J. Kevin Duplechain, M.D., F.A.C.S.
1103 Kaliste Saloom Road, Suite 300
Lafayette, LA 70508
P: (337) 456-3282 F: (337) 456-3491

Today's Date:	
Dates Revised:	

PATIENT INFORMATION

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):*	☐ M ☐ F	**DOB:**	**Age:**
Marital status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	**Social Security No.:**	- -
Street Address:		**City, State & Zip:**	
Cell Phone:	**Home Phone:**	**Work Phone:**	
Email Address:	**Permission to leave message on:** ☐ Cell ☐ Home ☐ Work		
☐ **Yes** ☐ **No**	I would like to receive email announcements on special discounts, new products or procedures. If yes, please specify if you would like sent to different email address than listed above:		
Occupation:	**If student, please list school/ college:**		
Spouse/ Parent Name:			
Emergency Contact-	**Name:**	**Phone:**	

How did you hear about us?	☐ Newspaper	☐ Friend:
	☐ Our Website:	☐ Our Patient:
	☐ Another Website:	☐ Physician Referral:
	☐ Magazine:	☐ Television:

Primary Care Physician (PCP)- Name:	**Phone:**
PCP Address:	**Permission to contact PCP?** ☐ Yes ☐ No
Preferred Pharmacy- Name:	**Phone:**

I authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

Name:	Relationship:	Phone:
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

Medications: List all medications you are currently taking, both by mouth & topically, including prescriptions, over-the-counter treatments, vitamins, herbal supplements & creams. Please let us know the reason you are taking each medication.

Medication	Dosage & Frequency	Reason for taking medication

Personal Surgical History:

Year	Procedure

Have you ever had surgical complications? If yes, please describe below. ☐ Yes ☐ No

Medical History- Personal & Family: Please mark all past & present medical conditions.						
	Self	**Mother**	**Father**		**Self**		**Self**
Allergies	☐	☐	☐	Acne	☐	History of Sinus Infections	☐
Arthritis	☐	☐	☐	Anemia	☐	HIV / AIDS	☐
Asthma	☐	☐	☐	Anorexia/ Bulimia	☐	Hoarseness	☐
Cancer (except skin cancer)	☐	☐	☐	Anxiety	☐	Irregular Heartbeat / Palpitations	☐
Diabetes	☐	☐	☐	Autoimmune Disorder	☐	Lupus	☐
Eczema	☐	☐	☐	Blood Clots	☐	Murmur / Mitral Valve Prolapse	☐
Lung Disease	☐	☐	☐	Blood Disorder	☐	Muscle Weakness	☐
Psoriasis	☐	☐	☐	Blood Transfusion	☐	Nasal Difficulties	☐
Tuberculosis	☐	☐	☐	Blurred / Double Vision	☐	Nerve Damage	☐
Other skin condition	☐	☐	☐	Bruise Easily	☐	Pacemaker	☐
Basal Cell Carcinoma	☐	☐	☐	Cholecystitis	☐	Pancreatitis	☐
Squamous Cell Carcinoma	☐	☐	☐	Chronic Cough	☐	Previous Nasal Injury	☐
Melonoma	☐	☐	☐	Chronic Lung Disease	☐	Psychiatric Hospitalization	☐
Heart Disease	☐	☐	☐	Claustrophobia	☐	Radiation to Face / Neck	☐
High Blood Pressure	☐	☐	☐	Cold Sores / Herpes	☐	Receive(d) Psychiatric Treatment	☐
				Colitis	☐	Reflux Disease	☐
				Cornea Problems	☐	Renal Failure	☐
				Depression	☐	Rosacea	☐
				Dialysis	☐	Scarring / Keloid Formation	☐
				Difficulty Breathing by Nose	☐	Seizure Disorder	☐
				Difficulty Opening Mouth	☐	Sexually Transmitted Disease	☐
				Drug / Alcohol Dependency	☐	Shortness of Breath	☐
				Dry Eye	☐	Sleep Apnea	☐
				Excessive Sweating	☐	Slow Wound Healing	☐
				Facial Paralysis / Weakness	☐	Spinal / Back Disorders	☐
				Glaucoma	☐	Staph / Strep / MRSA	☐
				Hay Fever	☐	Stomach Ulcers	☐
				Headaches	☐	Thyroid Eye Disease	☐
				Hearing Difficulties	☐	Thyroid Disease	☐
				Heart Attack	☐	Tuberculosis (TB)	☐
				Hepatitis (Type:_____)	☐	Wears Glasses or Contacts	☐

