearing loss ☐chronic otitis media ☐sleep apnea ☐sinusitis ☐reflux ☐obesity ☐anxiety ☐depression ☐Other:
Paternal Uncle Living / Deceased	☐cancer ☐heart disease ☐diabetes ☐hypertension ☐high cholesterol ☐anemia ☐asthma ☐hearing loss ☐chronic otitis media ☐sleep apnea ☐sinusitis ☐reflux ☐obesity ☐anxiety ☐depression ☐Other:
Other:	☐cancer ☐heart disease ☐diabetes ☐hypertension ☐high cholesterol ☐anemia ☐asthma ☐hearing loss ☐chronic otitis media ☐sleep apnea ☐sinusitis ☐reflux ☐obesity ☐anxiety ☐depression ☐Other:

Patient Name:_____ DOB:_____

NORTH ATLANTA EAR, NOSE, AND THROAT ASSOCIATES
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU IS USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

Introduction

At North Atlanta Ear, Nose, and Throat Associates (NAENTA), we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect from you, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This notice is effective as of 4/13/2003 and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit NAENTA, a record of your visit is made. Typically, this record contains your symptoms, diagnosis, treatment, and plan for future care. This information is often referred to as a:

- Basis for planning your care and treatment
- Means of communication among the many health care professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third-party payer can verify that services billed were actually provided
- A tool with which we can access and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to better understand who, what, when, where, and why others may access your health information.

Your Health Information Rights

Although your health record is the physical property of NAENTA, the information it contains belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request
- Request a copy of your health record (fees may apply)
- Request an amendment to your health record
- Obtain an accounting of disclosures of your health information
- Request communications of your health information by alternative means or alternative locations
- Request a restriction on certain uses and disclosure of your information
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities

North Atlanta Ear, Nose, and Throat Associates is required to:

- Maintain the privacy of your health information
- Provide you with this notice as to your legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we were unable to agree to a requested restriction
- Accommodate reasonable requests where you may have to communicate information by alternative means or at alternative locations

We reserve the right to change our practices and to make the new provision effective for all protected health information we maintain or disclose. Should our information practices change, we will post a copy of the revised notice in our office and mail a revised notice to the address you have given us.

Patient Signature: _____ Date: _____

Responsible Party's Name: _____ Relationship: _____

Responsible Party's Signature: _____ Date: _____

Patient Name:_____ DOB:_____

NORTH ATLANTA EAR, NOSE, AND THROAT ASSOCIATES
PRIVACY POLICY ACKNOWLEDGEMENT STATEMENT

I hereby acknowledge that I have been made aware that North Atlanta Ears, Nose, and Throat Associates (NAENTA) has a Privacy Policy in place in accordance with the Health Insurance Portability and Accountability ACT of 1996 (HIPAA). As a patient of NAENTA, I understand and acknowledge the following:

1. NAENTA has a privacy policy in effect in their office.
2. NAENTA has made this policy available for me to review by placing a complete version in a binder that resides in the waiting room, and/or by placing a poster of this policy in the waiting room or similar common area with patient access.
3. NAENTA has made me aware that, as a patient, I am entitled to a copy of the Privacy Policy.

☐ No, I do not want a copy, but acknowledge the Privacy Policy exists.

☐ Yes, I do want a copy of the Privacy Policy.

PATIENT COMMUNICATION AGREEMENT

I understand that as part of my healthcare, NAENTA will need to contact me in order to remind me of an appointment, provide test results, give instructions, or provide other information. I understand that NAENTA will use the minimum necessary information needed when communicating with me indirectly. I understand that I may revoke or modify this agreement at any time. Any revocation or change will not apply to past communications.

I authorize NAENTA to contact me in the following ways (check all that apply):

☐Home Phone: _____ ☐OK to leave voicemail

☐Cell Phone: _____ ☐OK to leave voicemail ☐OK to text

☐Work Phone: _____ ☐OK to leave voicemail

☐Fax: _____

☐E-Mail: _____

NAENTA does not use secure server for e-mail communication. Because a secure server is required by law for email communication with patients, NAENTA does not endorse the use of email communication with patients.

If I am unable to be reached, I authorize NAENTA to leave messages regarding my condition/care with the following:

Printed Name: _____ Relationship to Patient: _____

Printed Name: _____ Relationship to Patient: _____

Patient Signature: _____ Date: _____

Responsible Party's Name: _____ Relationship: _____

Responsible Party's Signature: _____ Date: _____

NORTH ATLANTA ENT & ALLERGY

Patient Name:_____ DOB:_____

RELEASE OF INFORMATION FORM

Authorization to Release Patient Files

Patient Name: _____ Date of Birth: _____

By signing this form, I authorize NAENTA to obtain and/or release confidential health information about me as specified below.

