EAR INSTITUTE OF TEXAS

The Ear Institute of Texas, P.A.

(210) 696-HEAR (4327) • (210) 798-2509 Fax
18518 Hardy Oak Blvd, Suite 300
San Antonio, Texas 78258

NEW PATIENT PACKET FOR DR. JESSICA KEPCHAR
CONSENT TO TREAT AND PATIENT RESPONSIBILITIES

Patient Name: _____ Date of Birth: _____/_____/_____

If the patient is a minor, please complete the following:

Your Name: _____ Telephone #: _____

Your Address: _____

Relationship to patient: _____ Parent _____Guardian _____Other (explain) _____

I hereby consent to the provision of care, diagnosis and/or treatment by the Ear Institute of Texas, the Voice & Swallow Institute of Texas and/or the Hearing Institute of Texas. This consent shall apply to physicians, non-physician providers, audiologists, and any other employee working under the direction of the physician, or other professional medical care provider, to provide medical care for me (or to the patient). This consent includes contact and discussions with other health care professionals for care and treatment as well as your health insurance plan company.

I understand that I have the right to refuse any diagnostic testing or other recommendations by my health care provider.

PATIENT RIGHTS

- To be treated with courtesy and respect and protection of your privacy.
- To prompt and reasonable response(s) to questions and requests.
- To know who is providing your medical care and/or testing at the time of your visit.
- To be provided information concerning diagnosis and treatment.
- To impartial access to medical treatment or accommodations regardless of race, national origin, religion, sexual orientation, gender identity, or handicap.
- The right to privacy and confidentiality of all records pertaining to your treatment.
- To have access to senior management for complaints, compliments, or other clinic related matters.

Signature: _____ Date Signed: _____/_____/_____

NOTICE OF PRIVACY PRACTICES –
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

RELEASE OF INFORMATION – MEDICAL PROVIDERS AND YOUR RIGHTS

(_____) INITIAL Your confidential information could potentially be transmitted to those who are not authorized to receive such information. The Ear Institute of Texas uses its best efforts to avoid such disclosure. I have been advised of this potential and authorize the Ear Institute of Texas to utilize facsimile to transmit my Protected Health Information ("PHI"), which may include, without limitation, contact information and medication history.

I hereby authorize the Ear Institute of Texas to release my PHI to the referring physician or to another physician or health care provider or facility associated with my care and treatment, or as otherwise permitted by applicable rules, regulations or laws. I understand and agree that the release of any such information may be transmitted, without limitation; telephonically, by facsimile, electronically, by mail, courier, or by overnight delivery services.

Further I hereby authorize the Ear Institute of Texas to obtain my PHI from the referring physician or another physician or health care provider or facility associated with my care and treatment including medication history from any pharmacy and that any such PHI information may be transmitted to the Ear Institute of Texas, without limitation, telephonically, by facsimile, electronically, by mail, courier, or by overnight delivery services.

You may ask to see or receive a copy of your medical records and other health information. If you want a copy, you will need to put your request in writing, there could be a small fee to cover the cost of printing and postal services. It may take up to but not exceed 30 days. You may request to change any incorrect information in your file or add information to your file if you think something is missing or incomplete.

If you believe your privacy rights have been violated, you may file an OCR complaint with us or the Secretary of Health and Human services. Under HIPAA, we cannot retaliate against anyone for filing a complaint.

You have the right to request a copy of this notice from us at any time.

RELEASE OF INFORMATION – FAMILY AND OTHERS

(_____) INITIAL In accordance with HIPAA regulations, the Ear Institute of Texas may not discuss your condition, care, or treatment plan with family members or other individuals unless that person(s) is authorized by you to access any such PHI information in regard to your condition, care or treatment plan. Any such authorization must be obtained by the Ear Institute of Texas, from you or your legally authorized representative, prior to the release of any such information.

However, pursuant to the regulations, this privacy provision may be waived dependent upon your medical condition.

Therefore I do hereby authorize the Ear Institute of Texas to release my PHI to the following person(s)

_____ _____
Name **Relationship**

_____ _____
Name **Relationship**

EMERGENCY CONTACT(s): Contact Person Name: _____ **Relationship:** _____

Emergency Contact Phone Number(s): Mobile: _____ **Work:** _____ **Other:** _____

General disclosure: Dr. Jackson functions as investor or in advisory role for the following companies: Precision Neuromonitoring, Astute Assistants, and Cochlear Corporation.

