DAVID R. BROWN, MD
Ear, Nose & Throat

Welcome to our practice!

Dr. Brown is an ear, nose and throat (ENT) physician who has served Santa Fe since 1987. He is board-certified in otolaryngology (ear, nose and throat) and fellowship trained as an ear, nose and throat allergist.

As a founding member of Southwestern Ear, Nose & Throat, which included a medical and surgical practice in Santa Fe, Las Vegas and New Mexico, Dr. Brown now has an independent medical ear, nose and throat practice in Santa Fe, providing medical evaluation and management of ENT disorders. His practice primarily focuses on the following aspects of ENT medicine:

- Evaluation and management of throat, nose and sinus disorders, with a special focus on advanced allergy care
- Evaluation and management of all ear, hearing and balance disorders (e.g., vertigo, Ménière's disease)
- Evaluation and management of migraines

To make your office visit as convenient as possible, please complete and return the attached patient registration forms in the enclosed self-addressed, stamped envelope at least one week prior to your appointment to ensure we receive the completed forms in advance of your visit. If you are unable to complete these documents, please plan to arrive at our office 30 minutes prior to your visit to complete your patient registration paperwork. You may then hand-carry the completed forms to your appointment.

Planning for your appointment

Please bring the following items to your appointment:

☐ Photo ID

☐ Insurance card(s)

☐ List of medications, including dosage (a handwritten list is OK).

☐ If your insurance plan requires a referral, please contact your PCP for a referral to a specialist.

(Note: Our office does not require a referral, but your insurance plan may. Contact your insurance plan if you have any questions regarding their requirements for a specialist referral.)

☐ Please be prepared to pay any unmet deductible, co-insurance or co-pay at the time of your visit.

☐ Completed patient registration forms (if you did not return them in the mail seven days in advance).

☐ Copies of test results, labs, CT, MRI, etc., for the problem Dr. Brown is evaluating. If you do not have the reports, please write down the name of the test, where the test was done and the date of the test.

Other considerations

Out of consideration for our allergy patients, we ask you to please leave your furry friends and favorite fragrances at home.

Thank you for notifying us at least two business days prior to your appointment if you need to reschedule or cancel. This courtesy allows us to offer your appointment time to another patient and for you to avoid a no-show fee of $75.00.

Our regular office hours are Monday–Thursday, 8 a.m.–4:30 p.m. We are closed for lunch from noon–1 p.m.

If you need a prescription refill, please contact your pharmacy.

We are a small and busy office. If we are not immediately available by telephone, we are likely helping another patient. Please leave a detailed message. We attempt to return every call by the end of the business day, Monday–Thursday. Thank you for your understanding.

Medical records

If you are a former Southwestern Ear, Nose & Throat or Christus St. Vincent Ear, Nose & Throat patient, please note that your medical records were not transferred to our practice. Please contact our office to request a medical release if you wish your records to be available to Dr. Brown.

If you have an email address and would like to use our patient portal to register, pay your bill or receive your medical records, please contact our office, and we will email a token (link) to you for the patient portal.

Directions to our office

We are located at 435 St. Michaels Drive, Suite B104, Santa Fe, NM 87505.

Our building is the first building east of Christus St. Vincent Hospital on the same side of the road. We are across the street from Botwin Eye Group and Oculus. Please note that navigation through Google and Bing is unlikely to help you find our office.

For additional information on our practice, please visit our website at www.santafeent.com.

We look forward to seeing you soon.

DAVID R. BROWN, MD
Ear, Nose & Throat

Patient Registration Form

Please print and fill out form completely.

Patient's First Name: _____ M.I.: _____ Last Name: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female Social Security #: _____

Marital Status: ☐ Single ☐ Married

Address: _____ City/State/Zip: _____

Home Phone: _____

☐ Okay to leave message cell phone: _____

☐ Okay to leave message: Email: _____

Referring Physician/Provider: _____

Reason for visit: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Guarantor information for minors (under age 18)

Name: _____ Sex: ☐ Male ☐ Female Date of Birth: _____

Patient's relationship to the guarantor: ☐ Child ☐ Spouse ☐ Other _____

SSN: _____ Phone: _____ Cell: _____

Street Address: _____ City/State/Zip: _____

Insurance Policy Holder

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Patient's relationship to the policy holder: ☐ Child ☐ Spouse ☐ Other

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I acknowledge full financial responsibility for any services rendered, and I understand that estimated patient-due amounts will be paid at the time of service. I also understand that the charges not covered by insurance remain my responsibility and assign insurance benefit to this office. I acknowledge receipt of the Financial and Billing Policy.

