Lisa B. David, M.D.
Brytton B. Eldredge, M.D.
Lizabeth F. Clarke, M.D.
OTOLARYNGOLOGY
HEAD & NECK SURGERY

Dear Patient,

Thank you for choosing David & Eldredge ENT Specialists for your ENT care. Our specialists are dedicated to providing your family with the highest standard of care for your ear, nose and throat health along with allergy/immunology, hearing/balance and sleep disorders.

Please bring the following items to your first appointment:

1. Your completed new patient packet, which is attached.
2. Your insurance cards and ID.
3. Complete medication list.

We look forward to having you as part of our practice. Please contact our office if you have any questions or concerns.

Welcome!

From the Staff and Physicians of David & Eldredge ENT Specialists

Lisa B. David, M.D.
Brytton B. Eldredge, M.D.
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OTOLARYNGOLOGY
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Patient Information

Patient

Last _____ First _____ MI _____

Maiden Name _____ Preferred Name _____

Mailing Address _____ City/Zip _____

D.O.B _____ SS # _____ Sex: ☐ Male ☐ Female Email _____

Hm. Ph. _____ Cell Ph. _____ Wk. ph. _____

PATIENT CONSENT FOR AUTOMATED APPT. REMINDER SYSTEM, BEST PHONE NUMBER: ☐ HOME ☐ CELL ☐ WORK

Employer _____ How did you hear about us? _____

Emergency Contact _____ Relation _____ Phone # _____

PRIMARY CARE PHYSICIAN _____

PHARMACY _____ LOCATION/PHONE # _____

Marital Status:

☐ Unknown
☐ Married
☐ Single
☐ Divorced
☐ Separated
☐ Widowed
☐ Partner

Ethnicity:

☐ Central American
☐ Cuban
☐ Dominican
☐ Hispanic or Latino/Spanish
☐ Latin American or Latin/Latino
☐ Mexican
☐ Not Hispanic or Latino
☐ Puerto Rican
☐ South American
☐ Spaniard

Race:

☐ American Indian
☐ Asian
☐ Asian Indian
☐ African American or Black
☐ European
☐ Filipino
☐ Japanese
☐ Korean
☐ Native Hawaiian or other Pacific Islander
☐ White

Reminder System:

Text: ☐ Yes ☐ No
Email: ☐ Yes ☐ No

SPOUSE/PARENT information

Husband/Father _____ Wife/Mother _____

Address _____ Address _____

City/Zip _____ City/Zip _____

Cell # _____ Cell # _____

Wk # _____ Wk # _____

Employer _____ Employer _____

Primary Insurance

Insurance Co. _____

Patient Relationship to insured _____

Policy Holder Name _____

DOB _____

SS# _____

Employer _____

ID # _____

Group # _____

Secondary Insurance

Insurance Co. _____

Patient Relationship to insured _____

Policy Holder Name _____

DOB# _____

SS# _____

Employer _____

ID # _____

Group# _____

I hereby authorize David and Eldredge ENT Specialists to furnish information to insurance carriers (and doctor's offices) concerning my illness and treatments. This Signature also authorizes you to give me reasonable and proper care by today's standards. I understand that I am responsible for all fees, regardless of my insurance coverage. In order to expedite insurance company payments, the necessary forms will be completed by this office. It is customary to pay for services when rendered unless other arrangements have been made in advance. I will also be responsible for any legal or other costs incurred in the collection of this account. Note: your health information will be kept confidential.

_____ _____

Patient's or Guardian's Signature **Date**

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Financial Agreement

Thank you for choosing David & Eldredge ENT Specialists as your otolaryngology health care providers. We are committed to caring for you and making your treatment successful.

Please be aware that payment for services is due at the time of service, unless other arrangements have been made and approved. This includes copays, allowables, and deductibles stipulated in your insurance policy for our participating insurance companies. We accept the following forms of payment: cash, check, credit card, or money order.

For minors, the adult accompanying the minor is responsible for full payment. Unaccompanied minors are responsible for payment in full. If a minor is accompanied by anyone other than the parent or legal guardian, a written release is required. In emergency situations, phone consent from the parent or guardian will be attempted.

I understand that it is my responsibility to know my insurance benefits and those services that are deemed non-medically necessary, or non-covered, will be my responsibility.

I understand that I must provide all insurance cards at each visit. If David & Eldredge ENT Specialists is a participating provider with your insurance plan, we will submit a claim on your behalf to your insurance carrier with benefits assigned to our practice. Unless you provide a current insurance card, you will be responsible for payment charges.

I agree should my claim be denied or remain unpaid for a period exceeding 60 days, I will assume full responsibility for payment. If the account is turned over for collection, I agree to pay all fees associated with collecting unpaid balances.