This authorization covers the period of healthcare from:

☐ Dates: _____ to _____ **OR** ☐ All past, present, and future periods.

☐I authorize the release of all records and types of health information per the discretion of NAENTA.

OR

☐I only authorize the release of the following records or types of health information per the discretion of NAENTA:

☐ Progress Notes / Consultations ☐ History & Physical ☐ ER Records ☐Discharge Summaries

☐ Immunization Record ☐ Medication Record ☐ All Pertinent Labs / Pathology Reports / Diagnostic Studies

☐ Operative Reports ☐ Other: _____

Patient Signature: _____ Date: _____

Responsible Party's Name: _____ Relationship: _____

Responsible Party's Signature: _____ Date: _____

Consent to Obtain External Prescription History

I authorize NAENTA to view my external prescription history via the RxHub service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions dating back several years. By signing below, I acknowledge that I have been advised of the patient Communication Agreement and Authorization to Request Patient Files.

Patient Signature: _____ Date: _____

Responsible Party's Name: _____ Relationship: _____

Responsible Party's Signature: _____ Date: _____

Patient Name:_____ DOB:_____

Outside Party HIPAA Release and Consent Form

I have been made aware that North Atlanta Ears, Nose, and Throat Associates (NAENTA) has a Privacy Policy in place in accordance with the Health Insurance Portability and Accountability ACT of 1996 (HIPAA). I understand and acknowledge that no outside parties will be permitted access to my medical records, information, providers, or appointment status without specific written consent in accordance with this document. I understand and acknowledge that this document **DOES NOT** grant permission to speak with my insurance company on my behalf as insurance companies are separate from North Atlanta ENT. I understand and acknowledge that this document is separate from the Release of Information document used to release medical records to or from other medical facilities.

_____ **I DO NOT** grant any access to any outside parties. **No medical information, records, or appointment information can be discussed or released.**

_____ **I WISH TO** grant specific individuals access to my healthcare providers and/or medical information as follows:

_____
(Print the name of the individual and indicate his/her relationship to you)

_____
(Print the name of the individual and indicate his/her relationship to you)

_____
(Print the name of the individual and indicate his/her relationship to you)

_____ I give the above-named individual(s) permission to act on my behalf with no limitations. I understand that they may contact any physician or member of the staff at North Atlanta ENT to schedule appointments, discuss my healthcare, and access my complete medical records. **THEY HAVE NO RESTRICTIONS.**

_____ I give the above-named individual(s) permission to contact and speak with any physician or member of the staff at North Atlanta ENT for the sole purpose of scheduling an appointment. **NO** access to my medical records or information regarding my healthcare can be discussed or provided. **APPOINTMENT ACCESS ONLY.**

_____ I give the above-named individual(s) permission to request refills and pick up my prescriptions.

_____ _____ _____
PATIENT/GUARANTOR SIGNATURE WITNESS SIGNATURE Date

I understand that I can withdraw consent at any time by providing North Atlanta Ears, Nose, and Throat Associates with written notice indicating the changes in access.

Effective Date: _____

NORTH ATLANTA ENT & ALLERGY

Patient Name:_____ DOB:_____

FINANCIAL AGREEMENT

We are committed to providing you with the best possible care and are pleased to discuss our professional fee with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your financial responsibility. **PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. WE WILL REQUEST TO PHOTOCOPY YOUR INSURANCE CARD(S) AND GOVERNMENT ISSUED ID / DRIVER'S LICENSE FOR YOUR FILE.**

APPOINTMENTS: 24 hours' notice must be provided in the event you cannot keep an appointment. If this notice is not provided, a cancellation fee of $25 may be added to your account.

CO-PAYMENTS: By law, we MUST collect your carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit. Should you not pay at the time of service and we subsequently send you a statement, an administrative fee of $20 may be added to your account. Some insurance companies require co-payments for post-operative visits.

REFERRALS: If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit or have your referring provider fax it over to our office prior to your appointment. If you do not have your referral, you will be requested to sign a financial waiver. It is then your responsibility to provide us with the referral within 48 hours or you will be personally responsible for that day's service.

DEDUCTIBLE: A deductible is a portion of the bill that is the responsibility of the patient to pay before an insurance company will cover the service. An office visit with our physicians will include a face-to-face encounter and evaluation. Generally, a co-payment is required for the visit. In addition, some services and ALL procedures performed in the office require the patient to meet their deductible before insurance pays benefits. If you have not met your deductible, you will be responsible for the full or partial payment, depending on your insurance contract. Procedures performed in the office are considered the same as surgery to the insurance company and are billed as surgery.