X: _____ Date: _____

Patient/Guarantor Signature

P: 505.820.9945 | F: 844.218.9645 | 435 St. Michaels Drive, Suite B104, Santa Fe, NM 87505 | www.santafeent.com

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ADULT INTAKE

Adult Patient: _____ **Date of Birth:** _____ **Today's Date:** _____

Reason for today's visit: _____ **Who referred you to our clinic?** _____

Medication Allergies: _____ **Latex Allergy?** [ ] NO [ ] YES

Medications: Please list on medication form. **What pharmacy do you use?** _____

Past Medical History Have you ever had problems in any of the following categories?
Please check the category and then circle specific conditions.

	No	Yes	If yes, please circle as appropriate.
Allergy/Immune			Hay fever, sinusitis, asthma, other:
Arthritis			Rheumatoid arthritis, lupus, other:
Cancer			Skin, melanoma, breast, colon, thyroid, lung, prostate, head/neck, other/specify:
Endocrine			Diabetes, low thyroid, other:
Gastrointestinal			Acid reflux, stomach ulcer, other:
Heart			Heart attack, heart failure, coronary artery disease, heart valve disease
Vascular			High blood pressure, aortic aneurysm, carotid stenosis, other:
Blood (Heme)			Bleeding disorder, clotting disorder, anemia, other:
Infectious			HIV, tuberculosis, hep C, other:
Kidney			Kidney disease, kidney stone, other:
Liver			Liver failure, hepatitis, other:
Lung			Asthma, sleep apnea, emphysema (COPD), pneumonia, other:
Neurologic			Stroke, seizure, headache, chronic pain, anxiety, depression, dementia
Other: Specify			

Height: _____ **Ft:** _____ **Inches** **Weight:** _____ **Pounds** **Are you pregnant?** [ ] N/A [ ] NO [ ] YES

Do you monitor your blood pressure? [ ] NO [ ] YES **If yes, most recent reading:** _____ **Diastolic** _____ **Systolic**

Do you have a history of falling? [ ] NO [ ] YES **If yes, how often?** _____ **Do you fear falling?** [ ] NO [ ] YES

Past surgical history: Please list past surgeries and approximate year.

_____

_____

Family history: Please list any family medical problems, especially related to those listed above. _____

_____

Social history: Do you or have you...

	No	Yes	Formerly	How much?	How often?	If formerly, when did you quit?
Smoke/d						
Chew/ed tobacco						
Consume/d alcohol						
Use/d recreational drugs						

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Occupation: _____ **Married?** [ ] No [ ] Yes **Widowed** [ ] **Live Alone** [ ]

Review of Systems **Please check below, if you have any of the following.**

	CONSTITUTIONAL		Hearing loss		**GASTROINTESTINAL**		**PSYCHIATRIC**
	Fever		Difficulty swallowing		Vomiting		Anxiety
	Weight loss		Hoarseness		Heartburn or reflux		Depression
	Fatigue		**CARDIOVASCULAR**		**NEUROLOGIC**		**HEME-LYMPH**
	EYES		Chest pain		Dizziness/vertigo		Easy bleeding or bruising
	Changes in vision		**RESPIRATORY**		Headaches		**ALLERGY**
	EAR, NOSE AND THROAT		Shortness of breath		**MUSCULOSKELETAL**		Sneezing
	Nasal congestion		Wheezing		Pain: joint, muscle, back		Itching
	Facial or sinus pain		Cough		**SKIN**		Seasonal allergy
	Sore throat		Sleep apnea		Rash, hives		

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Patient Medication Listing

Please print and fill out form completely.

Patient: _____ Date of Birth: _____ Today's Date: _____

Name of Medication	Dosage

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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

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, legal obligations, and your rights concerning your health information ("Protected Health Information" or "PHI"). We must follow the privacy practices that are described in this Notice (which may be amended from time to time). For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION:

- **Your PHI may be used and disclosed by the physician, our office staff, and others outside our offices that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the business, and any other use required by law. We may use and disclose PHI without your written authorization for certain purposes as described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are permissible under federal and state law.**

    1. **Treatment:** We may use and disclose PHI in order to provide treatment to you. For example, we may use PHI including your medication history, to diagnose, treat, and provide medical services to you. In addition, we may disclose PHI to other health care providers involved in your treatment.

    2. **Payment:** Under federal law we may use or disclose PHI so that services you receive are appropriately billed to, and payment is collected from your health plan. By way of example, we may disclose PHI to permit your health plan to take certain actions before it approves or pays for treatment services. Release of PHI to health plans require an authorization provided by you to us or to your health plan. We may contact the Guarantor for your visit in order to obtain payment.