Have you been on Accutane therapy within the past 24 months? ☐ **Yes** ☐ **No**

Have you taken any steroid preparation(s) over the past year? ☐ **Yes** ☐ **No**

Allergies:

If you have no allergies at all, please check this box & skip to next section. ☐

☐ **Penicillin** ☐ **Sulfa** ☐ **Lidocaine** ☐ **Eggs** ☐ **Latex**

Please list any other drug or food allergies, including products such as tape, and list the nature of your reaction:

Name the Drug or Food	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Weight	Have you had significant weight change in the past year?				☐ Yes	☐ No
	Current Weight:		Current Height:			
	How often do you exercise?	☐ Daily	☐ 4-6 x per week	☐ 2-3 x per weel		
		☐ 1 x per week	☐ Rarely	☐ Almost Never		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew	☐ Pipe	☐ Cigars	
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No

WOMEN ONLY

Number of pregnancies	List dates of pregnancies:	
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Date of last mammogram?	☐ Yes	☐ No
Was it normal?	☐ Yes	☐ No

COSMETIC & AESTHETIC INTEREST QUESTIONNAIRE

Please mark all products, procedures or treatments which you are interested in.

Acne Scarring ☐	Dermal Facial Fillers ☐	Laser Skin Tightening ☐
Age Spot Reduction ☐	Ear Pinning ☐	Laser Stretch Mark Reduction ☐
Arm Lift ☐	Earlobe Repair ☐	Liposuction ☐
Botox Injections ☐	Eyelid Lift ☐	Necklift ☐
Breast Augmentation ☐	Facelift ☐	Nose Contouring ☐
Breast Lift ☐	Fat Transfer ☐	Male Breast Reduction ☐
Breast Reduction ☐	Laser / Chemical Peel ☐	Microblading ☐
Browlift ☐	Laser Hair Removal ☐	Thigh Lift ☐
Chin Augmentation ☐	Laser Skin Resurfacing ☐	Tummy Tuck ☐

AUTHORIZATION

I hereby authorize medical treatment of the person named above and agree to pay all fees and charges for treatments and services rendered. I understand that medical treatment may include a review of personal, social and medical history, discussion of the reason(s) for the visit(s), and may include photographs of the area(s) being discussed and / or treated before and / or after treatment. I have read and agreed to the above.

Signature:_____ Date:_____

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above and fill in the information below.

Parent / Guardian Name (print):_____Date:_____

ACADIANA OTOLARYNGOLOGY HEAD & NECK SURGERY, L.L.C.
FINANCIAL POLICY AGREEMENT AND
AUTHORIZATION 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 and Agreement 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 copayment, 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 case, any applicable coinsurance or copayment 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 of Benefits and Rights - If you have health and accident insurance coverage, including worker's compensation benefits, automobile insurance or Medicare, your signature of 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 my 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 my 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.

I understand that I am fully responsible for all amounts, including deductible not met, equipment and supplies not covered by my insurance. I also understand that in the event my insurance carrier does not pay within 45 days from the day services were billed, I am responsible for payment in full within 60 days of notification.

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 concerns.

AUTHORIZATION FOR RELEASE OF INFORMATION

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.

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 AUTHORIZATION FOR RELEASE OF INFORMATION AND THAT I UNDERSTAND THE PROVISIONS THEREIN. I AGREE THAT I AM BOUND BY THE TERMS OF THIS AGREEMENT SO LONG AS I RECEIVE TREATMENT FROM ACADIANA OTOLARYNGOLOGY HEAD & NECK SURGERY, L.L.C AND FOR A PERIOD OF ONE YEAR FROM THE LAST DATE OF SERVICE, UNLESS ANY PROVISION(S) ARE EXPRESSLY REVOKED IN WRITING AND RECEIVED BY ACADIANA OTOLARYNGOLOGY HEAD & NECK SURGERY, L.L.C.

_____ Date _____
Name of Patient (Please print)

_____ _____
Signature of Responsible Party Witness

_____
Relationship to Patient