Delaware Otolaryngology Consultants LLC
Medical History Form

Date ____/____/____

*The following information is for use by your healthcare provider as part of your confidential medical record. The following information is also very important to your health.Please take time to fully and accurately fill out this form.

Name:_____ ☐ **Male** ☐ **Female** **Date of Birth**___/____/____

Pharmacy Name and Location:_____**Height**:_____ **Weight**:_____

Mail Order Pharmacy_____ **Ethnicity**_____

Primary Care Physician_____**Ref Physician**_____

Reason for your Visit:

_____

_____

_____

Past Medical History and Review of Systems:☑ Check Box

☐ Ringing in the Ears R or L	☐ Coughing	☐ Seasonal Allergies
☐ Ear Pain R or L	☐ Wheezing	☐ Arthritis
☐ Decreased Hearing	☐ Asthma	☐ Mouth Pain
☐ Sleep Apnea	☐ COPD	☐ Head Injury
☐ Snoring	☐ Blood Clots/Disorder	☐ Gout
☐ Itchy Ears R or L	☐ Heart Disease	☐ Dizziness/Vertigo
☐ Sore Throat	☐ Stroke	☐ Hepatitis A B C D E
☐ Voice Changes	☐ Pacemaker	☐ Parkinsons
☐ Difficulty Swallowing	☐ High Blood Pressure	☐ Multiple Sclerosis
☐ Acid Reflux/Heartburn	☐ Anxiety/Depression	☐ Loss of Taste
☐ Vomiting/Nausea	☐ Diabetes	☐ Loss of Smell
☐ Headache/Migraine	☐ HIV or AIDS	
☐ Thyroid Hypo or Hyper	☐ Pregnant Due:_____/_____/_____	
☐ Nose Bleeds	☐ Cancer Type and Date :_____	

If need be please explain problems further or if not listed add:

_____

_____

_____

Do you?

Tobacco	**Drink Alcohol**	**Caffeinated Drinks**
☐**No** ☐**Yes** ☐**Past**	☐**No** ☐ **Yes**	☐**No** ☐ **Yes**
How Much or When did you Quit?	**How Much/Often?**	**How Much/Often?**

Are you Allergic to any Medications or Latex? ☐ **No Known Drug Allergies** ☐**Yes (please explain)**

_____

_____

Please List All Medications You Take: ☐ **None**
Include over the counter medicine and vitamins

Drug Name and Dosage

1._____ 2._____

3._____ 4._____

5._____ 6._____

7._____ 8._____

9._____ 10._____

11._____ 12._____

Surgical History ☐ **None**

Year	Operation/Procedure	Year	Operation/Procedure

Have you recently had any lab work or imaging done? ☐ Yes ☐ No
If yes when and what for

_____

_____

*The above is true and correct to the best of my belief.

Patient/Guardian Signature:_____ **Date** _____/_____/_____

Delaware Otolaryngology Consultants LLC
Beth Duncan MD, MBA-HC
17316 Coastal Hwy Lewes De 19958
Office: 302-644-2232 Fax: 302-644-2237

Patient Name: _____ DOB:____/____/____

Patient Address: _____ City:_____ State:_____ Zip:_____

Insurance Name and ID #: _____

I hereby instruct and direct any insurance carrier that is providing insurance benefits on my behalf under any policy of insurance to make out a check to and directly pay Dr. Beth Duncan for professional services rendered to me. This includes a direct assignment of my rights and benefits under any such policy of insurance.

This assignment of insurance benefits is provided so that Dr. Beth Duncan may attempt to collect any unpaid and overdue insurance benefits directly from the insurance carrier.I authorize any holder of insurance information about me to release such information to Dr. Beth Duncan needed to determine the insurance benefits or to assist in the collection of payment for services. I authorize Dr. Beth Duncan to contact the insurance company for an exact dollar amount of insurance benefits that are available under any policy of insurance that affords coverage and to obtain any payout or check ledger reflecting insurance benefits that have been paid out on my behalf.