I have read this release before signing below and I fully understand the contents, meaning and impact of this release.

_____ _____
Signature: Patient/Guarantor/Legal Guardian **Date of Birth**

_____ _____
Print Name: Patient/Guarantor/Legal Guardian **Date**

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PATIENT INFORMATION

DATE: _____ CHART # _____

Full Legal Name _____ Sex _____ Age _____ Date of Birth: _____/ _____/ _____

Address _____City _____ State _____ Zip _____

Telephone: Home: ( ) _____ Work: ( ) _____ Cell:( ) _____

E-mail.: _____ Social Security Number _____/ _____/ _____

Marital Status: _____

Employer _____ Occupation _____

Address _____City _____ State _____ Zip _____

How did you find us: Doctor's Referral | Phone Book | Insurance Provider List | Web-Page | Friend | Other _____

Referring Physician's Name _____

Address _____City _____ State _____ Zip _____

Phone Number ( ) _____

Is your referring physician an Ear, Nose, Throat Specialist? _____ Yes _____ No

Primary Care/ Family Physician _____ Phone Number ( ) _____

Address _____City _____ State _____ Zip _____

Phone Number ( ) _____

INSURANCE INFORMATION (Disregard if patient is same as policy holder)

Primary Insurance Company _____ Group # _____ ID # _____

Policy Holder_____ Policy Holder's Social Security _____/ _____/ _____

Policy Holder's Date of Birth _____ Relationship to Patient _____

Secondary Insurance Company _____ Group # _____ ID # _____

Policy Holder_____ Policy Holder's Social Security _____/ _____/ _____

Policy Holder's Date of Birth_____ Relationship to Patient _____

GUARANTOR OR RESPONSIBLE PARTY FOR PATIENT'S FINANCIAL OBLIGATIONS, ***NOT YOUR INSURANCE COMPANY***

Full Legal Name _____ Sex _____ Age _____ Date of Birth: _____/ _____/ _____

Social Security _____/ _____/ _____ Relationship to Patient _____

Address _____City _____ State _____ Zip _____

Employer _____ Occupation _____

Address _____City _____ State _____ Zip _____

Employer's Phone Number: ( ) _____ Home Phone Number: ( ) _____

Alternate Phone Number: ( ) _____

IN CASE OF EMERGENCY:

Contact Person _____ Relationship to Patient _____

Address _____City _____ State _____ Zip _____

Work Phone Number: ( ) _____ Home Phone Number: ( ) _____

Federal Statistical Information: Primary Language: _____Race: _____Ethnicity: _____

PATIENT INFORMATION

Patient Policy: Payment is required at the time of service unless prior arrangements were made. Payment includes any and all applicable co-pays, co-insurance, or deductibles. For your convenience, this office accepts Visa, MasterCard, Debit cards, cash and local checks. There is a $35.00 service fee for returned checks. (_____) **Initials**

Services Not Covered: At the time of your appointment, you may be required to undergo diagnostic testing which may or may not be covered by your insurance provider. Any charges not covered by your insurance provider will be your responsibility. You will be responsible for payment of these charges at the time the services are provided. (_____) **Initials**

Insurance: This office bills participating insurance companies as a courtesy to our patients. You are expected to submit payment for all applicable co-pays, co-insurance, or deductibles at the time services are rendered, based on the requirements of your individual insurance plan. **If payment is not received from your insurance company, the total balance due will be your responsibility. Due to the various insurance plans, we ask that you verify your individual benefits with your insurance provider. This office provides your plan information as a courtesy only and is not responsible for interpretation of your individual plan. I hereby authorize this office to release all medical information to my health insurance provider in order to process my claim; and, I hereby assign all health insurance plan reimbursements to this office.** (_____) **Initials**

