Le Visage ENT & Facial Plastic Surgery, LLC

6410 Rockledge Drive #650~Bethesda, Maryland 20817

301-897-5858 301-897-5860 (fax) **ID # _____**

PATIENT INFORMATION

NEW PATIENT_____ RETURNING PATIENT_____ INFORMATION CHANGES_____

Name (First, M.Last) _____Nickname_____

Date of Birth: _____ Age_____ Marital Status: _____ Sex: Male/ Female _____

Address: _____

City, State, Zip_____

Social Security #: _____

Phone: _____Work #: _____

Other #: _____ Fax#: _____

Email Address: _____

Emergency Contact: _____ Relationship: _____

Phone: _____

Employer & Employer Address: _____

Occupation: _____

Preferred Pharmacy: _____

Referring Doctor: _____ Telephone: _____

Primary care Doctor: _____ Telephone: _____

How did you hear about us? _____

INSURANCE INFORMATION **ID#_____**

***PRIMARY** INSURANCE: _____

MEMBER ID #: _____ GROUP# _____

NAME OF GROUP_____POLICYHOLDER_____

INSURANCE COMPANY TELEPHONE #_____

***SECONDARY** INSURANCE: _____

MEMBER ID #: _____ GROUP#_____

NAME OF GROUP_____POLICYHOLDER_____

INSURANCE COMPANY TELEPHONE# _____

IS ANY OTHER POLICY IN EFFECT? YES NO IS THIS A LEGAL CASE? YES NO

IS THIS WORKER'S COMPENSATION CASE? YES NO DATE OF INJURY_____

SUBSCRIBER INFORMATION:
(This Section only needs to be completed if the Insurance is in another Name)

Name: _____ Relationship to patient: _____
Date of Birth: _____ Social Security: _____
Address: _____
Home Phone #: _____ Work Phone #: _____

Emergency Contact: _____ Phone#: _____

SELF PAY:
PERSON RESPONSIBLE FOR PAYING FORTHIS VISIT_____

CASH_____CHECK_____VISA/MC_____AMEX_____

I UNDERSTAND AND AGREE THAT, REGARDLESS OF WHO PAYS ON MY BEHALF, I AM ULTIMATELY RESPONSIBLE FOR ANY FEES RELATED TO RETURNED CHECKS AND FINAL PAYMENT FOR SERVICE RENDERED TO ME.

_____ _____

Signature **Date**

Name: _____ID#_____

Date: _____ Date of Birth: _____ Age: _____

What concerns brought you in today? _____

Please list any MEDICATION ALLERGIES: _____
Do you have a LATEX ALLERGY? □no □yes
Is there a possibility of PREGNANCY? □no □yes
Please list all other ALLERGIES: _____

Past Medical History:
Please check if you have any of the following. If so please explain.
□ Hypertension (High Blood Pressure) _____
□ Diabetes _____
□ Thyroid Disorder_____
□ Heart Disease_____
□ Respiratory Problems (asthma, COPD, bronchitis) _____
□ GI Problems (ulcers, reflux, heartburn, colitis) _____
□ Kidney disorders _____
□ Brain /Nervous system disorders_____
□ Other medical problems_____

Surgery History: List all major and minor surgery, and dates if known:

_____
Medications: List all medications prescription and nonprescription and how much you take daily (include herbal supplements and vitamins) _____

Social History:
Occupation: _____
Have you recently been out of the country? □yes □no
Please give specifics_____
Do you drink alcohol? □ No □Yes How often do you drink alcohol and how much?

_____
Do you smoke? □ No □ Yes if yes how much and for how long have you smoked:

_____
If No, have you smoked in the past □ No □ Yes Provide details:

_____

Do you use any recreational drugs? □ No □Yes provide details _____
Do you have or are you around pets? □ No □ Yes _____

Family History: Please check the box if you have had any relatives with these medical conditions if yes put down which relative:
□Hearing problems_____
□Allergies_____ □Anesthesia problems _____

□Diabetes_____ □Bleeding Disorders_____
□ Cancer_____ □Heart problems _____

Review of Systems: **ID# _____**

Please check yes or no to indicate whether you CURRENTLY have any of these symptoms:

Ear, Nose and Throat			Eyes	
Yes	No		Yes	No
□	□	Hearing loss	□	□ Pain
□	□	Dizziness	□	□ Blurred Vision
□	□	Ringing Noise in Ears	□	□ Dry
□	□	Nasal congestion	**Psychological**	
□	□	Problems with sense of smell	□	□ Depression
□	□	Throat clearing	□	□ Mental Health Disorder
□	□	Sense of lump in throat	Skin	
□	□	Hoarseness	□	□ Rash
□	□	Facial Pain/pressure	□	□ Itching
□	□	Snoring/stop breathing at night	□	□ bleeding areas
□	□	Dry Mouth		
Allergy			□	□ Color changes of moles
□	□	Environmental	□	□ Hair changes
□	□	Postnasal drip	**Neurological**	
□	□	Itchy nose	□	□ Headache
□	□	Sneezing	□	□ Facial weakness
Respiratory			□	□ Facial or ear numbness
			□	□ Weakness of arms/legs
□	□	Cough	**General**	
□	□	Wheezing	□	□ Fever
□	□	Coughing up blood	□	□ Chills
□	□	Shortness of Breath	□	□ Weight loss or gain
Gastrointestinal			□	□ Night sweats
□	□	Difficulty swallowing	□	□ Sleepy during the day
□	□	Indigestion	**Urinary**	
□	□	Vomiting blood	□	□ Frequent or Painful Urination
□	□	Painful Swallowing	□	□ Kidney Stones
Enodocrine			Cardiac	
Yes	No		Yes	No
□	□	Feel Cold Most of the time	□	□ Chest Pain
□	□	Feel Warm Most of the time	□	□ Palpitations
□	□	Blood and Lymphatic's	□	□ Pacemaker
□	□	Swollen Glands		
□	□	Bleeding Problems		
□	□	Easy Bruising		

Please do not write below this line (office use only)

Vitals: BP _____ P _____ R _____ T _____ Weight: _____

Reviewed by: _____

DISCLOSURE TO FAMILY/FRIENDS **ID# _____**

_____ I authorize Le Visage Ear, Nose & Throat and Facial Plastic Surgery to disclose Information related to my care and treatment to the following individual(s).