    3. **Health Care Operations:** We may use or disclose your PHI in order to support our business activities. These activities include, but are not limited to business associates, quality assessment activities, internal investigations, performance reviews, and training employees. In addition, we will use a sign-in sheet at the registration desk where you will be asked to provide your name and date of birth. We may also call you by name in the waiting room when the physician is ready to see you. We may use or disclose your PHI to contact you to remind you of an appointment, to notify you of test results, to inform you of health related services that may be of interest to you, and to check on your treatment, progress, and satisfaction with our services.

    4. **Required of Permitted by Law:** As required by law, Public Health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement concerns, funeral directors, organ donation, research, criminal activity, military activity, national security, worker's compensation, inmates and other required uses and disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services.

- **Permissible Uses and Disclosures That May Be Made Without Your Authorization, For Which You Have An Opportunity to Object**

    1. **Family and Other Persons Involved in Your Care.** We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience to make reasonable inference of your best interest in allowing a person to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of health information.

2. **Disaster Relief Efforts.** We may use or disclose protected health information to a public or private entity authorized by law or its charter to assist in disaster relief efforts for the purpose of coordinating notification of family members of your location, general condition, or death.

- **Other Permitted and Required Uses and Disclosures:** Use or discloses of your PHI for marketing or sale of your PHI to third parties will be made only with your authorization. Once given, you may withdraw authorization at any time in writing.

II. YOUR INDIVIDUAL RIGHTS

- **Right to Inspect and Copy.** You may request access to your medical records and billing records maintained by us in order to inspect and request copies of the records. All requests to access must be made in writing. Under limited circumstances, we may deny access to your records. Under federal law, you may not inspect or copy psychotherapy notes, information complied in anticipation of, or use in a legal proceeding, and PHI that is otherwise prohibited. We may charge a fee for the costs of copying and sending you any records requested.

- **Right to Alternative Communications.** You may request, and we will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations.

- **Right to Request Restrictions.** You may ask us not to disclose any part of your PHI for the purposes of treatment, payment, or health care operations. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. If you have paid for your services in full and ask us not to disclose your visit to your insurance company, we will honor that request. We are not required to agree to any other restriction that you may request.

- **Right to Accounting of Disclosures.** Upon written request, you may obtain an accounting of certain disclosures of PHI made by us in the last six years. This right applies to disclosures for purposes other than treatment, payment, or health care operations, excludes disclosures made to you or disclosures otherwise authorized by you, and is subject to other restrictions and limitations. We are required by law to notify you if your unsecured PHI is breached.

- **Right to 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. If we deny your written request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and provide you with a copy of any such rebuttal.

- **Right to Obtain Notice.** You have the right to obtain a paper copy of this Notice by submitting a request to the center's Compliance Officer at any time.

- **Questions and Complaints.** If you desire further information about your privacy rights or are concerned that we have violated your privacy rights, you may contact the center's Compliance Officer. You may also file a written complaint with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. We will not retaliate against you if you file a complaint with the Director or with our office.

III. EFFECTIVE DATE AND CHANGES TO THIS NOTICE

- **Right to Inspect and Copy.** The Notice is effective on November 2, 2018.

- **Changes to this Notice.** We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all PHI that we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the revised notice in the waiting area of our office and on our website. You may also obtain any revised notice by contacting the center's Compliance Officer.

I have reviewed the David R Brown, MD Ear Nose & Throat PC Notice of Privacy Practices and understand that I may request a copy of the policy at any time.

Printed Name: _____ Signature: _____ Date: _____

DAVID R. BROWN, MD
Ear, Nose & Throat

HIPAA-PROTECTED HEALTH INFORMATION—ACCESS FORM

I understand that state and federal laws do not permit David R Brown, MD Ear Nose & Throat PC, to share information about me, including information regarding the health care services I received (my protected health information), without my authorization.

I give permission to David R Brown, MD Ear Nose & Throat PC, to discuss or release any medical or financial records with the person or persons listed below:

Name: (Please Print) Relationship to Patient Telephone Number: _____

I understand that I may change or revoke this form at any time by contacting administration at David R Brown, MD Ear Nose & Throat PC. I understand that such changes or revocation will not be effective for disclosures that have already been made or for access which has already occurred based on this form.

☐ You may leave confidential clinical information on my answering machine/voice mail.