Policies and Procedures

All new patients must complete the required patient forms prior to their appointment.

If you are unable to keep a scheduled appointment, please call no later than 24 hours in advance. We reserve the right to charge $40 for missed appointments that have not been cancelled in advance. We document missed appointments and excessive abuse may result in discharge from the practice. Arriving more than 15 minutes late for an appointment will result in being rescheduled.

All calls will be triaged by the call nurse and returned within 24-48 hours.

Forms: Please allow up to 72 business hours for all forms to be filled out. Our staff will call when they are ready. There will be a $15 charge for the first page and $5 charge for every page after, for each set of forms.

Refills: The quickest way to get your medications refilled is to call your pharmacy and ask them to fax us a refill request. Certain conditions may require a follow-up appointment before your doctor will issue a refill.

Please bring an updated, detailed list of your medications to all appointments.

Please be aware of the physicians' affiliation with certain surgical facilities. Lisa B. David is a shareholder of Lafayette Surgical Specialty Hospital and Brytton B. Eldredge is a shareholder of Park Place Surgery Center. You have the right to choose the provider of your health care services. Therefore, you have the option to use a facility other than the above-mentioned hospitals.

Please indicate that you understand this financial agreement and policy and procedures.

Signature: _____ Date: _____

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Consent to Release Information

I authorize Dr. Lisa B. David, Dr. Brytton B. Eldredge and Dr. Lizabeth F. Clarke (D&E) to release medical records to any health care providers participating in my medical care including but not limited to primary care physicians, referring physicians, hospitals, extended care/rehabilitation facilities, home health agencies, and ambulance services.

I also authorize Dr. Lisa B. David, Dr. Brytton B. Eldredge, and Dr. Lizabeth F. Clarke to release information regarding my medical health to the following people listed below.

This authorization also authorizes any other physician, hospital, laboratory, imaging center, pharmacy or other health care providers to release to Dr. Lisa B. David, Dr. Brytton B. Eldredge and Dr. Lizabeth F. Clarke all medical records including but not limited to history and physical examination, progress notes, laboratory reports, imaging studies, audiograms, VNG/ENG reports, tympanograms, allergy tests, vial preparation information, immunotherapy schedules, and any other information contained within my medical record.

(Initial) _____ I authorize D&E to download my medication history automatically from Pharmacys' benefit managers.

Please indicate your agreement with this policy by signing below:

Patient Name: _____ DOB: _____

Signature: _____ Date: _____

Release health care information to the following persons:

List name and relationship to patient:

_____

_____

_____

_____

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

For office use only:

Patient Name: _____

Patient Number: _____

By signing this form, you acknowledge that David & Eldredge ENT Specialists has given you a copy of its Privacy Notice, which explains how your health information will be handled in various situations. We must try to have you sign this form on your first date of service with us after April 14, 2003.

If your first date of service with us was due to an emergency, we must try to give you this notice and get your signature acknowledging receipt of this notice as soon as we can after the emergency.

Check all that are true:

☐ I have received David & Eldredge ENT Specialists' Privacy Notice

☐ David & Eldredge ENT Specialists has given me the chance to discuss my concerns and questions about the privacy of my health information.

_____ _____

Patient's Signature Date

_____

Patient's Name (please print)

David & Eldredge ENT Specialists' staff should complete if Acknowledgement Form is not signed:

1. Does patient have a copy of the Privacy Notice? ☐Yes ☐ No
2. Please explain why the patient was unable to sign an acknowledgement form and David & Eldredge ENT Specialists' efforts in trying to obtain the patient's signature:

_____

_____

_____

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Consent for Treatment of a Minor

Patient Name: _____ DOB: _____ Date: _____

I, _____, authorize the individual(s) listed below to bring my child
(name of parent or legal guardian – please print)

_____, into the office of David & Eldredge ENT Specialists to receive medical care.
(name of child – please print)

I realize I am granting these individuals the authorization to make medical decisions, excluding authorization for surgery, on my behalf. This authorization is good for a period of 1 (one) year from the date on this form or until a written revocation is issued to our office by a parent or a legal guardian.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Please be aware that anyone not listed above (besides the parent or legal guardian who must have documentation to prove legal guardianship) does not have the authority to bring in the above-mentioned patient.

