Michael V. Riesberg, M.D.

Patient Information

Name____ Date of Birth______________________

Address_____________________________________ City____________ State_____ Zip_______

SSN__________________ Marital Status____________________ Sex________________________

Daytime Phone_______________________________ Evening Phone________________________

Primary Physician____________________________ Referred By__________________________

Employer____

Employer Address____________________________ City____________ State_____ Zip_______

Person Responsible for Account________________________________ SSN__________________

Responsible Person's Employer________________________________ Phone________________

Child's Caretaker (if not above)__________________________ Relationship________________

Spouse or Parent's name (if applicable)____

Insurance Information

Primary Insurance____

Policy Number_______________________________ Group Number________________________

DOB of Policy Holder__________________________ Effective Date of Policy________________

Secondary Insurance____

Policy Number_______________________________ Group Number________________________

DOB of Policy Holder__________________________ Effective Date of Policy________________

PATIENT MEDICAL HISTORY

Patient Name______________________________________ Date of Visit______________________

What are we seeing you for today?

____

List all medications (include vitamins and over-the-counter):

____

____

List any allergies or reactions to medication/anesthetics:

____

____

List any previous ear, nose, or throat surgeries, and date performed:

____

____

List any hospitalization or other surgery and date:

____

____

PERSONAL/SOCIAL HABITS

Do you smoke or have you ever smoked? ❑ Yes ❑ No

If so, how much and how long?____

Year stopped________________ Does anyone in your house smoke? ❑ Yes ❑ No

Do you now or have you ever used smokeless tobacco? ❑ Yes ❑ No

If so, how much and how long?____

Do you drink alcohol? ❑ Yes ❑ No How much per day?_____________________

Do you use or have you used any recreational drugs? ❑ Yes ❑ No

If so, what type?____

Do you take blood thinners other than aspirin? ❑ Yes ❑ No

If so, what type?____

Type of work?____

Retired? ❑ Yes ❑ No Disabled? ❑ Yes ❑ No

Are you a student? ❑ Yes ❑ No Grade in school?________________________

PLEASE CIRCLE ALL THAT APPLY

Ears

Decreased Hearing: Yes No

Dizziness: Yes No

Frequent Ear Infections: Yes No

Nose

Snoring/Sleep Apnea: Yes No

Difficulty breathing through nose: Yes No

Sinus Pressure: Yes No

Throat

Recurrent sore throats: Yes No

Difficulty swallowing: Yes No

Hoarseness: Yes No

Difficulty with singing voice: Yes No

Allergy

History of allergies: Yes No

Allergy Shots: Yes No

Endocrine

Diabetes: Yes No

Thyroid trouble: Yes No

Cardiovascular

Irregular pulse: Yes No

High blood pressure: Yes No

Previous heart attack: Yes No

Hematological

Previous transfusion: Yes No

Easy bruising: Yes No

HIV+: Yes No

Gastrointestinal

Heartburn/Reflux: Yes No

Vomiting blood: Yes No

Ulcer: Yes No

History of hepatitis: Yes No

Respiratory

Frequent Cough: Yes No

Asthma: Yes No

Emphysema: Yes No

Coughing Blood: Yes No

Neurological

Previous head injury: Yes No

Previous Stroke: Yes No

Migraines: Yes No

Seizures: Yes No

Psychiatric

Anxiety: Yes No

Depression: Yes No

Other

History of cancer: Yes No

Weight loss: Yes No

Frequent fever: Yes No

Are you pregnant: Yes No

Other Conditions

___

___

___

Consent for Purposes of Treatment, Payment, and Health Care Options

I consent to the use of disclosure of my protected health information by Michael V. Riesberg, MD for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of Michael V. Riesberg, MD

I understand that diagnosis or treatment of me by Michael V. Riesberg, MD may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or health care operations of the practice. Michael V. Riesberg, MD is not required to agree to the restrictions that I may request. However, if Michael V. Riesberg, MD agrees to a restriction that I request, the restriction is binding on Michael V. Riesberg, MD.

I have the right to revoke this consent in writing at any time, except to the extent that Michael V. Riesberg, MD has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Michael V. Riesberg, MD's Notice of Privacy Practices prior to signing this document. By signing I attest that Michael V. Riesberg, MD's Notice of Privacy Practices as been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of Michael V. Riesberg, MD.