_____ _____ _____

Signature of Patient or Responsible Party Signature Printed Name Date

DAVID R. BROWN, MD
Ear, Nose & Throat

FINANCIAL POLICY

Insurance Cards

We will ask you for your insurance card and check your picture identification each time you visit. Your insurance cards must be available at the time of each visit. If your card is not available, you will be asked to sign a waiver agreeing to be responsible for payment, and we may collect the full payment due. We submit claims to most insurances, although it's your responsibility to verify with your insurance company that we are a participating provider, and there are no geographic, preexisting conditions or prior authorization limitations. Plans vary within and between insurance payers and policies regarding prior authorization may changes frequently.

Copays, Coinsurance and Deductible

Copays are due at the time of check-in. Copays are set by your insurance, and we are obligated to collect these fees. If you have a deductible plan that will impact your visit, you will be asked to pay at the time of service. If not paid at the time of visit, an additional $10 processing fee will be applied. If you call us later in the day with a form of payment, this surcharge will be waived.

Specialist Procedures

As part of an ear nose and throat examination, an endoscopy may be felt necessary to complete the exam. Your insurance company may consider this a surgical procedure and applicable copays and patient responsibility may apply. If a hearing test is needed in addition to your office exam, your insurance company may apply an additional copay. Also, some insurance companies will only cover hearing tests for certain age groups or certain diagnosis. We encourage you to be familiar with your plan benefits.

Referrals

If you need a referral to be seen in our office, please contact your primary care physician to arrange for this. This must be available on the day of service. If this is being sent to us directly, you can contact our billing office at 505.820.9945 to verify its receipt. If a referral is needed and not available at the time of your visit, you will be asked to pay out of pocket.

Self-Pay Policies

Self-payments are due on the day of visit. Payment plans are available as recurring credit card or debit card transactions for balances greater than $300.00. Please contact our business office at 505.820.9945 if you need to make special arrangements for payment. We will make every effort to assist you.

No Shows

Cancellation of appointments should be made at least 48 hours in advance. This courtesy allows us to schedule and serve other patients. We reserve the right to bill you $75 for a missed appointment.

Past Due Accounts

Patients who have not made an effort to make payment arrangements and have not expressed an interest in meeting their financial obligation may be turned over to a collection agency. Patients who have allowed their account to be turned over to an agency will be expected to satisfy their financial obligation prior to scheduling any future appointments.

Returned Checks

There will be a $50 charge for a check returned by the bank.

Financial Responsibility for Minors

The parent or guardian who brings the minor patient for care in our office will be fully responsible for any out-of-pocket expenses to be paid at the time of service.

Finally...

Your insurance is a contract between you and your insurance group plan. While we have an experienced billing staff, it is not possible for us to know the details of each plan. We are happy to assist you in any way that we can to determine your coverage and meet patient responsibility prior to and after your visit to our office. Please contact us at 505.820.9945 with your questions and concerns. We look forward to serving you.

DAVID R. BROWN, MD
Ear, Nose & Throat

Authorization for Disclosure of Medical Records From Dr. Brown to Another Provider

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____

I hereby authorize my medical records to be released, inspected, copied and/or sent to:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Medical records will be: [ ] mailed [ ] picked-up [ ] faxed

Copy of medical records to include:

[ ] Complete copy of medical record

[ ] Partial copy of medical records to include the following: _____

_____

Patient Signature: _____ Date: _____

If signed by personal representative...

Printed Name: _____ Date: _____

Signature of Representative: _____ Relationship to Patient: _____

Witness Signature: _____ Date: _____
(Staff Member)

Date Records Released: _____ By Staff Member Name: _____

Fees:

10 pages or less	No charge	
11-15 pages @ $2/page	Page total: _____	Amount: _____
16 pages or more @ $0.50/page	Page total: _____	Amount: _____ Total due: $ _____

Please allow seven business days to process requests for the release of medical records. Thank you.

DAVID R. BROWN, MD
Ear, Nose & Throat

Authorization for Disclosure of Medical Records to David R. Brown, M.D.

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____

I hereby authorize my medical records to be released, inspected, copied and/or sent to:

David R. Brown, M.D., Ear, Nose & Throat, PC
435 St. Michaels Dr., Suite 104B
Santa Fe, NM 87505
505.820.9945 | 844.218.9645 (Fax)

Medical records will be ☐ mailed ☐ picked up ☐ faxed

Copy of medical records to include:

☐ Complete copy of medical record

☐ Partial copy of medical records to include the following:

☐ Last office visit notes

☐ Audiograms

☐ Vestibular studies

☐ Imaging reports

☐ AND, please list below any additional information:

_____

Patient Signature: _____ *Date:* _____

If signed by personal representative...

Printed Name: _____ *Date:* _____

Signature of Representative: _____ *Relationship to Patient:* _____

Witness Signature: _____ *Date:* _____
(Staff Member)

Date Records Released: _____ *By Staff Member Name:* _____