SURGERY: A 5-day notice is required to cancel a surgical procedure (both in office and NAENTA Surgery Center). Failure to give proper notice will result in a $500 cancelation fee. Cancelations for procedures booked at outside hospitals, such as Northside, are subject to that location's cancelation fees.

You are responsible for timely payment on your account. Should it become necessary for us to use an outside agency to collect payment, you will be responsible for any additional charges we incur as a result. WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, AND AMERICAN EXPRESS.

By signing below, I acknowledge and understand the information stated above. I authorize my insurance benefits to be paid directly to the physician, and I am financially responsible for all charges. I hereby consent to the release and re-disclosure of my medical records to enable or facilitate the collection, verification, or settlement of my account for any amounts due from me or any third-party payor, health maintenance organization, insurer, or other health benefit plan.

Patient Signature: _____ Date: _____

Responsible Party's Name: _____ Relationship: _____

Responsible Party's Signature: _____ Date: _____

NORTH ATLANTA ENT & ALLERGY

Patient Name:_____ DOB:_____

PATIENT NOTIFICATION FOR PAYER PAYMENT POLICIES FOR CERTAIN IN-OFFICE PROCEDURES

Please be aware that certain procedures performed in our office are not included in the standard office visits. These procedures will be billed separately in addition to our office visit charges. We have become aware that some insurance carriers are classifying these procedures as "surgery" and applying the charges to a higher deductible amount. This may result in insurance payment for an office visit, but not the procedure. In such cases, payment for the procedure will be due from the patient. Be assured that we are following accepted billing and coding guidelines and that all procedures are performed in the best interest of patient care.

Examples of in-office procedures:

- Flexible Laryngoscopy - This procedure involves passing a long, thin, flexible fiber optic scope through the nasal cavity and into the throat. The fiber optic scope enables the physician to visualize areas of the throat not readily seen using the laryngeal mirrors.
- Nasal Endoscopy - This procedure uses either a flexible or rigid scope attached to a light source to view areas of the nasal cavities that cannot be viewed by the physician using the standard nasal speculum and head mirror.
- Nasal Endoscopy with Debridement or Biopsy - This is the same procedure as above, but with the removal of crusting or tissue. This procedure is always performed on three different visits after any sinus surgery and is not included in the global package.
- Audiology Hearing Services
- Balloon Sinuplasty
- Biopsies
- Impacted Cerumen Removal

If you have any questions or concerns, please ask to speak with a member of our billing department.

Patient/Guarantor Initials: _____ Date: _____

Patient Name:_____ DOB:_____

NASAL ENDOSCOPY CONSENT FORM

Nasal Endoscopy

How do we look into your nose / sinuses? When you come to North Atlanta Ear, Nose and Throat with a nasal or sinus related problems, physicians may want to perform a nasal endoscopy. This is a surgical procedure using a small camera to look through the nostrils. This may allow your physician to:

- Obtain drainage for a culture
- Evaluate previous surgery, scaring, openings, masses, polyps, or causes of blockage
- Evaluate healing or complications of surgery
- Obtain specimens / biopsy for pathology evaluation
- Remove old blood, foreign material, packing, scabs, scars, or blockage

The nurse or medical assistant will have you sign this permission form first and then offer to spray your nose to make the procedure easier. The spray is a combination of Afrin (to shrink to tissue) and Lidocaine (for numbing). This spray does taste bad and can cause teeth/throat numbness that will wear off after about 45 minutes. Due to the numbing, some patients may also feel like they cannot swallow - do NOT panic - this will pass.

Some patients may experience significant discomfort/pressure during the procedure. The physician will stop the procedure at any time if the patient is unable to tolerate it. Less than 5% of patients faint or feel queasy. This is called a vasovagal reflex. If this occurs, the patient will be laid back in the chair and allowed to relax until they start to feel better.

PATIENT CONSENT

The procedure and description of this procedure, the more common risks associated with it, and the potential complications have been described to me. This includes:

- A small amount of pain/pressure
- A mild amount of bleeding
- A reaction to the nasal spray

I have had the opportunity to ask questions. I am satisfied with my understanding and the responses that I have received. I hereby authorize North Atlanta Ear, Nose, and Throat Associates personnel to perform a nasal endoscopy. I hereby authorize the physician or his/her associates to provide such additional services as he or she may consider to be medically advisable, including but not limited to suctioning, culturing the drainage, and biopsies.

Patient Signature: _____ Date: _____

Responsible Party's Name: _____ Relationship: _____

Responsible Party's Signature: _____ Date: _____