Lonny D. Matlick D.O. Otolaryngology

Date: Use Tab Key

Co-Pay $ None

For Office Use

Patient Information

Name: Date of Birth: Age:

Street Address:

City State: Zip:

e-mail: Home Phone: ( ) -

Social Security # - - Cell Phone: ( ) -

☐ **Medicare** ☐ **HMO** ☐ **PPO** ☐ **Self Pay** ☐ **Other**

Primary Insurance Carrier: Policy #

Contact Phone # on Back of Card: ( ) - - Group #

Secondary Insurance Carrier: Policy #

Contact Phone # on Back of Card: ( ) - - Group #

Spouses Name Spouses Social Security # - - -

Patient Employer: Employer's Phone #: ( ) -

If Patient is a Minor:

Father's Name: Social Security # - - D.O.B.

Mother's Name: Social Security # - - D.O.B.

Referring Physician: **Family Physician:**

Check here if your visit is related to a workplace injury or illness? ☐ If so, please be advised that you must have approval from your employer or worker's compensation carrier prior to being seen.

If evaluation or treatment is requested as a result of an accident; auto or otherwise, you will be required to provide specific information with regard to the incident, and any insurance carriers or individuals that may be involved in covering the expenses related to that accident.. Please be advised that we do not wait for settlement of lawsuit cases for payment of office visits. Payment is due at time of services unless advance arrangements have made.

Guarantee to Pay

Referrals and Copay-

I understand that payment for medical services is expected at the time the services are rendered to me. I understand that this Doctor's office will bill my insurance carrier for the visit if in fact I have coverage, and if the office provides services under direct contract with my insurer. I understand that it is solely MY responsibility to provide necessary referral forms to comply with MY insurance carrier's requirements.

Copayment (Copay) Billing-

If my coverage demands a copay, I understand that it is MY obligation to satisfy that amount at the time services are rendered. If for whatever reason I am unable to satisfy my copay at the time of service, that copay will be added to my account, and I agree to pay a $ 10 billing/processing fee for that courtesy. Please note: This office accepts Cash, Checks, and Credit Cards.

Outstanding Balance-

I understand that any outstanding balance not covered by my insurance carrier will be my responsibility to pay. If my account is turned over to an attorney or collection agency for non-payment in a timely fashion, I agree to be responsible for Attorney's fees, court costs, and any other costs incurred by the collection agency and/or Attorney. My electronic signature on this document shall have the same force and effect as the original toward this end.

Returned Check Fee-

I understand that the RETURNED CHECK FEE (for "Bounced Check") will be $2500, and should a check I write to pay for services be rejected due to insufficient funds to cover it, that I will be responsible for this charge.

Assignment of Medicare Benefits-

By agreeing to these terms, I request that payment of authorized Medicare benefits be made to Lonny D. Matlick D.O. on my behalf for any services furnished me by this Physician's practice. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services. I authorize that payment of my medical benefits for office services and/or procedures to be made directly to Lonny D. Matlick D.0

Privacy Policies:

This office will do all in its power to maintain the integrity and confidentiality of your personal and medical information. I understand that the above privacy policies prohibit Dr. Matlick from discussing my confidential health issues with anyone except except those permitted under the HIPAA Act. (when deemed necessary to insure my health). I understand that I have a right to review the office privacy policy, and can request a copy at any time. I **understand that this Office Privacy Policy conforms to the regulations set out in the HIPAA Act (Health Insurance Portability and Accountability Act of 1996), and that I am entitled to a copy of this policy, and may request one at any time.**

☐ I have read and agree to the terms outlined above. Date:

Name: Signature:

(Leave Blank if submitting electronically)

My agreement to these terms and submission of this electronic form shall serve the same force and effect as my original signature.

Name: _____ Date: _____

Medical History

Let us know if you carry a list of Medicines, or a printed Medical History so we can save you time by simply copying it and attaching it to your medical record.

☐ I will bring a current copy of my Medical History with me to my upcoming visit.

My Medications:

Prior Surgeries:

Allergies to Medications:

Check if you have:

Are you a smoker? ☐ Yes ☐ No ☐ Quit

Do you drink Alcohol? ☐ Yes ☐ No ☐ Quit

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Hearing Loss
- ☐ Asthma
- ☐ Swallowing Problems
- ☐ Voice Problems
- ☐ Cough
- ☐ History of Cancer Type:_____
- ☐ Thyroid Disorders
- ☐ Anxiety
- ☐ Depression
- ☐ Headaches
- ☐ Seasonal Allergies
- ☐ Indigestion

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