A copy of this agreement will be as valid as the original. I have read and understand this agreement thoroughly.

I also realize that there is a possibility that my insurance company may not pay for certain services rendered by Delaware Otolaryngology Consultants LLC. Delaware Otolaryngology Consultants LLC does not promise or guarantee that all services rendered to me will be paid by my insurance company. I agree to pay for all charges for services rendered to me if my insurance company denies payment.

Dated at ____:____ this ____day of _____ 20___
(Time) (Day) (Month)

_____ _____
Signature of Policyholder **Witness**

Please List Below any Emergency Contacts that you wish to be contacted in case of an Emergency.

Name:_____Relationship:_____Phone#:_____
Name:_____Relationship:_____Phone#:_____
Name:_____Relationship:_____Phone#:_____

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Acknowledgement of Receipt of Notice of Privacy Practices

Your name and signature on this sheet indicate that you have been given the opportunity to review and request a copy of the Delaware Otolaryngology Consultants LLC's Notice of Privacy Practices on the date indicated. If you have any questions regarding the information in Delaware Otolaryngology Consultants LLC's Notice of Privacy Practices, please do not hesitate to contact the office manager.

Patient Name: _____

If Patient Representative, Name (Printed):_____

Relationship to Patient: _____

Account # or Medical Record #:_____

Signature:_____

Date Notice Received: ____/____/____

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Financial Policy For Billing and Collection

Payment Policy
Thank you for choosing us as your healthcare provider. We are committed to providing you with quality and affordable healthcare. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

Insurance
We participate in most insurance plans, including Medicare and Medicaid. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do participate with, all insurance information must be given to us at the time of your visit. Claims are submitted within 24hrs of the date of service. If we have the incorrect insurance information you will be responsible for the visit. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Co-payments and Deductibles
All copays and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect copays from patients can be considered fraud. Please help us in upholding the law by paying your copay at each visit.

Non Covered Services
Please be aware that some and perhaps all of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for payment on these services.

Proof of Insurance
All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information at the time of your visit, you could be responsible for that claim.

Claims Submission
We will submit your claims and assist you in any way we reasonably can to help your claims get paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and the insurance company; we are not party to that contract.

Coverage Changes
If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you. It is important that we notify you of non payment so we can get your assistance in getting your claim(s) paid. Several insurance companies have imposed timely filing deadlines that possibly could impact payment on your account. Some deadlines are as early as 60 days from date the services were rendered.

Returned Checks
For all returned checks there will be a $40.00 processing fee (which is the fee we incur from the bank for a returned check) that fee will be added to the amount of the check and will be your responsibility to pay the balance with cash, money order or credit card within 72 hours. From that point on we will not accept a personal check from you.

Insurance Referral
Some insurance companies require a referral from your primary care doctor in order for you to see Dr. Duncan. If you require a referral, it would be written in your contract with your insurance company. Failure to obtain a referral may result in your claim being denied. If the insurance company denies the claim you will be financially responsible for the claim.

Non Payment (Patient)
If your account is over 90 days past due, you will receive a statement stating that you will have 10 days to contact our office and make payment arrangements. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. You will also be responsible for 35% of the past due balance in addition to the unpaid patient portion.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY FOR BILLING AND COLLECTION OF MY OFFICE VISIT;

_____	____/____/____
Patient Name (Print)	Date
_____	_____-_____-_____
Signature	Subscriber's SSN
____/____/____	_____-_____-_____
Patient's DOB	Patient's SSN
_____	____/____/____
Subscriber's Name (if different from patient)	Subscriber's DOB

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HIPAA Consent to Leave a Message

Patient Name:_____ **DOB:**_____

Email:_____

I wish to be called at home☐ cell☐ or other☐(check all that apply) regarding my care and follow up. The best telephone number(s) to reach me are:

Home_____ **Cell**_____

Other_____

I do ☐ , I don't☐ give permission to leave relevant medical information on my answering machine or voicemail.