_____ I do not authorize Le Visage ENT & Facial Plastic Surgery, LLC, to disclose any information concerning my care or treatment by Provider to individuals without my express written consent or legal authorization.

_____Relationship_____
Name
_____Relationship_____
Name
_____Relationship_____
Name

The authorizations provided for above are subject to the following limitations or restrictions:

_____

_____

_____

_____
Patient Name (Printed)

_____ _____
Signature of Patient (or legal responsible individual) Date

_____ _____
Witness Date

MEDICAL RELEASE AUTHORIZATION, FINANCIAL RESPONSIBILTIY AND INSURANCE ASSIGNMENT

ID# _____

I, _____ hereby authorize **Le Visage ENT & Facial Plastic Surgery** to apply for benefits on my behalf for covered services rendered. I request payment from my insurance company be made to the above named provider.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered, and that my insurance coverage is a contract between me and the insurance carrier, and not between the insurance carrier and **Le Visage ENT & Facial Plastic Surgery** and that I am ultimately responsible for all fees incurred. Any expenses incurred by such action shall become an additional liability for which I assume responsibility.

If applicable, I request that payment of authorized Medicare benefits be made to **Le Visage ENT & Facial Plastic Surgery** for any services rendered. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information, to my insurance company, or its agent, in order to determine insurance benefits to which I may be entitled. This authorizes **Le Visage ENT & Facial Plastic Surgery** to release and/or send medical information regarding my case to other consulting and/or referring physicians.

Due to our contractual agreement with your insurance company we require payment be made for all Co- pays, Coinsurances and Deductibles prior to your visit unless other arrangements have been made prior to services being rendered.

Our financial policy

ID#_____

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

1. Payment is due at the time of service unless arrangements have been made in advance by your carrier. We accept MasterCard, Visa and American Express

2. Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor—in other words, if you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.

3. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them, and you are required to pay a co-payment at the time of your visit.

4. Not all insurance plans cover all services. In the event your insurance plan determines a service to be “not covered,” you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

5. If you are insured by a plan that we do not have a prior arrangement with, we will prepare and send the claim for you on an unassigned basis. This means the insurer will send the payment directly to you. Therefore, our charges for your care are due at the time of service.

6. We will bill your insurance company for all services provided in the hospital. You are responsible for any balance due.

I have read and understand the practice’s financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

_____

Signature of patient (or responsible party, if minor) Date

_____

Please print the name of the patient

Le Visage ENT & Facial Plastic, LLC

NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY
.
Le Visage ENT & Facial Plastic, LLC is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information
Treatment we may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. (example)

"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with **Le Visage ENT & Facial Plastic, LLC.**

""It is our policy to provide a substitute health care provider, authorized by **Le Visage ENT & Facial Plastic, LLC** *to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."*

Payment
We may disclose your health information to your insurance provider for the purpose of payment or health care operations. (example)

"*As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to* **Le Visage ENT & Facial Plastic, LLC** *for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an Itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received."*

Workers' Compensation
We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Law Enforcement.
We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons.
We may disclose your health information to coroners or medical examiners.

Organ Donation.
We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

Research.
We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety.
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies.
We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing.
We may contact you for marketing purposes or fundraising purposes, as described below: (example)
"As a courtesy to our patients, it is our policy to call your home on the prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal Health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment." It is our practice to participate in charitable events to raise awareness,food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of Comeau Health Care Associates sponsored fund-raising events."

Change of Ownership.
In the event that **Le Visage ENT & Facial Plastic, LLC** is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, **Le Visage ENT & Facial Plastic, LLC** is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that **Le Visage ENT & Facial Plastic, LLC** amend your protected health information. Please be advised, however, that **Le Visage ENT & Facial Plastic, LLC** is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by **Le Visage ENT & Facial Plastic, LLC**
- You have a right to a paper copy of this Notice of Privacy Practices any time upon request.

Changes to this Notice of Privacy Practices

Le Visage ENT & Facial Plastic, LLC reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Le Visage ENT & Facial Plastic, LLC is required by law to comply with this Notice. Le Visage ENT & Facial Plastic, LLC is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: [Practice Privacy Officer] by calling this office at 978-774-5600. If [Practice

Privacy Officer] is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints

Complaints about your Privacy rights, or how Le Visage ENT & Facial Plastic, LLC has handled your health information should be directed to [Practice Privacy Officer] by calling this office at 301-897-5858 If [Practice Privacy Officer] is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building, Washington, DC 20201

This notice is effective as of _____/_____/_____

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Le Visage ENT & Facial Plastic, LLC Practice with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

_____
Patient's Name (print)

_____ _____
Patient's Signature Date (parent if minor or legal guardian)

_____ _____
Authorized Facility Signature Date

ID# _____