The Notice of Privacy Practices for Michael V. Riesberg, MD is also provided at 2411 Executive Plaza Dr., Suite 1, Pensacola, FL 32504. This Notice of Privacy Practices also describes my rights and the duties of Michael V. Riesberg, MD with respect to my protected health information.

Michael V. Riesberg, MD, reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy to be sent in the mail, or by asking for one at the time of my next appointment.

_______________________________________	_______________________________________
Signature of Patient or Personal Representative	Date
_______________________________________	_______________________________________
Printed Name of Patient or Personal Representative	Description of Personal Representative's Authority

Consent To Use or Disclose Health Information

I authorize Michael V. Riesberg, MD to use and disclose my medical information for the purposes of **Treatment, Payment, and Health Care Operations.**

- **Treatment** includes activities performed by a health care provider, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers my practice by telephone as the on-cal physician.

- **Payment** includes activities involved in determining your eligibility for health plan coverage billing and receiving payment for your health benefit clams, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization.

- **Health Care Operations** Includes the necessary administrative and business functions of our office.

I further authorize Michael V. Riesberg, MD to use and disclose the following specific health and medical information for the below listed purpose(s):

Specific medical information consisting of:

For the specific purpose of:

I understand that I have the right to revoke this consent provided that I do so in writing, except to the extent that Michael V. Riesberg, MD has already used or disclosed the information in reliance on this consent.

____

Signature of Patient

____

Signature of Person Authorized by Law

____

Date

Michael V. Riesberg, MD Financial Policy

OUR FINANCIAL POLICY: Michael V. Riesberg, MD is very concerned about the cost of your healthcare and has spent considerable time in setting our fees. We want to assure that the charges accurately reflect the complexity of care rendered and the skill and expertise required for you case.

INSURANCE USUAL AND CUSTOMARY: If an insurance company indicated that our fees are above the "usual and customary," please understand that most fees are above the rate which insurance companies choose to pay. We use many sources to determine the appropriateness of our fees. We cannot allow the payment or allowance of insurance companies to set the amount that we charge for services.

OUR POLICY: Our policy requires payment of co-payments and any deductibles at the time of service. If there is any balance owed after all insurance companies have made their payments, we will bill you for the remaining amount.

HMO AND PPO MEMBERS: If you are a member of an HMO or PPO in which we participate, your deductible or co-payment is required at the time of service. You are also responsible to see that we have a current referral on hand if your insurance carrier requires one. If we do not have this referral at the time of the visit, your insurance company may hold you responsible for all charges. You may also be sent back to your primary care physician prior to being treated to obtain a current referral.

Our agreement is with YOU and NOT your insurance company. You have chosen your insurance coverage. Although we will assist you in submitting your claim to your carrier you are ultimately responsible for the services you receive. Payment to our office is not contingent or dependent on your insurance carrier.

In your interest, we are pleased to accept MasterCard and Visa for your charges. Returned checks will receive a $25 overdraft charge. A $5 monthly billing fee will be added to all account balances outstanding beyond 30 days from the date of service. A $100 rescheduling fee will be applied to any surgery. Refer to our surgical rescheduling policy for specific information. We require 24 hours advance notice to avoid a $25 appointment rescheduling fee. Please contact our billing office to make payment arrangements at (850) 476-0700.

A collection agency may take over delinquent accounts. If your account is placed with a collection agency, you will be responsible for all costs of collection. Timely payment will prevent consequences to your credit rating.

If you have any questions about our financial policy or you insurance reimbursement, please feel free to discuss them with any staff member.

_______________________________________ ____________________

Patient/Responsible Party Signature Date

Michael V. Riesberg, MD.
2411 Executive Plaza Dr.
Pensacola, FL 32504
Phone: (850) 476-0700
Fax: (850) 476-4300

ACKNOWLEDGMENT OF REVISED NOTICE OF PRIVACY PRACTICES

____
Patient Name

I hereby acknowledge that I have received the revised Notice Of Privacy Practices statement dated December 13, 2004 of Michael V. Riesberg MD.

____
Signature

____
Date