

Financial Policy

We are committed to providing you with the best possible care. If you have Medical Insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve this goal we need your assistance and your understanding of our payment policy.

Payment is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, check, MasterCard, American Express, Discover or Visa. We will be happy to process your insurance claim as a courtesy to you. However, it is your responsibility to verify eligibility and benefits with your insurance company before being seen.

Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges of 1.5% per month. Charges may also be made for missed appointments and appointments cancelled without 24 hours advance notice.

By signing below, you understand:

1. **Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.**
2. Our fees are generally considered to fall within the acceptable range by most companies. Therefore, our fees are covered up to the maximum range by most companies and up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of usual, customary, and reasonable (U.C.R) fees for this region. Most companies consider our fees usual, customary, and reasonable. This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.
3. Not all services we render are considered a covered benefit in some contracts. Some insurance companies arbitrarily select certain services they will not cover for you. While we extend the courtesy of filing insurance claims to all of our patients, all charges are your responsibility from the date the services are rendered.

We must emphasize that as medical care providers, our relationship is with you, **not your insurance company.** While the filling of insurance claims is a courtesy that we extend to our patients, **all charges are your responsibility from the date the services are rendered.** We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. If you have any questions about the above information or any uncertainty regarding your insurance coverage, **please do not hesitate to ask us. We are here to help you.**

Signature

Date

Patient History Form

Date: _____

Name: _____ **Height:** _____ **Weight:** _____ **Age:** _____

Present Illness: (Please describe in your own words your present problem.)

Past Medical History: (Please indicate if you have – or have ever had – any of the following illnesses. Give details in the next section.)

- | | | | |
|--|---|--|---------------------------------------|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Meningitis |
| <input type="checkbox"/> Syphilis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Polio | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Thyroid Disease | |
| <input type="checkbox"/> Seizure | <input type="checkbox"/> High Blood
Pressure | <input type="checkbox"/> Other | |

Serious Medical Illnesses: (Please list your past and present illnesses including the date and location you were treated.)

1. _____
2. _____
3. _____
4. _____

Serious Injuries: (Please list any serious injuries along with the date; including car accidents, broken bones, head trauma, etc.)

1. _____
2. _____
3. _____

Past Operations: (Please list type and date, hospital, and surgeon)

1. _____
2. _____
3. _____

Do you wear seat belts? Yes No

Pregnancies ____ Miscarriages/ Abortions ____ Any complications? (If yes, please explain) _____

List your children with age and sex:

Medications: (Please list all medications, including the strength and frequency. Please include any vitamins, hormones, birth control pills, and over-the-counter products.)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Do you use tobacco products? Yes No If yes, what kind?

If yes, for how many years and how much? _____

If you smoked in the past, when did you quit? _____

Do you drink alcoholic beverages? Yes No If yes, what kind?

If yes, how much and how often? _____

Allergies: (Please list medications to which you are allergic or ones you cannot tolerate for any reason.)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Who in your family has had: (ex: Mother, Father, Brother, Sister, etc.)

1. Cancer (Please list what type) _____

2. Diabetes

3. High Blood Pressure _____

4. Heart Disease/ Heart Attack

5. Mental Disease

6. Migraine Headaches

7. Seizures/ Epilepsy _____

8. Stroke

9. Tuberculosis

10. Kidney Failure/ Dialysis _____

11. Brain aneurysm _____

12. Other _____

Have you ever had significant problems with any of the following? (Please circle all that apply)

- | | | |
|----------------------------|--------------------------------|------------------------------|
| Headaches | Muscle cramps | Suicidal ideas |
| Nausea | Muscle twitching/ jerking | Nervousness |
| Vomiting | Difficulty walking | Loss of appetite |
| Convulsions/ Seizures | Unsteady balance | Difficulty getting words out |
| Fainting | Loss of coordination | Hearing or seeing things |
| Loss of vision | Trembling/ Shaking | Heat intolerance |
| Droopy eyelids | Difficulty controlling bladder | Palpitations |
| Loss of smell | Difficulty controlling bowel | Chest pain |
| Loss of taste | Recent weight loss | Chronic cough/ cough blood |
| ringing or buzzing in ears | Memory loss | Stomach pain |
| Dizziness | Confusion | Jaundice |
| Slurred speech | Depression | Swelling |
| Numbness/ Tingling | Anxiety/ Chronic worry | Constipation |
| Insomnia | Weakness | Penicillin allergy |
| Latex allergy | Anemia | Asthma |