Santa Fe Ear, Nose & Throat

David R. Brown, MD · Nizhoni Denipah, MD

Appointment Date: _____ Time: _____

Please arrive 15 minutes prior to your appointment with your completed documents.

Please bring your insurance cards, your picture ID and a list of medications. Thank you!

WELCOME TO OUR PRACTICE!

David R. Brown, MD, is a board-certified otolaryngologist (ear, nose and throat) physician who has proudly served the Santa Fe community since 1987. As a founding member of Southwestern Ear, Nose & Throat, Dr. Brown now leads an independent ENT practice in Santa Fe, offering comprehensive medical evaluation and management of ENT disorders. He is board-certified in otolaryngology and fellowship-trained in ENT allergy. Dr. Brown's practice focuses on:

- Evaluation and management of throat, nose and sinus disorders, with a special emphasis on advanced allergy care
- Evaluation and management of ear, hearing and balance disorders (including vertigo and Ménière's disease)
- Evaluation and management of migraine

Nizhoni Denipah, MD, is a board-certified otolaryngologist (ear, nose and throat) physician with over 13 years of experience providing expert care for disorders of the ear, nose and throat. At Santa Fe ENT, she delivers precise, evidence-based care with a direct, patient-centered approach. Dr. Denipah holds advanced training in physiological sciences and otolaryngology–head and neck surgery. As a physician of Navajo, Ohkay Owingeh and Hopi heritage, she brings a culturally grounded perspective to patient care. She is actively engaged in community leadership and advocacy, serving on multiple boards and working to expand access to care and advance health equity across Northern New Mexico.

To make your visit as smooth and convenient as possible, please complete the enclosed patient registration forms and return them in the self-addressed, stamped envelope provided at least one week before your appointment. This ensures your information is on file prior to your visit.

If you are unable to return the forms in advance, please plan to arrive 30 minutes early to complete your registration paperwork at our office—or simply bring your completed forms with you on the day of your appointment.

PLANNING FOR YOUR APPOINTMENT

Please bring the following items to your appointment:

- ☐ Photo ID (required)
- ☐ Insurance card(s) (required)
- ☐ 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, especially if it is an HMO. Contact your insurance plan if you have any questions regarding its requirements for a specialist referral.)
- ☐ Please be prepared to pay any unmet deductible, co-insurance and/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 or online)
- ☐ Copies of test results, labs, CTs, MRIs, etc., for the problem the doctor is evaluating. If you do not have the reports, please write down the name of the test, where it was done and the date of the test.

Only patients, unless they need assistance, are allowed to enter our office.

If you have any flu and/or COVID symptoms, please contact our office at (505) 820-9945 to reschedule your appointment. Symptoms include fever, cough, temperature, shortness of breath, chest pain, loss of taste and/or smell and fatigue. If you have these symptoms, do not come to our office. Stay home and self-quarantine.

ADDITIONAL CONSIDERATIONS

Out of consideration for our allergy patients, 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.

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PATIENT REGISTRATION FORM

Patient's First Name: _____ MI: _____ Last Name: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ ☐ Okay to leave message

Cellphone: _____ ☐ Okay to leave message

Email: _____

Primary Care Physician: _____

Reason for Visit: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

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 I assign insurance benefits to this office. I acknowledge receipt of the Financial and Billing Policy.

Signature: _____ Date: _____

Patient/Guarantor

DIRECTIONS:

We are the first building east (toward the mountains) of the new CSV Cancer Center and west of the light at Arroyo Chamiso. B104 is on the lower level at the end of the building.

Note: GPS may NOT be accurate.

Visit www.santafeent.com for more information.

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ADULT PATIENT INTAKE FORM

Patient Name: _____ 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 below. What Pharmacy Do You Use? _____

_____

_____

_____

Past Medical History

Have you ever had problems in any of the following categories?

	No	Yes	If yes, please circle.
Allergy/Immune			Hay fever, sinusitis, asthma, other:
Arthritis			Rheumatoid arthritis, lupus, other:
Cancer			Skin, melanoma, breast, colon, thyroid, lung, prostate, head/neck, other:
Endocrine			Diabetes, low thyroid, other:
Gastrointestinal			Acid reflux, stomach ulcer, other:
Heart			Heart attack, heart failure, coronary artery disease, heart valve disease, other:
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:
Other: Specify			

Height: _____ Weight: _____lbs. Are you pregnant? ☐ NA ☐ 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 the approximate year for each.

