SLENT

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1420 North Causeway Blvd. Mandeville, LA 70471
Phone 985-327-5905 Fax 205-623-1080

PATIENT INFORMATION & CONSENTS **DATE:** _____

Name: _____ **Date of Birth:** _____

Gender: ☐ Male ☐ Female ☐ Other **SS#:** _____ **Marital Status:** ☐ S ☐ M ☐ D ☐ W

Address: _____
Street Address *Apt #* *City* *State* *Zip Code*

Billing Address: _____
Street Address *Apt #* *City* *State* *Zip Code*

Home#: _____ **Cell#:** _____ **Other#:** _____

Email: _____ **Parent/Guardian's Name:** _____

Emergency Contact: _____ **Relationship:** _____ **Contact#:** _____
May we release Personal Health Information to emergency contact? ☐ Yes ☐ No

Do you have an Advance Care Directive? ☐ Yes ☐ No *If yes, please provide SLENT with a copy.*

Referring MD: _____ **Primary MD:** _____

How did find us? MD/Hospital _____ Google Facebook Self Referral Other _____

Pharmacy: _____
Name Street City Phone Number

GOVERNMENT REQUIRED QUESTIONS

Race: ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native
☐ Native Hawaiian/Other Pacific Islander ☐ Other ☐ Unreported/Declined to Report

Ethnicity: ☐ Hispanic or Latino ☐ Non Hispanic or Latino ☐ Unreported/Decline to Report

Language Preference: ☐ English ☐ Spanish ☐ **Other** _____

Employment Status: ☐ Employed ☐ Not Employed ☐ Retired **Occupation:** _____

INSURANCE INFORMATION *Patient must bring insurance card and driver's license to appointments.*
If information provided below is incorrect or incomplete you will be financially responsible for all charges rendered.

Primary Insurance: _____

Member ID #: _____

Relationship of Patient to Insured
☐ Self ☐ Spouse ☐ Parent ☐ Other
*(Complete below if patient is **not** policy holder)*

Name: _____

DOB: _____ **Phone:** _____

SS#: _____

Secondary Insurance: _____

Member ID #: _____

Relationship of Patient to Insured
☐ Self ☐ Spouse ☐ Parent ☐ Other
*(Complete below if patient is **not** policy holder)*

Name: _____

DOB: _____ **Phone:** _____

SS#: _____

New patient information and consent forms must be completed & returned prior to your appointment.
If unable to return in advance, patient must arrive at least 15 minutes early.

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Office Use Only
Area: _____ Age: ____
Insurance: _____

Patient: _____
please print name

Primary Care Physician: _____ **Pharmacy:** _____

Reason for today's visit: _____

List daily medications and dosage: _____

_____

_____

Drug Allergies? _____

Prior surgeries? _____

_____

MEDICAL HISTORY

Patient - please check the appropriate boxes below for any conditions you are *currently* experiencing.

		FAMILY HISTORY	
Condition	**Patient**	**Mother**	**Father**
Allergic rhinitis	☐	☐	☐
Anxiety	☐	☐	☐
Asthma	☐	☐	☐
Heart Condition*	☐	☐	☐
Lung Disease*	☐	☐	☐
Diabetes	☐	☐	☐
Hearing Loss	☐	☐	☐
Heartburn/Reflux	☐	☐	☐
High Blood Pressure	☐	☐	☐
Sleep Apnea	☐	☐	☐
Snoring	☐	☐	☐
Kidney Failure	☐	☐	☐
Sinusitis	☐	☐	☐
Stroke	☐	☐	☐
Smoking	☐	☐	☐
Anemia	☐	☐	☐
Depression	☐	☐	☐
Heart Attack	☐	☐	☐
Hypothyroidism	☐	☐	☐
Migraine	☐	☐	☐
Cancer*	☐	☐	☐
Other			

**specify condition*

☐ Family history unknown

Previous Radiation
☐ Yes ☐ No

Prior Chemotherapy
☐ Yes ☐ No

Smoking Status
☐ Never

Current Smoker
☐ Yes ☐ No
Number of cigarettes/day: _____
How many years? _____

Former Smoker
☐ Yes ☐ No
Number of cigarettes /day: _____
How many years? _____
Quit Date: _____

Do you drink alcohol?
☐ Yes ☐ No
☐ Beer ☐ Wine ☐ Liquor
Number of drinks: _____
☐ daily ☐ weekly ☐ monthly ☐ yearly

Have you ever used illegal or IV drugs?
☐ Yes ☐ No
Type: _____

SLENT

Patient: _____
please print name

Check the appropriate boxes for symptoms you are *currently* experiencing.