Missed Appointments: This office is committed to providing quality services to as many patients as possible. Resources are assigned for each individual patient. Missed appointments (including being 15-minute or more late for your scheduled appointment **or not arriving in time to complete your paperwork prior to the scheduled appointment time**) represent a cost to this office and are an inconvenience to other patients who could have been scheduled for your assigned time slot. **WE REQUIRE A 24-HOUR NOTICE TO CANCEL YOUR SCHEDULED APPOINTMENT, 48-HOURS TO CANCEL YOUR VESTIBULAR TESTING AND 72-HOURS TO CANCEL YOUR SURGERY.** (_____) **Initials**

The cancellation fees are: $50.00 for an appointment, $75.00 for vestibular testing and $250.00 for surgery (canceled in less than 72-hours prior to your scheduled time) and $500.00 (if canceled less than 24-hours prior to your scheduled time). These fees may also apply to patients who are more than 15 minutes late for their scheduled appointment. (_____) **Initials**

Mid-Level Providers: Dr. Jackson employs mid-level providers (physician assistant and/or nurse practitioner) to support him in caring for the high volume of patients requiring medical care each day. The mid-level providers are highly qualified and trained by the doctor to treat the medically complex patients seen by the doctors. Patients may be seen by either the physician or one of the mid-level providers. The individual doctor supervises the care of each of their patients but do require assistance to provide care in a timely manner. In some instances, the mid-level provider will begin evaluation of a patient on the doctor's schedule. You may request to see the doctor, if necessary. (_____) **Initials**

Please initial each item above and sign/date this form prior to your first visit. Feel free to ask our reception staff or the office manager should you have any questions regarding the information contained within this form. Thank you for being our valued patient!

Patient/Guarantor/Legal Guardian Signature: _____

Date: _____/ _____/ _____ Printed Name: _____

Dr. Kepchar Health History **Room:**

Name:	**Age:**	**DOB:**	**Phone Number:**
Preferred Pharmacy (name and number): **PCP:**			

Reason for today's visit: _____

☐ **please check, If there is no changes to your health history**

Medical history (circle all that apply): Diabetes High blood pressure Stroke Heart attack Heart disease Irregular heartbeat Asthma COPD Pneumonia Kidney disease Liver disease Thyroid disorder Bleeding disorder Allergies Reflux Ulcers Hearing Loss Migraine Obstructive sleep apnea Autoimmune condition Immunodeficiency Cancer Arthritis

Surgical history (list year and complications if any):

Ear, nose, throat, neck surgery _____

Other surgery _____

Medications (include name/dose/frequency of prescribed, over-the counter, supplements, vitamins, herbal or attach list if necessary):

_____

_____

_____

Allergies (include medication, food, environmental): _____

Immunizations up to date: Yes No

Tobacco (circle one): Yes No Past **Type (circle):** Cigarettes Smokeless Vape

Alcohol use (circle one): Yes No Past

Occupation: _____

Family history (circle all that apply and note relationship): Bleeding disorder Ear problems Hearing loss Thyroid disease Heart disease Neurological disease Cancer

Review of symptoms (circle all that apply):

Fever Weight loss Weight gain Fatigue	Joint pain Muscle pain
Vision changes Glaucoma Itchy/watery eyes	Hives Rash Itchy skin
Hearing loss Ear pain Ringing in ears Dizziness Loud noise exposure Ear fullness	Frequent urination Blood in urine
Nosebleeds Change in smell Sinus problems Nasal congestion Runny nose Post nasal drip	Numbness/weakness Headaches
Chest pain Irregular heartbeat	Swollen glands Easy bleeding/bruising
Cough Shortness of breath Snoring	Anxiety Depression
Heartburn Nausea Difficulty swallowing Sore throat Voice Change	Skin diseases Hormone problems

*****OFFICE USE ONLY******

BP: **HR:** **Temp:** **Height:** **Weight:**

HPI:

Physical Exam

Ear: Weber R M L Rinne: A>B B>A

Right: Left: Bino Y/N

Nose:
R DNS L DNS Turbinate hypertrophy

Throat:
0/1/2/3/4 Tonsils Long redundant palate

Neck: TMJ: Y/N

NE/NP/FFOL:

A/P: 99203 99204 99213 99214

Audio VNG: positional/caloric Posturography ECOG ABR

Allergy testing

PSG: SNAP VITAL

FNA

Imaging: CT MRI US Call with results

F/u: weeks/months PRN