TrahanENT
AND AESTHETICS
SINUS | ALLERGY | AUDIOLOGY

3935 I-49 South Service Road· Opelousas, LA 70570
Phone (337)594-6002 · Fax(888)491-1354

Today's Date_____

Last Name: _____ First Name: _____ MI: _____

SSN#: _____ Date of Birth: _____ Gender: _____

Billing Address: _____

City: _____ State: _____ Zip Code: _____

Contact Number : _____ Second Contact number: _____

Guardian Name (if minor):_____

Email:_____

Primary Care Doctor:_____ Who referred you here?_____

Reason for visit:_____

Does the patient have a living will/advance directive/LaPost? ☐ YES NO **Religious Preference**_____

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Race ☐ White ☐ Black/African American Hispanic ☐ Other_____
Ethnicity ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Declined **Language** ☐English Other_____

Preferred Pharmacy: _____

Guarantor/Policy Holder Information: please check here if Policy Holder is yourself ( )

Name: _____ Insurance Company: _____

Employer: _____

Emergency Contact:

Name: _____ Phone: _____
Name: _____ Phone: _____

Disclosure Consent

I, _____, hereby authorize Trahan ENT & Aesthetics to provide any medical information pertaining to my health to the following individuals:
Name: _____ Phone: _____ Relationship: _____
Name: _____ Phone: _____ Relationship: _____

Assignment and Release

I, undersigned, certify that I (or my dependent) have insurance coverage with the above insurance company and assign directly to Trahan ENT & Aesthetics all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by my insurance company. I hereby authorization Trahan ENT & Aesthetics to release all information necessary to secure the payment of benefits.

_____ _____
Patient or Guardian Signature ***Date***

*****No Show Policy*****

Our goal is to provide quality individualized medical care in a timely manner. "No-shows" and late cancellations inconvenience those individuals who need access to medical care in a timely manner. In order to be respectful of the medical needs of other patients, please notify Trahan ENT & Aesthetics promptly if you are unable to show up for an appointment. If it is necessary to cancel your scheduled appointment, we advise that you call at least 24 hours in advance. This policy enables us to better utilize available appointments for our patients in need of medical care. A "no-show" is someone who misses an appointment without cancelling it in an adequate manner. A failure to be present at the time of a schedule appointment will be recorded in your medical records as a "no-show. **Any Medicaid No Show will need a new referral from their referring phsyician. All other No Show patients will be charged $25.00 for the first missed appointment, $50.00 for the second, and could result in being discharged from our practice.**

Patient or Guardian Signature *Date*

Medical & Surgical History

Height:_____ Weight:_____

Do you have any food/medication allergies? _____ If yes, please list_____

Do you currently, or have a history of smoking? _____ If yes, how much? _____

Do you drink alcohol? _____ If yes, how much and how often? _____

Are you currently, or think you could be pregnant? _____

Please list any surgeries that you have had: _____

_____

Please list all medications/supplements: _____

_____

Patient Medical History:

Heart Disease:	Y	N			
High Blood Pressure:	Y	N	Thyroid Disease:	Y	N
Hearing Loss:	Y	N	Bleeding Disorder:	Y	N
Autoimmune:	Y	N	Anesthesia Issue:	Y	N
Cancer:	Y	N	Other:_____		

Family Medical History (Mother, Father, Siblings, Maternal or Paternal Grandparents)

Heart Disease:	Y	N	Who: _____
Cancer:	Y	N	Who & Type: _____
			_____
Bleeding Disorder:	Y	N	Who: _____
Anesthesia Issue:	Y	N	Who: _____
Thyroid Disease:	Y	N	Who: _____
Hearing Loss:	Y	N	Who:_____
Autoimmune:	Y	N	Who & Type: _____

I certify that the above information is correct to the best of my knowledge. I will not hold Trahan ENT & Aesthetics or any members of his staff responsible for any errors or emissions that I may have made in the completion of this form.

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

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Jason Trahan, MD · Lauren Jarrell, FNP-BC · Loren Thibodeaux, Au.D.