Signature: _____ Date: _____

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Patient Information (Please Print)

Patient

Name _____ Date of Birth _____
First MI Last

Primary Care Physician: _____ Cardiologist: _____

PHARMACY: _____ LOCATION/PHONE: _____

MEDICAL HISTORY:

Are you allergic to any medication? ☐ Yes ☐ No

Please list: _____

_____

List medications you are currently taking (include blood thinners, ibuprofen, aspirin and/or OTC meds): _____

_____

_____

PAST SURGICAL HISTORY:

Have you had any surgical procedures? ☐ Yes ☐ No

Please list: _____

_____

Have you had any anesthesia complications/concerns: ☐ Yes ☐ No

If yes, please explain: _____

_____

Are you Pregnant? ☐ Yes ☐ No How many months? _____ Breast Feeding? ☐ Yes ☐ No

Daycare: ☐ Yes ☐ No Immunizations up to date: ☐ Yes ☐ No

SOCIAL HISTORY: DO YOU…

Exercise Regularly: ☐ Yes ☐ No

Use Herbal Products/Medications Please list: _____

Use Alcohol: ☐ Yes ☐ No

Beer/Wine/Liquor

How often: _____

Use Tobacco: ☐ Yes ☐ No

Cigarettes/Cigars/Pipe/Snuff/Chew Tobacco

How often: _____

PATIENT MEDICAL HISTORY: Have you ever had or still have (check for yes):

- ☐ Acid Reflux (GERD)
- ☐ AIDS/HIV related illness
- ☐ Alcoholism
- ☐ Allergy Problems/Sneezing/Itchy Eyes
- ☐ Anemia/Sickle Cell
- ☐ Arthritis
- ☐ Asthma
- ☐ Birth Defects
- ☐ Bleeding Disorder
- ☐ Cancer
- ☐ Circulation Problems/Stroke/Paralysis
- ☐ Development Delay
- ☐ Diabetes
- ☐ Dizziness/Disequilibrium
- ☐ Ear Pain/Pressure/Drainage
- ☐ Epilepsy/Convulsions
- ☐ Eye Pain/Drainage
- ☐ Glaucoma
- ☐ Gout
- ☐ Headaches/Migraines
- ☐ Hearing Loss/ Ringing in Ears
- ☐ Heart Conditions
- ☐ Hoarseness/Sore Throat
- ☐ Hypertension
- ☐ Immune System Disorder
- ☐ Kidney/Bladder Disease
- ☐ Liver Problems/ Jaundice
- ☐ Lung Disease
- ☐ Mental Illness
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Sinus/Nasal Congestion/ Obstruction
- ☐ Skin Problems
- ☐ Skin Rash/Hives
- ☐ Sleep Disorder
- ☐ Speech Delay
- ☐ Stomach, Intestine/ Bowel disorder
- ☐ T.B.
- ☐ Throat Swelling/Fullness
- ☐ Thyroid Problems
- ☐ Venereal Disease
- ☐ Weight Loss/Night Sweats

FAMILY HISTORY: Have any blood relatives had (please indicate which relative):

- ☐ Heart Disease _____
- ☐ Glaucoma _____
- ☐ Epilepsy _____
- ☐ Bleeding Problems _____
- ☐ Thyroid Problems _____
- ☐ Cancer _____
- ☐ High Blood Pressure _____
- ☐ Diabetes _____
- ☐ TB _____
- ☐ Stroke _____
- ☐ Asthma _____
- ☐ Other _____

Signature: _____ Date: _____

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Review of Symptoms

Name _____

DOB _____ Date _____

Review of Symptoms:
Please check any of the following symptoms that you have had in the PAST or CURRENTLY have related to your visit.

Symptoms	Current	Past	No	Symptoms	Current	Past	No
Fever	☐	☐	☐	Palpitations	☐	☐	☐
Weight Loss	☐	☐	☐	Chest Pain	☐	☐	☐
Night Sweats	☐	☐	☐	Shortness of Breath	☐	☐	☐
Eye Pain	☐	☐	☐	Coughing	☐	☐	☐
Eye Drainage	☐	☐	☐	Constipation	☐	☐	☐
Itchy Eyes	☐	☐	☐	Diarrhea	☐	☐	☐
Blurred or Double Vision	☐	☐	☐	Heartburn	☐	☐	☐
Ear Pain	☐	☐	☐	Painful Urination	☐	☐	☐
Ear Drainage	☐	☐	☐	Frequent Urination	☐	☐	☐
Decreased Hearing	☐	☐	☐	Muscle/Joint Aches	☐	☐	☐
Ringing in Ears	☐	☐	☐	Skin Rashes or Hives	☐	☐	☐
Dizziness or Disequilibrium	☐	☐	☐	Headaches	☐	☐	☐
Nasal Congestion/Obstruction	☐	☐	☐	Learning Disorder	☐	☐	☐
Sneezing	☐	☐	☐	Speech Delay	☐	☐	☐
Throat Swelling/Fullness	☐	☐	☐	Mental Health Problems	☐	☐	☐
Sore Throat	☐	☐	☐	Thyroid Condition	☐	☐	☐
Hoarseness	☐	☐	☐	Bleeding Problems	☐	☐	☐

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health records and other Protected Health Information ("PHI") used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential.