Eyes
☐ Pain ☐ Dry ☐ Watery/Itchy ☐ Vision loss ☐ Blurring/Double vision ☐ Discharge

Ear, Nose, Throat
☐ Ear Pain ☐ Hearing loss ☐ Ringing ☐ Dizzy ☐ Stuffy Nose ☐ Runny Nose
☐ Hoarseness ☐ Sore throat ☐ Trouble swallowing

Cardiovascular
☐ Chest Pain ☐ Palpitations ☐ Fainting ☐ Shortness of breath with activity
☐ Shortness of breath while resting ☐ Swelling in legs

Respiratory
☐ Cough ☐ Shortness of breath ☐ Excessive sputum ☐ Coughing up blood ☐ Wheezing

Gastrointestinal
☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation

Genitourinary
☐ Pain urinating ☐ Waking up to urinate ☐ Blood in urine ☐ Discharge
☐ Trouble starting ☐ Trouble stopping ☐ Genital sores

Musculoskeletal
☐ Back pain ☐ Joint pain ☐ Joint swelling ☐ Muscle cramps ☐ Muscle weakness ☐ Stiffness

Skin
☐ Scarring ☐ Eczema ☐ Rashes ☐ Skin cancer ☐ Suspicious lesions

Neurologic
☐ Paralysis ☐ Focal loss of sensation ☐ Blackouts ☐ Seizures
☐ Restless legs ☐ Insomnia ☐ Sleep Apnea ☐ Snoring

Psychiatric
☐ Depression ☐ Anxiety ☐ Memory loss ☐ Mental disturbance ☐ Suicidal
☐ Hallucinations ☐ Paranoia

Endocrine
☐ Cold intolerance ☐ Heat intolerance ☐ Always thirsty ☐ Always hungry

HemeLymphatic
☐ Abnormal bruising ☐ Abnormal bleeding ☐ Enlarged lymph nodes
☐ Tender lymph nodes ☐ Frequent illnesses

Allergic/Immune
☐ Ocular allergies ☐ Nasal allergies ☐ Allergic dermatitis ☐ Recurring infections
☐ HIV exposure ☐ Immuno-compromised

Signature: _____ **Date:** _____
Patient or Legal Guardian

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MEDICAL RECORDS REQUEST
REQUEST FOR PROTECTED HEALTH INFORMATION (PHI)

Patient: _____ **Date of Birth:** _____

This request will expire on the following date _____ or in the event of _____.
If date or event is not indicated, authorization will expire on January 1st the next calendar year.

I hereby request a copy of the sections of my medical record as indicated below to be forwarded to SLENT at fax number 205-623-1080.

- ❑ History and Physical Exam and Progress Notes
- ❑ Audiology: Hearing Test / Balance Study / ABR / Etc.
- ❑ Consultation Reports
- ❑ Hospital Operative/Discharge Summary
- ❑ Lab/Pathology Results
- ❑ Radiology Reports: CT / MRI / X-Ray / Ultrasound/ Etc.
- ❑ Sleep Study Results / Compliance Downloads
- ❑ Other _____

Signature: _____ **Date:** _____
Patient or Legal Guardian

Please include this request as a coversheet when returning records.

