

CURRENT PROBLEM AND PAST MEDICAL AND SOCIAL HISTORY FORM

Please return completed form to the front desk. NO PENCIL PLEASE. Thank you.

NAME _____
(last) (first) (middle initial)

TELEPHONE (home) _____
(work) _____
(cell) _____

ADDRESS _____

REFERRING AND/OR PRIMARY DOCTOR:

E-Mail _____

PARENT'S NAME (IF PATIENT IS A MINOR) AND ADDRESS IF DIFFERENT _____

ARE YOU CURRENTLY EMPLOYED? _____
IF YES, EMPLOYERS NAME AND ADDRESS _____

PLEASE CONTACT IN CASE OF EMERGENCY _____

EMERGENCY PHONE NO. _____

ARE YOU CURRENTLY A STUDENT? _____

PERMITTED TO DISCLOSE MEDICAL INFORMATION TO: ___ SPOUSE ___ PARENT ___ CHILD (OVER 18) OTHER _____
COMMENTS _____

IF YES, WHAT SCHOOL? _____

MARITAL STATUS S M D W

SEX M F

(Permission given per electronic signature)
SOCIAL SECURITY NO. _____
DATE OF BIRTH _____

INSURANCE CO. _____
(Will take a copy of card)

ALLERGIC TO LATEX YES NO

ADDRESS _____

DRUG ALLERGIES _____

SUBSCRIBER'S INFO IF OTHER THAN SELF
NAME _____ DOB _____
S.S. OR ID NO. _____
GROUP NAME AND NO. _____

CURRENT MEDICATIONS _____

ARE YOU OR YOUR SPOUSE COVERED BY ANY OTHER INSURANCE PLANS, PLEASE LIST _____

PREVIOUS HOSPITALIZATIONS AND/OR OPERATIONS _____

CURRENT OR PAST MEDICAL CONDITIONS _____

PRIMARY COMPLAINT TODAY? _____

HOW DID YOU HEAR ABOUT US? _____

HAVE YOU OR ANY FAMILY MEMBERS BEEN PREVIOUSLY SEEN BY THE DOCTOR? _____

IF YES, WHEN AND WHY? _____

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits to be paid directly to the undersigned physician. I am financially responsible for the non-covered services. I authorize the physician to release any information required. I understand and agree that (regardless of my insurance statue) I am ultimately responsible for the balance on my account for any professional services rendered. I certify that this information is true and correct to the best of my knowledge. I will notify you of any change in my health status or the above information.

SIGNED _____ DATE _____

We are committed to providing you with the best possible medical care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals we need your assistance with supplying accurate insurance information and understanding our payment policies.

For you information, please be aware that it may be necessary as part of your treatment to do some diagnostic tests. Many insurance companies, particularly PPO's process these in office tests under your individual surgical deductible which may incur more out of pocket costs.

Payment for office visits is due at the time of your visit. We accept checks, cash, and credit cards. We will be happy to help you process your insurance claim for reimbursement. A receipt will be issued after payment is made which will provide all the codes and fees necessary to your insurance company. We will submit for any hearing tests or other procedures that are done in our office. After your insurance company pays their allotted amount for any procedures we submit, you will be billed the remaining balance. We must emphasize that as health care providers, our relationship is with you and not the insurance company. While filing insurance claims is a courtesy we extend to our patients, all charges are ultimately your responsibility from the day the services are rendered. We realize that there are exceptions to our rules, and these are listed as follows:

MEDICARE: We are participating physicians in Medicare and therefore will submit for the patient. After we receive payment, we will bill the patient for any deductible or co-insurance balance. We will submit to your co-insurance if you provide us with the correct information and/or insurance forms to do so.

PENNSYLVANIA BLUE SHIELD: We will submit all procedure claims to PA Blue Shield. We will receive payment directly and you will receive an Explanation of Benefits from them. This will explain what has been paid and what is your responsibility.

WORKMAN'S COMPENSATION AND AUTOMOBILE: The account will be placed in the patient's name. If this information is inaccurate, the bill will remain 100% the patient's responsibility and we will expect payment at the time of service. Please bring information including name and address of the insurance company to be billed and employer information, a valid claim and policy number, and the adjuster's name.

HMOs: (AETNA/US HEALTHCARE, KEYSTONE HEALTH PLAN EAST, CIGNA, ETC.): At the present time we are participating in these insurances and will file all the necessary forms for you provided you have provided us with a valid referral or authorization form and paid your co-pay. Failure to bring the proper referral form will result in 1) rescheduling your appointment or 2) the patient paying for the visit in full. Sorry, no exceptions to this – this is the insurance company's rule, not ours.

PPO INSURANCES: At the present time, we are enrolled in several PPO programs. If you have one we **participate with**, we will file all claims for you.

DEPENDENT CHILDREN: The parent who brings the child in for his/her visit is responsible for payment.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. If you have any questions or uncertainties, PLEASE do not hesitate to ask us.

I have read and understand the above financial policy of Otolaryngology Plastic Surgery Associates, PC and agree to abide by this policy.

Patient Signature: _____

Date: _____