3935 I-49 South Service Road · Opelousas, LA 70570

Consent for Treatment

The undersigned, as a patient or authorized representative of the patient, hereby consents to any and all medical, behavioral, preventative, and other healthcare related evaluation and management ("healthcare services") as may be deemed by the healthcare provider. I am aware that providing healthcare services is not an exact science. I acknowledge that no guarantees have been made to me by the clinic or healthcare provider as to the results of healthcare services including: diagnosing, examinations, or treatments in any clinic or hospital, or other healthcare organization. I hereby consent to the performance of all nursing and technical procedures and tests as directed by my physician(s). I understand that my medical care may require samples, including fluids or tissues, from my body. This may include blood drawn or tissues removed during tests, treatment, or surgery. Further, I understand that should any medical personnel or other person(s) be exposed or report an exposure to my blood or body fluids, my blood will be tested for blood borne infections including Hepatitis B and C as well as HIV/AIDS. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examination. I have the right to refuse tests or treatment (as far as the law allows) and to be told what might happen if I do. I have the right not to have any photos or videos taken of me unless I agree to this, except as needed to treat me. I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force until revoked in writing.

Use of Protected Health Information

The undersigned, as a patient or authorized representative of a patient, hereby understand and agrees that as part of my healthcare, this organization originates and maintains health records describing my health history symptoms, examinations, test results, diagnoses, treatment, and any plans for future care of treatment, so that my healthcare provider can get paid, and for various uses related to my healthcare provider's clinic administration. I hereby consent to my provider using and disclosing my health information in connection with my treatment in order to get paid for healthcare services provided to me, and as necessary for the administration of the clinic. Further, I understand that medical Information and records may be released to other institutions, agencies, healthcare organizations of healthcare providers, who accept me for medical or institutional care. In addition, I understand that my medical information may be released to my insurer(s), managed care organization(s), governmental entities responsible for paying for my care, and/or pharmaceutical manufacturers and their respective agents, for purposes including, but not limited to, payment, utilization review and quality assurance review, and to support applications for patient assistance. I acknowledge receipt of a copy of the clinic's Notice of Privacy Practice.

Patient Rights

The undersigned, as a patient or authorized representative of a patient, understands that I have certain rights and responsibilities. They include the following: Every patient, and/or his/her representative, shall whenever possible, be informed of the patient's rights in advance of receiving his or her healthcare services. The rights of the patient and or his/her representative when appropriate include the right to:

1. Receive treatment and medical services without discrimination based on race, age, religion, national origin, sex, sexual preference, handicap, diagnosis, ability to pay or source of payment.
2. Be treated with consideration, respect, dignity and recognition of their individuality, including the need for privacy in treatment; and respect for their personal values, beliefs, cultural, psychosocial, spiritual needs and preferences.
3. Be informed of the names and functions of all Nurse Practitioners and other health care professionals who are providing direct care to the patient.
4. Receive, as soon as possible, the services of a translator or interpreter to facilitate communication between the patient and the clinic's health care personnel or individuals outside the clinic.
5. Receive and participate in the development and implementation of his/her plan of care.
6. Make informed decisions regarding his or her care, and be informed about the outcomes of care, treatment and services that have been provided, including unanticipated outcomes.
7. Be informed of his/her health status, be involved in care planning and treatment, and be able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.
8. Be included in experimental research only when he or she gives informed, written consent to such participation, and to refuse to participate in experimental research, including the investigations of new drugs and medical devices.
9. Be informed if the hospital has authorized other health care and/or educational institutions to participate in the patient's treatment and to know the identity and functions of these institutions and may refuse to allow their participation in his/her treatment.
10. Be informed by the attending physician and other providers of health care services about any continuing health care requirements after his/her services rendered from clinic and to have clinic staff make arrangements for the required follow-up care after discharge.
11. Have his/her medical records, including all computerized medical information, kept confidential; and to access information contained in his/her medical records within a reasonable time frame.
12. Be informed of unanticipated outcomes of care, treatment and services that relate to sentinel events considered reviewable by The Joint Commission, by the hospital and/or the LIP.
13. Be free from all forms of abuse and harassment.
14. Receive care in a safe setting.
15. Receive assistance in pain management.
16. Examine and receive an explanation of the patient's clinic bill regardless of source of payment.
17. Be informed in writing about the clinic's policies and procedures for initiation, review and resolution of patient complaints or grievances, including the address and telephone number of where complaints may be filed with the department.
18. Be informed of his/her responsibility to comply with clinic's rules, cooperate in the patient's own treatment, provide a complete and accurate medical history, be respectful of other patients, staff and property and provide required information regarding payment of charges.
19. Access, request amendment to, and receive an accounting of disclosures regarding his/her own health information as permitted under applicable law.
20. Access protective and advocacy services.