I do ☐ , I don't ☐ want relevant medical information shared with the person who may answer the telephone. The name(s) of the individual(s) with whom you may leave pertinent information are:

_____ _____

_____ _____

_____ _____

Patient Signature **Date**

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Late Arrivals / Missed Appointment Policy

At Delaware Otolaryngology Consultants, we pride ourselves in offering you personalized care and reserve appointment times to accommodate your needs. Missed/canceled appointments, and late arrivals without sufficient notice create gaps in our providers schedule. These are appointments that could have been utilized to offer care to another patient.

Late Arrivals

If a patient presents to the office late (15mins after) for a scheduled appointment without notice we reserve the right to reschedule.
When a patient arrives late it disrupts the schedules of the providers and other patients.

Allergy Patients

It is your responsibility to make sure you are on the schedule each week for your shots. If you come in and are not on the schedule we may not be able to see you and we may not have serum available for you. You must call us as soon as possible if you are unable to make your apt or you will be subject to a Missed Appointment fee. If you are scheduled for an Allergy Test and you do not come in you will be billed for a Missed Appointment.

Last Minute Cancellations and Missed Appointments

We do require a 24hr notice on all cancellations. As a courtesy to our patients we try to confirm all appointments. We do recognize that situations arise that are out of your control; however it is imperative that you contact our office immediately to notify us of your cancellation in a timely manner. Appointments canceled with less than 24hrs notice or appointments not kept will be subject to a $40 fee. Multiple(3+) missed appointments in any 12 month period may result in termination from our practice. We ask for your consideration and cooperation in scheduling your next appointment. Please understand we are partners in your health care and we are committed to offering you appropriate care when you need it.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____ _____/_____/_____

Printed Name **Date**

_____

Signature

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you may obtain access to this information. Please read it carefully. This notice reflects the privacy practices for Delaware Otolaryngology Consultants LLC, hereto referred to as the practice.

If you have any questions about this notice, please contact the practice at 302-644-2232 or in writing to 17316 Coastal Hwy Lewes, DE 19958.

Who is this Notice intended for?

The Privacy Practices described in this Notice are followed by our team members at the Practice and any affiliated sites, the members of the medical practices who are affiliated with the Practice by contractual agreement, as well as certain other contracted business entities. As an organized health care arrangement, we may jointly use and disclose confidential health information as is necessary for your treatment, for obtaining payment and for carrying out internal operations, such as evaluating the quality of care that you receive. Covered by this Notice are: any health care professional authorized to enter information into your Health Information Management, including members of our medical and consulting staff; all team members working at the Practice and at all departments, units, and any medical centers or affiliated sites; all health care professionals associated with the medical practices who are affiliated with the Practice by contractual agreement; and certain contracted Business Associates who perform health care services on the Practice's behalf.

How does the Practice use or disclose your medical information?

The following categories describe different ways in which we use and disclose medical information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of these categories:

For Treatment We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, clinical students, or other personnel who are involved in taking care of you at the Practice. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process.

For Payment We may disclose medical information about you so that the treatment and services you receive at the Practice may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about surgery you received so your health plan will pay us or reimburse you for the surgery.

For Health Care Operations We may use and disclose medical information as necessary to run the Practice and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may send medical data to other health care organizations and agencies for the purpose of comparing patient data to improve treatment methods. We will remove certain information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are.

For Communications We may contact you for appointment reminders or to tell you about or recommend possible treatment options, alternatives, health-related benefits or services that may be of interest to you. For Delaware Health Information Network (DHIN) We maintain membership with the DHIN, Delaware's first operational statewide Health Information Exchange. The DHIN maintains a safe and secure repository for clinical results, reports, and demographic and billing information that allows member health care providers access to health care information. The DHIN provides a statewide health information network that addresses Delaware's needs for timely, reliable and relevant health care information, and provides information on a strict need-to-know basis. To obtain more information on the numerous benefits including improved care, reduced time in obtaining record information, enhanced privacy, as well as information on opting-out of the program, you may contact the DHIN at www.dhin.org or by calling (302) 678-0220. In addition to the disclosures listed above, we may also disclose medical information about you to disaster relief authorities so that your family can be notified about your condition, status, and location.