_____

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						

Occupation: _____ Married? ☐ No ☐ Yes ☐ Widowed ☐ Live Alone

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

Constitutional

☐ Fever

☐ Weight loss

☐ Fatigue

Eyes

☐ Changes in vision

Ear, Nose and Throat

☐ Nasal congestion

☐ Facial or sinus pain

☐ Sore throat

☐ Hearing loss

☐ Difficulty swallowing

☐ Hoarseness

Cardiovascular

☐ Chest pain

Respiratory

☐ Shortness of breath

☐ Wheezing

☐ Cough

☐ Sleep apnea

Gastrointestinal

☐ Vomiting

☐ Heartburn or reflux

Neurologic

☐ Dizziness/Vertigo

☐ Headaches

Musculoskeletal

☐ Pain: joint, muscle, back

Skin

☐ Rash, hives

Psychiatric

☐ Anxiety

☐ Depression

Heme-Lymph

☐ Easy bleeding or bruising

Allergy

☐ Sneezing

☐ Itching

☐ Seasonal allergy

PATIENT MEDICATION LISTING

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

Name of Medication	**Dosage**

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FINANCIAL AND BILLING POLICIES

INSURANCE CARDS

We will ask you for your insurance cards and check your photo identification each time you visit. Your insurance cards must be available at 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 amount due. We submit claims to most insurances, but it's your responsibility to verify with your insurance company that we are a participating provider and that there are no geographic, preexisting condition or prior authorization limitations. Plans vary within and between insurance payers, and policies regarding prior authorization may change 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 you do not pay at the time of the 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 and/or biopsy may be necessary to complete the exam. Your insurance company may consider this a surgical procedure, and applicable copays and patient responsibility may apply. In the case of a biopsy, additional fees may be billed by the laboratory. 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 and/or certain diagnoses. We encourage you to familiarize yourself with your plan's benefits.

REFERRALS

If you need a referral to be seen in our office, please contact your primary care physician to arrange for it; the referral may be faxed to (505) 982-1797. The referral must be available on the day of service. If your referral is being sent directly to us, you may contact our 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.

NO-SHOWS

Cancellation of appointments should be made at least 24 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 or keep payment arrangements may be turned over to a collection agency. Patients who have allowed their accounts to become delinquent will be expected to satisfy their financial obligations prior to scheduling any future appointments. Patients shall be held responsible for any interest, penalties and legal fees associated with the collection of past-due balances.

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 to our office for care 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 plan. While we have an experienced billing staff, it is not possible for us to know the details of each plan. Please call the number on your insurance card if you have questions regarding your coverage. We look forward to serving you.

Santa Fe Ear, Nose & Throat
David R. Brown, MD · Nizhoni Denipah, MD

NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information about you may be used and disclosed, as well as 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:

a. **Your PHI may be used and disclosed by your physician, our office staff and others outside our offices who 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; rather, they are meant to describe the types of uses and disclosures that are permissible under federal and state law.**

i. **Treatment.** We may use and disclose PHI 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.

ii. **Payment.** Under federal law, we may use or disclose PHI so that services you receive are appropriately billed to your health plan, and payment is collected from it. 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 requires an authorization provided by you to us or to your health plan. We may contact the Guarantor for your visit to obtain payment.

iii. **Health Care Operations.** We may use or disclose your PHI 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.

iv. **Required or 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, workers' compensation, inmates and other required uses and disclosures. Under the law, we must make disclosures to you as well as when required by the Secretary of the Department of Health and Human Services.

b. **Permissible Uses and Disclosures That May Be Made Without Your Authorization, for Which You Have an Opportunity to Object**

i. 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, 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 health care. We will also use our professional judgment and our experience to

i. make a 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.

ii. 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.

a. **Other Permitted and Required Uses and Disclosures: Use or disclosure 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.**

I. YOUR INDIVIDUAL RIGHTS

a. **Right to Inspect and Copy. You may request access to your medical records and billing records maintained by us 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 compiled in anticipation of or used in a legal proceeding or PHI that is otherwise prohibited. We may charge a fee for the costs of copying and sending you any records requested.**

b. **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.**

c. **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.**

d. **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.**

e. **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.**

f. **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.**

g. **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.**

II. EFFECTIVE DATE AND CHANGES TO THIS NOTICE

a. **Effective Date. The Notice is effective on November 2, 2018.**

b. **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 Santa Fe Ear, Nose & Throat Notice of Privacy Practices and understand that I may request a copy of the policy at any time.

Printed Name: _____

Signature: _____

Date: _____

At Santa Fe Ear, Nose & Throat, we are committed to providing high-quality medical care while incorporating advanced technology to enhance efficiency and accuracy. Our physicians may utilize artificial intelligence (AI) technology to assist in documenting your medical visit, which helps streamline the recording of clinical notes and ensures comprehensive and precise medical records, while allowing your provider to focus on you during your visit.

Your physician reviews, edits and approves all content before it enters your medical record and remains fully responsible for its accuracy. All data is encrypted in transit and at rest, will not be used to train AI models and is never sold or shared for marketing purposes.

☐ **I CONSENT** to AI-assisted documentation as described above.

☐ **I DO NOT CONSENT.** I understand my provider will use traditional documentation methods.

HIPAA PROTECTED HEALTH INFORMATION—ACCESS FORM

I understand that state and federal laws do not permit David R Brown, MD Ear, Nose & Throat PC dba Santa Fe Ear, Nose & Throat 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 dba Santa Fe Ear, Nose & Throat, David R Brown, MD, and/or Nizhoni Denipah, MD, 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 the administration at (505) 820-9945. I understand that such changes or revocation will not be effective for AI-assisted dictations and/or disclosures that have already been made or for access that has already occurred based on this form.

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

_____

Signature of Patient or Responsible Party Signature

_____

Printed Name

_____

Date