PATIENT REGISTRATION & HEALTH QUESTIONNAIRE

Marital Status
(S)(M)(W)(D)(SEP)

Name:_________________________ DOB:______________ Date:_____________
Street Address_________________________ City_________________________
State/Zip_________________________
Phone#-Home(   )______________ Work (   )______________ Employer:_________________________
Spouses Name:_____________________ DOB:__________ Employer:_________________________

If under 18
Parent/Guardian:_________________________ Phone#:_________________________

EMERGENCY CONTACT PHONE#:_________________ RELATIONSHIP:_____________
(Other than Spouse)
ADDRESS:____

INSURANCE & BILLING INFORMATION

BILLING NAME_________________________ RELATIONSHIP:_____________________
(if other than patient)

BILLING ADDRESS:____________________________________ PHONE:_________________

PAYMENT REQUIRED AT TIME OF SERVICE-UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE

INSURANCE COMPANY_________________________ ADDRESS:_________________________
____

NAME OF INSURED_________________________ RELATIONSHIP TO PATIENT__________ GROUP#_________

INSURANCE COMPANY_________________________ ADDRESS:_________________________

NAME OF INSURED_________________________ RELATIONSHIP TO PATIENT__________ GROUP#_________

MEDICARE ID#_________________________ **MEDICAID ID #**_________________________

OTHER COVERAGE____

ASSIGNMENT OF INSURANCE BENEFITS

I HEREBY AUTHORZE DIRECT PAYMENT OF SURGICAL/MEDICAL BENEFITS TO DR. _________________FOR SERVICES RENDERED BY HIM/HER IN PERSON OR UNDER HIS /HER SUPERVISION. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE.

MEDICARE-MEDICAID

I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT IS CORRECT. I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF.

A photocopy of these assignments shall be as valid as the original

PATIENT NAME (PLEASE PRINT) ____ DATE ___________________

PARENT/GUARDIAN (PLEASE PRINT) ____

HEALTH QUESTIONNAIRE

REASON FOR VISIT____

FAMILY HISTORY *IF ANY BLOOD RELATIVE HAS SUFFERED ANY OF THE FOLLOWING-PLEASE CIRCLE AND INDICATE WHICH RELATIVE*

Epilepsy	Thyroid	Osteoporosis	High Colesterol	Relative:________________________
Migraine	Hayfever	Arthritis	Alcoholism	________________________
Mental Illlness	Asthma	Heart Disease	Hepatitis	________________________
Glaucoma	Anemia	Stroke	Cancer	________________________
Diabetes	Bleeds easily	High Blood Pressure		

HOSPITAL ADMISSIONS (NOT INCLUDING PREGNANCIES)
YEAR:_________________ ILLNESS OR OPERATION____
YEAR:_________________ ILLNESS OR OPERATION____

LIST ALL MEDICATIONS YOU ARE NOW TAKING-INCLUDE THOSE YOU BUY WITHOUT A PRESCRIPTION:

ALLERGIES:____ **SUPPLEMENTS:**_____________________________

VACCINES:	YEAR:	TEST/EXAM:	YEAR:
Tetanus/Td		Rectal/Stool	
Influenza (flu)		Cholesterol	
Pneumonia		Eye Exam	
Hepatitis		TB Test	
Covid		Hepatitis	

MEDICAL HISTORY **MARK (C) FOR CURRENT PROBLEMS. CHECK AND INDICATE AGE WHEN YOU HAD ANY OF THE FOLLOWING:**

( )Decreased hearing
( )Ringing in the ear
( )Ear Infections-frequent
( )Dizzy spells ( )fainting spells
( )Failing vision ( )Eye pain
( )Double or Blurred vision
( )Nose Bleeds-recurrent
( )Sinus Trouble
( )Sore Throats
( )Horseness-prolonged
( )Hayfever/Allergies
( )Pneumonia/Pleurisy
( )Bronchitis/Chronic Cough
( )Asthma/Wheezing
( )Shortness of Breath
( )on exertion ( )lying flat
( )Chest pain
( )High Blood Pressure
( )Heart Murmur ( )Swollen ankles
( )Irregular pulse ( )palpitations
( )Leg pain-when walking
( )Varicose veins/Phlebitis
( )Cold numb feet
( )Loss of Appetite-recent