What are the circumstances where parts of your medical record may be released without your specific authorization?

Federal, State, or Local Law We will disclose medical information about you when required to do so by federal, state, or local law.

Health and Safety We may use and disclose medical information about you when necessary to prevent a serious threat to your health, your safety, or to the health and safety of the public or another person. **Organ Donation** As a potential organ donor, we may release medical information to an organization that handles organ or tissue transplantation or to an organ donation bank.

Military Member or Veteran If you are a member or veteran of the armed forces, we may release medical information about you as required by military command authorities.

Workers' Compensation We may release medical information about you for Workers' Compensation benefits for any workrelated injuries or illness.

Public Health Authorities We may disclose medical information about you to public health authorities for the purpose of: reporting, preventing or controlling disease or injuries; reporting births and deaths, child abuse or neglect, any reactions to medications or problems with products; notifying people of recalls of products they may be using; notifying people who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; notifying the appropriate government authority if we believe a patient has been the victim of abuse or neglect.

Health Oversight Agencies We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities may include audits, investigations (including Workers' Compensation), inspections, and licensure.

Lawful Needs We may disclose medical information about you in response to a subpoena, discovery request, or other lawful process involved in a dispute; however, only if efforts have been made to tell you about the request or to obtain an order protecting the information requested. We may release medical information if asked to do so by a law enforcement official: in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; or for inquiries about a victim of a crime or criminal conduct that may have involved someone's death.
Coroners, Examiners, or Funeral Directors We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the Practice to funeral directors as necessary to carry out their duties.
Federal Requirements We may release medical information about you to authorized federal officials if required for intelligence, counterintelligence, and other national security activities authorized by law.
Correctional Institutions We may disclose your health information to correctional institutions or to the custody of a law enforcement official if you are an inmate.

Written Permission Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons you have specified. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

What are your Privacy Rights as a patient? You have the following rights regarding medical information that we maintain about you:

You have the right to look at or get a copy of medical information, which we use to make decisions about your care, in most cases, when you submit a written request to the Practice. We will respond to your request between thirty (30) and sixty (60) days unless a shorter time frame is required by law. Should there be the need for a delay that exceeds thirty (30) days, we will provide you with a written notice both explaining the reason for the delay and the expected date by which the request will be completed. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. If we deny your request to inspect and copy your records, which may occur in certain very limited circumstances, you may request that the denial be reviewed by another licensed health care professional chosen by the Practice. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

You have the right to a list of instances where we have disclosed medical information about you, also called an "accounting of disclosures." Typically these accesses of your medical information are made for reasons other than for treatment, payment, and health care operations, and are without your written authorization. To request an accounting of disclosures, you must submit a written request to the Practice. Your request must state a time period that may not exceed seven (7) years from the date of request. Your request should indicate in what form you wish to receive the list, such as on paper or electronically.

You have the right to request that your medical information be communicated to you in a confidential manner, such as sending mail to an address other than your home, by notifying the Practice in writing of the specific way or location for us to use to communicate with you. Your written request must specify how or where you wish to be contacted, and we must consider your request to be reasonable. Please note that we reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response.

Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note: We are required to retain records of your care. Again, if you have any questions regarding this notice or our health information privacy policies, please contact the Privacy Officer.

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have received this notice electronically, you are still entitled to a paper copy of this notice.

What if you feel that your Privacy Rights have been violated in any way? If you are concerned that your privacy rights may have been violated, or you disagree with a decision we made about access to your records, you may file a grievance with the Practice or with the Secretary of the U.S. Department of Health and Human Services at www.hhs.gov. You will not be penalized for filing a complaint.