Patient Responsibilities

The undersigned, as a patient or authorized representative of a patient, understands that I have certain responsibilities in order to remain a patient at this clinic and under the care of the healthcare provider. They include the following:

1. It is the patient's responsibility to treat others with respect. All patients deserve respect, and also, staff, other patients and visitors deserve respect. This includes following rules about smoking, noise, number of visitors, conduct and respect of property that belongs to others or the clinic.
2. It is the patient's responsibility to give accurate information. There may be a need to answer numerous questions about their health, medical history, etc.
3. The patient is responsible for bringing their advance medical directive to the clinic, if available. This may include living wills, durable power of attorney for health care, and other forms of healthcare decisions.
4. The patient is responsible for following their health care team's treatment plan
5. The patient is responsible for asking questions if they do not understand certain aspects of their care.
6. The patient is responsible for accepting financial responsibility associated with his/her care.
7. The patient is responsible for following the clinic's rules and regulations.
8. It is the patient's responsibility to advise the nurse, nurse practitioner, and/or patient advocate of any dissatisfaction they may have regarding their care or safety.

Complaints and Grievances

The undersigned, as a patient or authorized representative of a patient, understands should I have a complaint or grievance that I should ask for the practice administrator to be called at any time or location or by calling the main clinic at (337) 594-6002. I understand and agree that if the practice administrator can immediately resolve my complaint, that the matter will be deemed resolved, but that if the complaint cannot be resolved to my satisfaction, that the complaint will be considered a grievance and be subject to those policies and procedures. I understand and agree that the practice administrator will respond to all grievances, within ten (10) days. The response will include the nature of the grievance, the investigation into that grievance, findings, if any, of the investigation, and the resolution of the grievance. I also understand that I may call the Louisiana Department of Health and Hospitals to make a complaint at (866) 280-7737. Further, I understand that I may call my insurer to make a complaint and the insurer's phone number is usually found on the back of the Insurance card.

In the event your complaint remains unsolved with the clinic, you may file a complaint with Manager via their email (manager@trahanent.com) or via phone 337-594-6002.

Treatment of Minors

The undersigned, as a patient or authorized representative of a patient, understands and agrees that the parent or legal guardian must consent to the treatment of the child (for the purposes of this agreement a minor or child is defined as any person under the age of majority [17 or younger] in Louisiana) prior to the provision of healthcare services. The consent and authorization may be amended or revoked at any time by the parent or legal guardian. The undersigned, as a patient or authorized representative of a patient, understands and gives permission for minors protected health information to be disclosed for purposes of communicating results, findings, and care decisions to the individual(s) listed on the demographics sheet in the patients chart. Please note this does not allow these individuals to obtain copies of medical records without a complete and valid authorization.

Reproduction of Medical Records

The undersigned, as a patient or authorized representative of a patient, understands and agrees that upon each visit the patient has an opportunity to receive a printed summary of their visit, a copy of any diagnostic tests or procedures, and any pertinent health education. I agree and understand that should I, or other party I designate in writing on a properly executed Consent to Release Protected Health Information form to receive my medical record, want a printed copy of my entire medical record that I will be required to pay the Louisiana mandated medical record reproduction fees as described in RS 40·1299.96 "If the original treatment records are generated, maintained, or stored in paper form, copies shall be provided upon payment of a reasonable copying charge, not to exceed one dollar ($1.00) per page for the first twenty-five (25) pages, fifty cents ($.50) per page for twenty-six (26) to three hundred fifty (350) pages, and twenty-five cents ($.25) per page thereafter, a handling charge not to exceed twenty-five dollars ($25.00) for hospitals, nursing homes, and other health care providers, and actual postage." "If treatment records are generated, maintained, or stored in digital format, copies may be requested to be provided in digital format and charged at the rate provided by this item: however, the charges for providing digital copies shall not exceed one hundred dollars ($100.00), including all postage and handling charges actually incurred. If requested, the healthcare provider shall provide the requester, at no extra charge, a certification page setting forth the extent of the completeness of records on file."

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The undersigned, as a patient or authorized representative of the patient, attests that they have reviewed, understand, and agree to all information included within the authorization and consent document.

_____ _____

Patient Full Name (Printed) *Date of Birth*

_____ _____ _____

Patient/Guardian (Printed) *Relationship to Patient* *Date*

_____ _____

Patient/Guardian Signature *Date*