( )Difficulty swallowing
( )Heartburn ( )peptic ulcer
( )Nausea/vomiting
( )Abdominal pain
( )Gallbladder trouble
( )Jaundice/Hepatitis
( )Diarrhea ( )Constipation
( )Diverticulosis ( )Crohns/Colitis
( )Inflammatory Bowel Syndrome
( )Bloody or Tarry stools
( )Hemorrhoids ( )Hernia
( )Overactive bladder
( )Overnight more than twice
( )More than 8 times in 24 hours
( )Urgency to urinate ( )with leakage
( )Decrease in force or flow ( )painful
( )Stress incontinence ( )with exercise
( )Blood in Urine ( )kidney stones
( )Urine infections-frequent
( )Weight loss/gain ( )Height loss
( )Appetite
( )Anemia ( )Bruise easily
( )Blood transfusions
( )Cancer ( )Easily fatigued

( )Decreased energy/endurance
( )Diabetes ( )Thyroid disease
( )Seizures ( )Stroke
( )Tremor/hands shaking
( )Numbness/Tingling sensations
( )Headaches-frequent
( )Arthritis/Rheumatism
( )Back Pain-current
( )Bone Fracture/joint injury
( )Osteoporosis
( )Foot pain ( )Gout
( )Rashes ( )Hives
( )Psoriasis ( )Eczema
( )Concentration problem ( )Sleep problem
( )Depression ( )Nervousness
( )Agitation ( )Memory Loss
( )Moodiness ( )Suicidal Thoughts
( )Phobias ( )Mental Illness
( )Feelings of Worthlessness
( )Rheumatic Fever ( )Scarlett Fever
( )Chickenpox ( )Polio ( )Mumps
( )Measles ( )German Measles
( )Tuberculosis ( )Herpes
( )AIDS/HIV ( )STD

( )Sexual Problems/Enjoyment
( )Decreased life enjoyment
( )Decrease work performance
( )Alcohol _______oz./week
( )Coffee/tea _______cups/day
( )Smoking ____cig/day____#yrs
( )Exercise
( )Street Drugs
( )Hair loss ( )prog ( )recent

MALES ( )**Prostate problems**

FEMALES **MENSTRUAL FLOW ( )REG ( )Irreg ( )Pain/Cramps #days of flow_______ Cycle Length________ First day of last period_____________**
( )Pain/Bleeding during or after sex ( )Birth Control ( )Flushing/Menopause
#PREGNANCIES__________ #ABORTIONS___________#MISCARRIAGES____________#LIVE BIRTHS_____________
DATE OF LAST PAP TEST_______________ ( )Normal ( )Abnormal DATE OF LAST MAMMOGRAM________________ ( )Normal ( )Abnormal

Notice of Privacy Acknowledgment

Michael Hirsch DO, LLC

I understand that under the Health Insurance Portability and Accountability Act (HIPPA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a cop of your Notice of Privacy Practices. I also understand that this practice has the right ot change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

____ ____________________

Patient Name or Legal Guardian (print) Date

____

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of Notice of Privacy Practice:

Date:____________________ Attempt:____

Staff Name:____

Patient Name:____

Financial Agreement:

I, whether signing this form as the patient or the responsible party (“Responsible Party”), agree to pay Dr. Michael Hirsch DO its charges for services rendered to the above mentioned patient (“Patient”). I further agree that all ascertainable copayments, deductibles, and/or coinsurance payments at the time services are rendered. I understand that I may be responsible for additional payments after the insurance carrier issues payment and an explanation of benefits. At such time, I will be billed for any unpaid balance due. Payment must be rendered within thirty (30) days of invoice. Interest at the rate of 1.5% per month (18% simple interest per year) shall be assessed on all outstanding balances thereafter of the maximum rate of interest allowable at the time of assessment.

Payment for services rendered is the obligation of the Responsible Party as well as that of the Patient in the event the Patient is not the Responsible Party signing this agreement. We reserve the right to send unpaid balances to collection. The Responsible Party shall be responsible for payment of all costs associated with the collection of any unpaid balance including interest and reasonable attorney’s fees.

