GOAD, JAMES (id #421423, dob: 06/12/1961)

EAR, NOSE & THROAT INSTITUTE
The Center of Excellence for Ear, Nose & Throat Disorders

MILTON HALL SURGICAL ASSOCIATES, LLC
1050 EAGLES LANDING PKWY SUITE 202
STOCKBRIDGE, GA 30281-9200
Phone: (770) 740-1860, Fax: (678) 783-1376

Date: 10/09/2017

Dear James Goad,

The following is a summary of your visit today. If you have any questions, please contact our office.

Sincerely,

Electronically Signed by: JAMES HAWKINS, PA, PASUP

Patient Care Summary for James Goad

Most Recent Encounter

10/09/2017 James Tyler Hawkins: 1050 Eagles Landing Pkwy, Suite 202, Stockbridge, GA 30281-9200, Ph. tel:+1-770-7401860

Reason for Visit

CMA

Assessment and Plan

The following list includes any diagnoses that were discussed at your visit.

1. Chronic sinusitis

- doxycycline monohydrate 100 mg tablet
- Medrol (Pak) 4 mg tablets in a dose pack
- Zofran ODT 8 mg disintegrating tablet
- mupirocin 2 % topical ointment
- fluticasone 50 mcg/actuation nasal spray,suspension
- amoxicillin 250 mg/5 mL oral suspension

2. Obstructive sleep apnea syndrome

3. Pre-surgery testing

- CBC
- CMP, serum or plasma
- PT/PTT, plasma

4. Preoperative cardiovascular examination

5. Hypertrophy of nasal turbinates

6. Deviated nasal septum

7. Perforation of nasal septum

Discussion Note: None recorded.

Patient educational handouts: No information available.

Plan of Care

Reminders			Provider
Appointments	Surgery150	10/31/2017 7:30AM	Daniel Gordon Carothers, MD
	Comp Outcome Assessment	11/03/2017 9:00AM	Daniel Gordon Carothers, MD
Lab	Cbc	10/09/2017	Quest Diagnostics PSC
	CMP, Serum or Plasma	10/09/2017	Quest Diagnostics PSC
	PT/PTT, Plasma	10/09/2017	Quest Diagnostics PSC
Referral	None recorded.		
Procedures	None recorded.		
Surgeries	None recorded.		
Imaging	None recorded.		

Lab Results

None recorded.

Allergies

Please review your allergy list for accuracy. Contact your provider if this list needs to be updated.

Code	Code System	Name	Reaction	Severity	Onset
NKDA					

Problems

Name	Status	Onset Date	Source
Obstructive Sleep Apnea Syndrome	Active	06/05/2017	History
Sinusitis	Active	06/05/2017	History
Singers' Chorditis	Active	06/05/2017	History
Finding of Esophagus	Active	06/05/2017	History
Lesion of Nose	Active	06/05/2017	History

Procedures

Date	Name	Performed by
	Removal of Brain Lesion	Information not available

Notes: Cardiac ablation

Vaccine List

Here is a copy of your most up-to-date vaccination list.

None recorded.

Smoking Status

Smoking Status	Never Smoker

Past Encounters

10/09/2017
Chronic Sinusitis; Obstructive Sleep Apnea Syndrome; Pre-surgery Testing; Preoperative Cardiovascular Examination; Hypertrophy of Nasal Turbinates; Deviated Nasal Septum; Perforation of Nasal Septum
James Tyler Hawkins, PA: 1050 Eagles Landing Pkwy, Suite 202, Stockbridge, GA 30281-9200, Ph. (770) 740-1860

Demographics

Sex:	Male	Ethnicity:	Information not available
DOB:	06/12/1961	Race:	Information not available
Preferred language:	Information not available	Marital status:	Information not available

Contact: PO Box 292, Pine Lake, GA 30072-0292, Ph. tel:[redacted]

Milton Hall Surgical Associates

Jeffrey M. Gallups MD, FACS
Thomas N. Guffin Jr., MD
Mark M. Beaty MD
Ronald J. Alvarez, MD
J. Courtney French Jr., MD
Earnest C. Riley MD
James G. Burson MD
N. Hadley Heindel III, MD
Daniel G. Carothers, MD, FACS
Johnny Won, MD
Matthew T. Gill, MD
Debbie E. Joseph, MD
Mary E. Williamson, MD
John L. Ditto Jr., MD

FINANCIAL AGREEMENT

This will confirm the financial agreement made for (patient) James Goad

For the scheduled procedure Septoplasty, Turbinate Reduction, Maxillary Right Concha Bullosa, Tonsillectomy, UPPP, Septal Perforation

Our office will file your claim for the surgery fee expenses for the above named procedure(s). By signing this agreement, you authorize payment of your insurance benefits directly to Milton Hall Surgical Associates, LLC d/b/a Nasal Sinus & Allergy Institute for your planned functional surgery. Although we are temporarily deferring full payment of your account by initially billing your insurance carrier for you, you should understand that **any unpaid balance is ultimately your responsibility. Any outstanding balance to your account after thirty (30) days is due in full. You are responsible for your deductible; co-insurance and co-pays and will be billed accordingly**. A 1.5% per month interest charge will be added to all account balances 30 days past due. The patient understands that they are responsible for any balance of this bill not covered or paid by the insurance. Should any balance be forwarded to a collection agency for collections, a fee of 25% will be added to the balance. Court costs and attorney fees are also the responsibility of the patient, if required. For all return checks, a $30 fee will be added to your balance.

If you reschedule your surgery more than once or cancel your surgery after rescheduling, you will be required to pay 20% of the surgery's standard fee before rescheduling. If you cancel your surgery with less than seven (7) days notice, you will forfeit 40% of any prepaid surgical fee. Any expenses related to complications from this surgery are the responsibility of the patient.

In preparation for your surgery, you may also be required to have laboratory work done and purchase certain prescription medications. The surgical fee does not include anesthetic costs (if hospital/surgery center based), hospital/surgery center costs (if work done outside of the office), hospital accommodations, supplies, laboratory studies, or post-operative nursing coverage (if required).

If you have any questions about any of the above, please do not hesitate to ask. A clear understanding of this agreement prior to surgery is essential.

I, the undersigned, understand and agree to the above:

Signed: _____ Date: 10/9/17

Witness: _____ Date: 10/9/17

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PATIENT NAME: James Goad

DATE OF SURGERY: 10/31/17

IN THE EVENT OF A SHARPS INCIDENT, NEEDLESTICK, OR OTHER EXPOSURE DURING MY PROCEDURE AT MILTON HALL SURGICAL CENTER OR ENT INSTITUTE OFFICES, I JAMES GOAD
print name
AUTHORIZE MILTON HALL SURGICAL ASSOCIATES TO OBTAIN A BLOOD SPECIMEN FROM ME FOR THE PURPOSE OF TESTING FOR ANY / ALL COMMUNICABLE DISEASE(S) TO INCLUDE HIV AND HEPATITIS.

Signed: _____ Date: 10/9/17

Witness: NB PA-C Date: 10/9/17