CAMELLIA ENT
EAR | NOSE | THROAT | HEAD & NECK SURGERY

PATIENT INFORMATION
(Please print and fill out completely)

DATE:_____

PATIENT NAME: _____ BIRTHDATE: ____/____/_____
First Middle Last

PRIMARY LANGUAGE_____ RACE_____ AGE:_____ SEX: ☐ M ☐ F

SSN: _____/_____/_____ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOW ☐ HISPANIC/LATIN: YES ☐ NO ☐

HOME ADDRESS:/MAILING ADDRESS: _____

CITY:_____ STATE: _____ ZIP: _____ HOME#:_____ WORK#:_____

CELL PH: _____ EMPLOYER:_____ OCCUPATION: _____

YEARS THERE:_____ CITY/STATE:_____ EMAIL:_____

SPOUSE:_____ BIRTHDATE: ____/____/_____ AGE: _____

EMPLOYER:_____ OCCUPATION: _____ YEARS THERE:____

CITY/STATE: _____ CELL PH: _____ SSN:_____/_____/_____

Name of Policyholder (Insured):_____

Patient Relationship to Policyholder (Please Check One): Self_____ Spouse_____ Child_____

Policyholders Date of Birth :_____/_____/_____ SS# of Policyholder:_____-_____-_____

Is this your first visit with Camellia ENT? Y___N___

If not, was your last appointment within the past year? Month:___Year:_____

Complete this section if the patient is a minor

FATHER:_____ BIRTHDATE: ____/____/_____ SSN: _____/_____/_____

EMPLOYER:_____ YEARS THERE:_____ W PH: _____

CITY/STATE: _____ OCCUPATION: _____ CELL: _____

MOTHER:_____ BIRTHDATE: ____/____/_____ SSN: _____/_____/_____

EMPLOYER:_____ YEARS THERE:_____ W PH: _____

CITY/STATE: _____ OCCUPATION: _____ CELL: _____

Guardian Information, if other than above information

STEPFATHER/
STEPMOTHER:_____ BIRTHDATE: ____/____/____ SSN:____/_____/_____

EMPLOYER:_____ YEARS THERE:_____ W PH: _____

CITY/STATE: _____ OCCUPATION: _____

IN CASE OF EMERGENCY:

Name:_____ Phone (Other than home):_____ Relationship_____

MEDICAL INFORMATION
(Please print and fill out completely)

DATE:_____

Patient Name: _____ DOB: _____/_____/_____ AGE:_____Weight:_____ Height:_____

REASON FOR SEEING THE DOCTOR:_____

_____

Have you been treated for this before? No☐ Yes☐ When? _____ Doctor? _____

History of present illness (How and when did symptoms begin): _____

_____

Past Medical History

Blood	○ Anemia ○ Lymphoma ○ Leukemia ○ Bleeding Disorder
Circulation	○ Peripheral Vascular Disease ○ DVT ○ Coronary Artery Disease ○ Pulmonary Embolism
Cardiovascular	○ Atrial Fibrillation ○ Congestive Heart Failure ○ Hypertension ○ Heart Attack
Endocrine	○ Diabetes ○ Osteoporosis ○ Hyperthyroidism ○ Hypothyroidism ○ Graves Disease
Gastroenterology	○ Gerd/Reflux ○ Hepatitis ○ Liver Disease ○ Barrett's Esophagus ○ Gastric Ulcers ○ Ulcerative Colitis ○ Diverticulosis
Pulmonary	○ Asthma ○ Emphysema ○ COPD ○ Sleep Apnea
Neurology	○ Dementia ○ Stroke ○ Epilepsy ○ Migraine ○ Bell's Palsy
Psychiatric	○ Anxiety ○ Depression ○ Bipolar Disorder
Urinary	○ Enlarged Prostate ○ Renal / Kidney Failure ○ Kidney Stones ○ Prostate Cancer
Orthopedic	○ Cervical Disc Disease ○ Back Pain
Rheumatology	○ Rheumatoid Arthritis ○ Lupus ○ Hashimotos ○ Sjogren's
Infectious	○ HIV ○ Immunodeficiency
Other:	

Past ENT Medical History

○ Chronic Sinusitis	○ Hearing loss	○ Tinnitus	○ Vertigo
○ Meniere's Disease	○ Sleep Apnea	○ Head/Neck Cancer	○ Thyroid Cancer
○ Hoarseness	○ Frequent Ear Infections	○ Chronic Nasal Congestion	○ Snoring
○ Difficulty Swallowing	○ Chronic Cough	○ Melanoma Face/Head/Neck	○ Recurrent Tonsillitis
○ TMJ	○ Bell's Palsy	○ Chronic Post Nasal Drainage	○ Facial Trauma
○ Epistaxis/Nosebleeds	○ Cholesteatoma	○ Other:_____	