OUR LEGAL DUTY: We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice currently in effect was updated on 03/26/13 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the Company Contact information listed at the end of the Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION: Without specific written authorization, we are permitted to use and disclose your health care records for the purpose of TREATMENT, PAYMENT, HEALTH CARE OPERATIONS, and OTHER REASONS REQUIRED BY LAW.

TREATMENT: This means providing, coordinating, or managing health care and related services by one or more health care providers/physicians. For example, if your specialist asks your primary care doctor to share PHI related to any physical exams or diagnostic procedures done.

PAYMENT: This means such activities as obtaining reimbursement for services, confirming coverage, billing, or collection activities, and utilization review. An example of this would be billing your insurance company or Medicare for services rendered.

HEALTH CARE OPERATIONS: This is the business aspect of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service. An example of this would be a periodic quality review/assessment of our documentation protocol, etc.

PUBLIC HEALTH, ABUSE or NEGLECT, HEALTH OVERSIGHT, and OTHER REASONS REQUIRED BY LAW: We will use and disclose your PHI when we are required to do so by federal, state or local laws. We may disclose your PHI to public health authorities that are authorized by law to collect information, or to a health oversight agency for activities including but not limited to: response to a court order or administrative order; if you are involved in a lawsuit or similar proceeding; and response to a discovery request, subpoena, or other lawful process by another party involved in the dispute-- but only if we made an effort to inform you of the request or obtain an order protecting the information the party has requested. We may release your PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death or if you are an organ donor. We may release your PHI to the tumor registry. We may use and disclose PHI when necessary to reduce or prevent a serious threat to the health and safety of you, another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your PHI if you are a member of the U.S. or foreign military (including veterans) when required for appropriate intelligence or national security activities authorized by law. We may disclose to authorized federal official's health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary for the institution to provide health care services to you, for the safety and security of the institution, and to protect your health and safety or that of other individuals or the public. We may release your PHI for worker's compensation and similar programs.

In addition, your confidential information may be used to remind you of an appointment (electronically, by mail, letters, voicemail messages, or postcards) or provide you with information about treatment options or other health related services including release of information to friends or family members that are directly involved in your care or assist in taking care of you.

PATIENT RIGHTS

AUTHORIZATION: Any uses or disclosures of your PHI not addressed above may only be made with your authorization. You may revoke such authorization in writing and we are required to honor and abide that written request, except to the extent that we have already taken actions relying on your authorization.

ACCESS: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to your physician to obtain access to your health information. We will charge you a reasonable cost-based fee for expenses such as copies, electronic media storage, and staff time.

RESTRICTIONS: The following uses and disclosures will be made only with your authorization: (i) most uses and disclosures of psychotherapy notes; (ii) uses and disclosures of PHI for fundraising or marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this NPP.

ADDITIONAL RESTRICTIONS: You have the right to request additional restrictions on our use or disclosure of your health information. This must be made in writing and must identify: (i) the information to be restricted; (ii) the type of restriction being requested (i.e., on the use of information, the disclosure of information, or both); and (iii) to whom the limits should apply. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

RESTRICTING DISCLOSURE TO YOUR INSURANCE COMPANY: We must comply with your restriction request if you have paid for your services out-of-pocket, in full, and you are requesting that we not disclose your PHI related solely to those services to your health plan. This request must be made in writing prior to or on the date of the service to allow our office to provide you with the information on your out-of-pocket cost, collect necessary fees for service, obtain a signature of this request, and avoid filing to your insurance.

DISCLOSURES OF ACCOUNTING: You have the right to receive a list of instances in which we, or our business associates, disclosed your health information for purposes other than treatment, payment, health care operations and other reasons required by law herein, for the last six years. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

ALTERNATIVE COMMUNICATION: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. Your request must be in writing and specify the alternative means or location and provide satisfactory explanation about how payments will be handled under the alternative means or location you request.

AMENDMENT: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

ELECTRONIC NOTICE: If you receive this Notice on our Website, you are entitled to receive this Notice in written form.

BREACH: We are required to notify you if there is a breach and/or unauthorized use of your PHI.

QUESTIONS AND COMPLAINTS: If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information, you may contact the person below. You may also submit a written complaint to the U.S. Department of Health & Human Services. We support your rights to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health & Human Services.

CONTACTS:

Company's Contact:
Billie Rabalais-Touchet
109 Rue Fontaine
Lafayette, LA 70508
PHONE: 337-266-9820
FAX: 337-266-9822

Government Contact:
U.S. Dept. of Health & Human Services
Office of Civil Rights
200 Independence Ave. S.W.
Washington, D.C. 20201
Toll Free 877-696-6775

Revised on 01/01/2018