Delaware Otolaryngology Consultants LLC
Medical History Form

Date ____/____/____

*The following information is for use by your healthcare provider as part of your confidential medical record. The following information is also very important to your health.Please take time to fully and accurately fill out this form.

Name:_____ □ **Male** □ **Female** **Date of Birth** ___/____/____

Pharmacy Name and Location:_____**Ht**:_____ **Wt**:_____

Reason for your Visit:

_____

_____

_____

Past Medical History and Review of Systems:

- □ Ringing in the Ears R or L
- □ Ear Pain R or L
- □ Decreased Hearing
- □ Sleep Apnea
- □ Snoring
- □ Itchy Ears R or L
- □ Sore Throat
- □ Voice Changes
- □ Difficulty Swallowing
- □ Acid Reflux/Heartburn
- □ Vomiting/Nausea
- □ Headache/Migraine
- □ Thyroid Hypo or Hyper
- □ Nose Bleeds
- □ Coughing
- □ Wheezing
- □ Asthma
- □ COPD
- □ Blood Clots/Disorder
- □ Heart Disease
- □ Stroke
- □ Pacemaker
- □ High Blood Pressure
- □ Anxiety/Depression
- □ Diabetes
- □ HIV or AIDS
- □ Pregnant Due:_____/_____/_____
- □ Cancer Type and Date :_____
- □ Seasonal Allergies
- □ Arthritis
- □ Mouth Pain
- □ Head Injury
- □ Gout
- □ Dizziness/Vertigo
- □ Hepatitis A B C D E
- □ Parkinsons
- □ Multiple Sclerosis
- □ Loss of Taste
- □ Loss of Smell

If need be please explain problems further or if not listed add:

_____

_____

_____

Do you?

Smoke
□**No** □**Yes** □**Past**

How Much or When did you Quit?
_____

Drink Alcohol
□**No** □ **Yes**

How Much/Often?
_____

Caffeinated Drinks
□**No** □ **Yes**

How Much/Often?
_____

Please Complete Other Side

Are you Allergic to any Medications or Latex? □ **No Known Drug Allergies** □**Yes (please explain)**

_____

_____

Please List All Medications You Take: □ **None**
Include over the counter medicine and vitamins

Drug Name and Dosage

1._____ 2._____

3._____ 4._____

5._____ 6._____

7._____ 8._____

9._____ 10._____

11._____ 12._____

Surgical History □ **None**

Year	Operation/Procedure	Year	Operation/Procedure

Have you recently had any lab work or imaging done? □ Yes □ No
If yes when and what for

_____

_____

*The above is true and correct to the best of my belief.

Patient/Guardian Signature:_____ **Date** _____/_____/_____

Delaware Otolaryngology Consultants LLC
Beth Duncan MD, MBA-HC
17316 Coastal Hwy Lewes De 19958
Office: 302-644-2232 Fax: 302-644-2237

Date: ____/____/____

Name: _____ DOB: ____/____/____

Address: _____

City:_____ State: _____ Zip: _____

Phone #: _____ Cell #: _____

Email: _____

Pharmacy: _____

Primary Care Physician: _____

Address: _____

Phone #: _____

Referring Physician: _____

Address : _____

Phone #: _____

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Patient Name: _____ DOB:____/____/____

Patient Address: _____ City:_____ State:_____ Zip:_____

Insurance Name and ID #: _____

I hereby instruct and direct any insurance carrier that is providing insurance benefits on my behalf under any policy of insurance to make out a check to and directly pay Dr. Beth Duncan for professional services rendered to me. This includes a direct assignment of my rights and benefits under any such policy of insurance.

This assignment of insurance benefits is provided so that Dr. Beth Duncan may attempt to collect any unpaid and overdue insurance benefits directly from the insurance carrier.I authorize any holder of insurance information about me to release such information to Dr. Beth Duncan needed to determine the insurance benefits or to assist in the collection of payment for services. I authorize Dr. Beth Duncan to contact the insurance company for an exact dollar amount of insurance benefits that are available under any policy of insurance that affords coverage and to obtain ay payout or check ledger reflecting insurance benefits that have been paid out on my behalf.

A copy of this agreement will be as valid as the original. I have read and understand this agreement thoroughly.

I also realize that there is a possibility that my insurance company may not pay for certain services rendered by Delaware Otolaryngology Consultants LLC. Delaware Otolaryngology Consultants LLC does not promise or guarantee that all services rendered to me will be paid by my insurance company. I agree to pay for all charges for services rendered to me if my insurance company denies payment.

Dated at ____:____ this ____day of _____ 20___
(Time) (Day) (Month)

_____ _____
Signature of Policyholder **Witness**

Please List Below any Emergency Contacts that you wish to be contacted in case of an Emergency.

Name:_____Relationship:_____Phone#:_____
Name:_____Relationship:_____Phone#:_____
Name:_____Relationship:_____Phone#:_____

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Acknowledgement of Receipt of Notice of Privacy Practices

Your name and signature on this sheet indicate that you have been given the opportunity to review and request a copy of the Delaware Otolaryngology Consultants LLC's Notice of Privacy Practices on the date indicated. If you have any questions regarding the information in Delaware Otolaryngology Consultants LLC's Notice of Privacy Practices, please do not hesitate to contact the office manager.

Patient Name: _____

If Patient Representative, Name (Printed):_____

Relationship to Patient: _____

Account # or Medical Record #:_____

Signature:_____

Date Notice Received: ____/____/____

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Financial Policy For Billing and Collection

Payment Policy
Thank you for choosing us as your healthcare provider. We are committed to providing you with quality and affordable healthcare. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

Insurance
We participate in most insurance plans, including Medicare and Medicaid. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do participate with, all insurance information must be given to us at the time of your visit. Claims are submitted within 24hrs of the date of service. If we have the incorrect insurance information you will be responsible for the visit. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Co-payments and Deductibles
All copays and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect copays from patients can be considered fraud. Please help us in upholding the law by paying your copay at each visit.

Non Covered Services
Please be aware that some and perhaps all of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for payment on these services.

Proof of Insurance
All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information at the time of your visit, you could be responsible for that claim.

Claims Submission
We will submit your claims and assist you in any way we reasonably can to help your claims get paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and the insurance company; we are not party to that contract.

Coverage Changes
If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you. It is important that we notify you of non payment so we can get your assistance in getting your claim(s) paid. Several insurance companies have imposed timely filing deadlines that possibly could impact payment on your account. Some deadlines are as early as 60 days from date the services were rendered.

Returned Checks
For all returned checks there will be a $40.00 processing fee (which is the fee we incur from the bank for a returned check) that fee will be added to the amount of the check and will be your responsibility to pay the balance with cash, money order or credit card within 72 hours. From that point on we will not accept a personal check from you.

Insurance Referral
Some insurance companies require a referral from your primary care doctor in order for you to see Dr. Duncan. If you require a referral, it would be written in your contract with your insurance company. Failure to obtain a referral may result in your claim being denied. If the insurance company denies the claim you will be financially responsible for the claim.

Non Payment (Patient)
If your account is over 90 days past due, you will receive a statement stating that you will have 10 days to contact our office and make payment arrangements. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. You will also be responsible for 35% of the past due balance in addition to the unpaid patient portion.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY FOR BILLING AND COLLECTION OF MY OFFICE VISIT;

_____	____/____/____
Patient Name (Print)	Date
_____	_____-_____-_____
Signature	Subscriber's SSN
____/____/____	_____-_____-_____
Patient's DOB	Patient's SSN
_____	____/____/____
Subscriber's Name (if different from patient)	Subscriber's DOB