Past Surgical History

○ PE Tubes	○ Adenoidectomy	○ Tonsillectomy	○ Septoplasty
○ Sinus Surgery	○ Thyroidectomy	○ Tympanoplasty	○ Mastoidectomy
○ Cochlear Implant	○ Neck Dissection	○ Vocal Cord Surgery	○ Thyroid Biopsy
○ BAHA	○ Nasal Cautery	○ Repair of Facial Fractures	○ Parotidectomy

○ Any Other Surgical History/Details of Surgeries:_____

_____

Hearing History

Hearing Loss: Right☐ Left☐ None☐

When did you first notice a problem?_____

When do you experience the most trouble hearing?_____

Ringing/Sounds in the ear: Right☐ Left☐ None☐

If yes, please describe? _____

Fullness/Pressure in the ear: Right☐ Left☐ None☐ History of ear infections: Right☐ Left☐ None☐

Dizziness: Yes☐ No☐ Noise Exposure: Military☐ Occupational☐ Recreational☐

Diagnostics Studies/Testing

If you have had any imaging and/or diagnostic studies/testing in the past 3 years, (such as, Ultrasounds, CT scans, Hearing tests, MRI of brain, chest X Rays, etc.) please indicate below:

_____

Specify date/facility here:

_____

Family History

Please indicate if your **immediate** family members (mother, father, or sibling) have had bleeding disorders, hearing loss, thyroid cancer, head and neck cancer, hypertension, heart disease, diabetes, or hyperlipidemia:

Mother:_____

Father:_____

Sibling:_____

Social History

Do you currently smoke? Y___ N___ If no, previously? Y___ N___ Years Smoked:____ Packs/day:____

Is your child exposed to cigarette smoke? Y___ N___ Do you use other tobacco products? Y___ N___

Consume Alcohol? Y___ N___ If yes, drinks per week:_____ Are you currently pregnant? Y___ N___

Have we seen a member of your family? Y___N___ If so, whom?_____

Did a physician refer you to Camellia ENT? Y___N___ If so, whom?_____

Did someone else refer you? Y___N___ If so, whom?_____

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ALLERGY & MEDICATION INFORMATION
(Please print and fill out completely)

DATE:_____

Patient Name: _____ DOB: ____/____/_____

Allergies

Do you have any allergies to medications or other substances (pets, food, etc.)? Y☐ N☐

If yes, please list allergies and reactions (including rash, hives, throat swelling, anaphylaxis, etc.):

Allergy	Reaction

Medications

PLEASE INDICATE YOUR PREFERRED PHARMACY FOR MEDICATIONS:_____

Please list ALL of your current medications, including over the counter medications, supplements, and herbs:

Medication Name	Dose

ACADIANA OTOLARYNGOLOGY HEAD & NECK SURGERY, L.L.C.
FINANCIAL POLICY AGREEMENT AND CONSENT FOR RELEASE OF INFORMATION

Thank you for choosing Acadiana Otolaryngology Head & Neck Surgery, L.L.C. as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is our Financial Policy Agreement and Authorization for Release of Information, which we require that you read and sign before any treatment.

All new patients must complete our "Patient Information Sheet" and "Patient History Sheet" before seeing the doctor.

General Payment Requirements – Unless other arrangements are approved, FULL PAYMENT IS DUE AT THE TIME OF SERVICE. We accept cash, checks, and credit cards. For surgery patients, any pre-operative visit charge and surgery co-payment, based on insurance benefit verification, are due in full at the time of the pre-op visit. If payment in full creates a hardship, ask to speak with the manager to discuss other payment options.

For minors, the adult accompanying a minor is responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied, unless there is payment by cash or check at time of service, or insurance coverage has been verified. In such cases, any applicable coinsurance or co-payment must be paid in full.

If for some reason your out-of-pocket payment was too much, we will refund the overpayment to you where that amount is in excess of $3.00.

Assignment or Benefits and Rights - If you have health and accident insurance coverage, including worker's compensation benefits, automobile insurance or Medicare, your signature on this document evidences your agreement to irrevocably assign and transfer all right, title and interest in any benefits payable under such programs to Acadiana Otolaryngology Head & Neck Surgery, L.L.C. You agree to authorize and direct that any such payments be made directly to Acadiana Otolaryngology Head & Neck Surgery, L.L.C. You further agree to irrevocably assign and transfer to Acadiana Otolaryngology Head & Neck Surgery, L.L.C any and all of your rights to pursue administrative appeals of denials of claims for benefits and to assert legal claims or causes of action that may arise against your insurer or health plan for the wrongful denial of claims for benefits. This transfer and assignment shall be for the sole purpose of granting Acadiana Otolaryngology Head & Neck Surgery, L.L.C the independent right of recovery against your insurer or health plan, but shall not be construed as creating an obligation to exercise such rights.