Faxed To: _____ **Fax Number:** _____ **Date:** _____

From: _____ **Phone Number:** 985-327-5905 **Ext:** _____ **Date:** _____
Practice Representative

Warning: *This message is intended only for the person listed above. The attached information is confidential and considered privileged by law. If the reader of this fax is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you are not the intended recipient, please notify us and shred this information. Thank you for your cooperation.*

SLENT

Patient: _____
please print name

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I received, read and understand *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its *Notice of Privacy Practices* at any time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

Signature: _____ **Date:** _____
Patient or Legal Guardian

ASSIGNMENT OF BENEFIT AGREEMENT

I hereby authorize my insurance company, including Medicare if I am a Medicare Beneficiary, to make payments to South Louisiana Ear, Nose, Throat & Facial Plastics (SLENT) for medical or surgical services or items rendered to me or my dependent by SLENT. Should my insurance carrier deny SLENT, I understand that I am financially responsible for the charges. I authorize SLENT to release any and all of my records to my insurer, or any other third party payer, legally responsible for the payment of medical expenses. I certify that the information provided or to be provided by me is correct and complete to the best of my knowledge. It is my responsibility to update any and all personal, insurance and health information.

Signature: _____ **Date:** _____
Patient or Legal Guardian

NOTICE OF IN-OFFICE PROCEDURE BILLING & FINANCIAL RESPONSIBILITY POLICY

Please be aware that certain procedures performed in our office are not included in the standard office visit. These procedures will be billed separately and in addition to the office visit charge. We are aware that some insurance carriers are classifying these procedures as "Surgery" and apply the charges to a higher co-pay or deductible amount. The result may be 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 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 include:

- 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 seen using the laryngeal mirrors.
- Nasal endoscopy: This procedure uses the 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 with removal of crusting or tissue.

Please speak with our nurse or clinical assistant if you have any questions.

Signature: _____ **Date:** _____
Patient or Legal Guardian

SLENT

Patient: _____
please print name

NOTICE OF FORM REQUEST POLICY

It is the goal of our practice to accommodate form completion request as timely as possible.

Work and School Excuses should be requested at time of visit. Due to HIPPA regulations we are not allowed to fax excuses to work or school. Forms not requested at time of visit **must** be picked up at the office.

Medical Records

- Medical release forms are included in our new patient packet and on our website. Completion of the forms allows us to request your records from other healthcare providers.
- A copy of your office visit at our clinic will be automatically sent to other healthcare providers you identify.
- A signed release is required if you are requesting transfer of care to another provider. Depending on the number of documents a processing fee may apply.

FMLA/Disability/Supplemental Insurance Forms

- Blank forms will not be accepted. Personal information must be completed.
- Turnaround time is usually 7 business days.
- Forms are completed for those accounts in good standing. Outstanding balances need to be paid prior to forms being filled out.
- A $25 fee due when forms are completed.
- Forms will be mailed only if pre-addressed envelope is provided and fee is paid in advance.

Signature: _____ **Date:** _____
Patient or Legal Guardian

CANCELLATION AND NO-SHOW POLICY

OFFICE VISITS
We understand there are times when appointments must be missed due to emergencies or family and work obligations. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. **If an appointment is not cancelled at least 24 hours in advanced you will be charged a twenty-five dollar ($25) fee; this will not be covered by your insurance company.** Additionally three last minute cancellations or no-shows within a 12 month period may result in discharge from the practice.

SURGERY & OFFICE PROCEDURES
Due to the block of time reserved, the coordination among our practice, outside facilities, and your insurance provider, last minute cancellations causes problems and added expenses for the office. **If surgery is not cancelled at least 10 days in advance you will be charged a one hundred dollar ($100) fee; this is not covered by your insurance company.**

Signature: _____ **Date:** _____
Patient or Legal Guardian

Practice Use Only
I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement but was unable to do so because _____

Practice Representative Signature: _____ **Date:** _____

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RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient: _____ **Date of Birth:** _____

☐ I authorize **South Louisiana Ear Nose and Throat & Facial Plastics (SLENT)** to release my protected health information (PHI) including medical records, appointments, and financial information to the person(s) listed below:

Please provide name, relationship, and telephone number for each person to whom you are authorizing release of your private health care information.

Name	Phone Number	Relationship

☐ My protected health information (PHI) shall **NOT** be released to anyone.

This authorization shall be in force and effect until I notify SLENT in writing to revoke this authorization. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Officer at 1420 N Causeway Blvd. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the PHI or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. The use or disclosure requested under this authorization may result in direct or indirect remuneration to the physician from a third party.

Signature: _____ **Date:** _____
Patient or Legal Guardian