Assignment of Insurance Benefits:

I understand and acknowledge that a valid assignment of benefits does not alter the insured’s obligations under his or her insurance policy for payment of deductibles, coinsurance, or any other charge for services rendered. The assignment of benefits only relates to the payment obligation that the insured’s health plan owes to the insured under the terms of the policy. I hereby assign to Dr. Michael Hirsch DO any insurance or other third party benefits available for the health care services provided to me. I further authorize my insurance carrier, or other third- party payor, to render payment directly to Dr. Michael Hirsch DO of all benefits which may be due and payable under insurance coverage for the patient. If I am a Medicare of Medicaid beneficiary, I authorize direct remittance of payment of all Medicare of Medicaid benefits to Dr. Michael Hirsch DO for all covered medical services and supplies provided to me during all course of treatment provided and care provided by Dr. Michael Hirsch DO and/or its affiliated entities or otherwise at its direction.

If the benefits are not assignable or if an insurance carrier renders payment directly to the insured, I agree to forward to Dr. Michael Hirsch DO all health insurance and other third-party payments received by patient or Responsible Party for services rendered to the patient immediately upon receipt. Failure to forward health insurance or other third-party payments may result in waiving any negotiated discounts I may otherwise enjoy. I further acknowledge that this assignment of benefits does not in any way relieve me of liability and that I will remain financially responsible to Dr. Michael Hirsch DO for services rendered to the patient.

I understand and agree that this Assignment of Benefits will have continuing effect for so long as I am being treated or cared for by Dr. Michael Hirsch DO, and will constitute a continuing authorization, maintained on file with Dr. Michael Hirsch DO, which will authorize and allow for direct payment to Dr. Michael Hirsch DO of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by Dr. Michael Hirsch DO.

Consent for Use and Disclosure of Protected Health Information:

Dr. Michael Hirsch DO may use and disclose my protected health information for the purpose of carrying out my treatment, obtaining payment for my health care or for carrying out the health care operations of Dr. Michael Hirsch DO even if I do not sign this consent. My “protected health information” includes all individually identifiable information which is created or received by Dr. Michael Hirsch DO and which relates to my past, present or future physical or mental health or condition, the provision of health care to me, or the past, present or future payment for the provision of health care to me.

I certify that I read and understood each of the above paragraphs and am the Patient or Responsible Party with the authority to execute this document and accept these terms. I acknowledge that I received a coy of the Dr. Michael Hirsch DO Notice of Privacy Practices.

____ ______________________

Signature of Patient or Responsible Party Date

Relationship to Patient______________________________________

If signed by a Responsible Party (other than the patient) please indicate legal authority:

( ) Parent/Guardian of a minor

( ) Power of Attorney (attach document)

( ) Healthcare Surrogate (attach document)

( ) Court Appointed Guardian (attach document)

Statement of Financial Responsibility

Patient Name:____ DOB:_______________

Dr. Michael Hirsch appreciated the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf, however, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your carrier. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to Dr. Michael Hirsch for providing rehabilitative services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Dr. Michael Hirsch the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient Signature:____ Date:____________________

Guarantor Signature:____ Date:____________________

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Patient/Guarantor signature:___________________________________ Date:____________________

Consent for Treatment and Authorization to Release Information

I hereby authorize___________________________________,through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

I further authorize___________________________________, to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

Patient/Guarantor signature:___________________________________ Date:___________________

Cancellation/No Show Policy

Patients/Guarantor unable to keep their scheduled appointments MUST CALL TO CANCEL 24-48 HOURS IN ADVANCE. This will allow us to accommodate patient(s) that are waiting to be seen in our office. Failure to do so may result in an administrative fee of $50.00 charged to their account and a no-show on their record.

Please arrive 15 minutes ahead of prior to your scheduled appointment. If you arrive 15 minutes or more to your scheduled appointment time, you may be asked to reschedule your appointment, and this will result in a cancellation on your medical record.

We DO NOT accept walk-in appointments. If you have an urgent matter, you may call the office and ask for a triage.

I have read the above information and agree.

Patient /Guarantor signature:___________________________________ Date:_________________