Regarding Insurance - This office will file on your behalf insurance claims for major in-office diagnostic and surgery procedures upon receipt of necessary insurance information. This is a service that we provide, but please remember that you may be ultimately responsible for payment if your insurer or health plan does not pay in full.

Our practice is committed to providing the best treatment possible for our patients and we charge what is usual and customary for our area. You may be responsible for payment of the difference between the insurer's determination of what we should be paid and our billed charges.

We participate in several managed care plans. If you are enrolled in a managed care plan, you agree to cooperate and comply with all pre-certification or pre-authorization, benefit verification or other requirements.

We make an effort to understand the covered services under your plan. We also comply with insurance company pre-certification and insurance verification, however this does not guarantee payment. If your insurance company denies payment of services provided or does not pay for all services billed, you may be responsible for the balance.

Payment arrangements on outstanding balances will be expected. For balances greater than $100, you will be expected to pay the outstanding balance in equal installments over a three month period. Balances under $100must be paid in full upon request.

Past Due Accounts – Open accounts with no acceptable* payment activity for 60 days will be considered past due. A billing charge may be assessed to the account balance along with a finance charge of 1.5% per month. You may be responsible for the original past due balance along with these additional charges.

Collections – Open accounts with no acceptable* payment activity for 120 days may be automatically placed with our collection agency. If this action becomes necessary, you will be responsible for payment of the original balance plus any billing charges, finance charges, collection fees, and attorney fees and expenses incurred in collecting amounts owed.

(*Acceptable payment on an account will be determined on an individual basis. Please contact the Manager if you intend to make payments on your account to avoid any misunderstandings.)

Thank you for understanding our financial policy. Please let us know if you have any questions or concern.
Both State and Federal law require your physician to disclose his/her ownership or financial interest in any healthcare facility or entity to which you are referred as a patient. David Foreman, M.D. has an interest in Lafayette Surgical Specialty Hospital, L.L.C. and James White, M.D. has an interest in Park Place Surgical Hospital We will provide this information to you upon request and suggest that you speak with your physician directly.

CONSENT TO RELEASE INFORMATION AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I authorize Acadiana Otolaryngology Head & Neck Surgery, L.L.C to release medical information and supporting documentation contained in my medical records maintained in this office to any entity that may be financially responsible for payment of expenses related to my treatment, including my insurer, health plan, Medicare, Medicare carriers, the Health Care Financing Administration and any external professional review organization acting on their behalf, for the purpose of administering benefits under such plans. If my treatment is work-related, I authorize Acadiana Otolaryngology Head & Neck Surgery, L.L.C to release medical information regarding such treatment to my employer and/or its designee. I authorize Acadiana Otolaryngology Head & Neck Surgery, L.L.C to. release medical records to the applicable above-listed entities that may require medical record review pursuant to a quality improvement program. I hereby consent to Acadiana Otolaryngology Head & Neck Surgery; L.L.C. using any of my protected health information for any treatment, payment, or healthcare operation activity, as described in their Notice of Privacy Practices, a copy of which I acknowledge having access to today.

This authorization specifically includes the release of medical information concerning substance use or abuse, nervous and mental disorders and infectious diseases.

I authorize Acadiana Otolaryngology Head & Neck Surgery, L.L.C to release medical records and reports to any health care provider participating in the care rendered by Acadiana Otolaryngology Head & Neck Surgery, L.L.C, including but not limited to referring physicians, hospitals, ambulance services or home health providers. I also authorize any other physician, laboratory, hospital, or other provider to release to Acadiana Otolaryngology Head & Neck Surgery, L.L.C all medical records, reports and X-rays necessary for my care.

I CERTIFY THAT I HAVE READ THE FOREGOING FINANCIAL POLICY AGREEMENT AND CONSENT TO RELEASE INFORMATION AND THAT I UNDERSTAND THE PROVISIONS THEREIN. I ALSO ACKNOWLEDGE THAT ACADIANA OTOLARYNGOLOGY HEAD & NECK SURGERY, L.L.C.'S NOTICE OF PRIVACY PRACTICES WE MADE ACCESSIBLE TO ME.

_____ _____

Name of Patient (Please print) **Date**

_____ _____

Signature of Responsible Party **Witness**

_____

Relationship to Patient

Release of Information Questionnaire:
May we inform family members about your treatment general medical condition, diagnosis, healthcare operations and/or your payments: Yes_____ No_____
If you want to limit this information to only specific members please list whom we can release information to:
_____

Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, or other health care information if other than your home phone number: ( ) _____

Can confidential messages be left on your telephone answering machine? Yes_____ No_____