

MICHAEL E VILLANO, MD, FACS LLC
Board Certified, American Board of Otolaryngology, Head and Neck Surgery

PATIENT INFORMATION

Last name: _____ First name: _____ Middle initial: _____

Date of Birth: _____ Gender: Male Female ___ Marital Status: M S W D

Phone (H): _____ Phone (W): _____ ext. _____ Phone (C): _____

Address: _____ City/State: _____ Zip: _____

Did another physician **refer** you to Dr. Villano? YES NO Referring Physician: _____

Do you have a **primary care** physician? YES NO Primary Care Physician: _____

If you were not referred by a physician, please tell us how you did hear about us: _____

Email: _____ Preferred Pharmacy: _____

May we leave a message on your phone? Y or N (circle)

May we send you updates and information regarding the practice? (Circle) Yes or No

Occupation _____

GUARANTOR INFORMATION

Last name: _____ First name: _____ Middle initial: _____

How patient is related to me: (circle one) self spouse my child other: _____

Date of Birth: _____ Gender: Male Female SSN: _____ Marital Status: M S W D

Phone (H): _____ Phone (W): _____ ext. _____ Phone (C): _____

Address: _____ City/State: _____ Zip: _____

INSURANCE INFORMATION - Primary

Insurance: _____ How patient is related to me: self spouse my child other: _____

Policy holder last name: _____ Policy holder first name: _____

Policy holder Date of Birth: _____ Policy holder employer: _____

Phone (H): _____ Phone (W): _____ ext. _____ Phone (C): _____

Address: _____ City/State: _____ Zip: _____

Policy holder SSN: _____ Insurance Group number: _____ Policy number: _____

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INSURANCE INFORMATION - Secondary

Insurance: _____ **How patient is related to me: self spouse my child other:** _____

Policy holder last name: _____ Policy holder first name: _____

Policy holder Date of Birth: _____ Policy holder employer: _____

Phone (H): _____ Phone (W): _____ ext. _____ Phone (C): _____

Address: _____ City/State: _____ Zip: _____

Policy holder SSN: _____ Insurance Group number: _____ Policy number: _____

Employer: _____ Occupation: _____

AUTHORIZATIONS

I authorize medical treatment of the person named above and agree to pay all fees and charges for such treatment. I am signing this as a lifetime authorization for Michael E. Villano, MD, LLC to bill my insurance, Medicare, Medicaid and/or Medigap for these services; and to accept assignment of the benefits for Medicare, Medicaid, and/or Medigap. I authorize Michael E Villano, MD LLC to disclose complete information concerning medical finding and treatment of the undersigned, from the initial office visit until date of the conclusion of such treatment, to those individuals who, in Michael E Villano, MD LLC determination, are required to receive such information for the purpose of medical treatment, medical quality assurance, peer review, and if applicable to process the insurance claim for services rendered at Michael E Villano, MD LLC.

I understand that I am responsible for any balance due for professional services in excess of the benefits provided by my policy. I agree to pay for services not covered by my insurance policy. I understand I am responsible for obtaining any prior authorizations required by my insurance policy. I understand that in the event of collection action, I am responsible for any legal fees incurred.

Signature: _____ Date: _____

MEDICARE ASSIGNMENT

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who may be responsible for paying for my treatment. (Section 112B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding information.) Regulations pertaining to Medicare assignment of benefits also apply.

Signature: _____ Date: _____

Medical History

Patient Name: _____ Date of Birth: _____

Reason for your visit: _____

Symptom(s): _____

Date symptom(s) began: _____ How did symptom(s) start: _____

Duration: _____ How did symptom(s) progress: _____

What brings it on: _____ What relieves it? _____

What makes it worse: _____ Associated symptoms? _____

ALLERGIES

List all Allergies:

Describe your Reaction:

CURRENT MEDICATIONS

Drug Name (brand/generic)

Dosage:

Schedule (frequency)

PAST MEDICAL HISTORY

Have you ever had any of the following? Please check (√) all that apply

- | | | | |
|-------------------|-----------------------------------|---------------------|---------------------|
| Anemia | Depression | Heart Disease | Shortness of Breath |
| Ankle Swelling | Diabetes | Heart Attack | Stroke |
| Bleeding Tendency | Dizziness | Hearing Problems | Thrombophlebitis |
| Cancer | Emphysema | High Blood Pressure | Ulcer |
| Chest Pain | Endocrine Problem such as thyroid | HIV (AIDs) | Vision Problems |
| Coughing Blood | | Pneumonia | |

Illnesses	Date	Hospitalizations	Date	Injuries	Date	List all surgeries	Date

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FAMILY HISTORY

Relative	Current Health	Age if Living	Age of Death	Cause of Death	Known Illnesses
Mother					
Father					
Brother(s)					
Sister(s)					

HISTORY OF TOBACCO

Have you ever smoked? Yes No If yes, when? _____

Are you currently smoking? Yes No

Cigarettes _____ How many a day? _____ How many years? _____

Cigars _____ How many a day? _____ How many years? _____

Smokeless tobacco _____ How many a day? _____ How many years? _____

HISTORY OF ALCOHOL

Do you drink alcohol? Yes No Recovery Alcoholic? Yes No Probably an Alcoholic? Yes No

Drink Alcohol _____ How many times a week? _____ OR times a month? _____

Cigars _____ How many a day? _____ How many years? _____

Preferred beverage? _____

HISTORY OF RECREATIONAL DRUGS

Have you ever used illicit drugs? Yes No

Do you currently use illicit drugs? Yes No Drug(s) of choice _____

Acknowledgment and Consent

I understand that Michael E. Villano MD, LLC (referred to below as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception area.

I acknowledge that I have been informed that at times, new information about the practice may be promulgated via e-mail. I have the right to refuse receiving this information at any time by notifying the practice in writing.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

By: _____ (Patient)	Date: _____
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Financial Policy

We are committed to meeting your healthcare needs. Our goal is to keep your insurance or other financial arrangements as simple as possible. In order to accomplish this in a cost effective manner, we ask that you adhere to the following guidelines.

Payment Options:

We accept Visa, MasterCard, personal checks and cash for insurance co pays. Please be aware that we will add a \$35.00 charge to your account for returned checks. We reserve the right to send all accounts with balances over 60 days old to an outside collection agency. All accounts sent to collections will be charged a \$50.00 processing fee and any additional fees associated. You will be responsible for all reasonable collections and attorney costs incurred. **Cancellations and No Show**, Cancellations' within two business days of your scheduled appointment will result to a \$50.00 cancellation fee. Failure to show for your appointment will result in a "no show" fee of \$50.00.

Insurance

We offer benefit verification as a courtesy, however, it is your responsibility to obtain insurance coverage and benefits prior to your visit with us. As a patient, you will be responsible for any co pays, additional testing, and services not covered by your insurance. If you do not have your insurance card, or we do not participate with your insurance plan, you can either reschedule your appointment or pay for your visit in full at the time services are rendered. We will supply you with the necessary information to submit the claim to your insurance company. Any balance left after your insurance has paid must be remitted within 30 days, if your account is not paid in full there will be a \$5.00 rebilling fee applied to your account monthly.

Uninsured Patients

If you plan to pay privately for your services, please be advised that it is the policy of CascadeENT practice to collect payment in full at the time of service. If you are unable to make payment in full at the time of service, your appointment will be rescheduled to a more convenient time.

Motor Vehicle Accidents (MVA)/Third Party Liability

We will require all claim detail (claim#, contact info, billing address) at the time of your appointment; otherwise we will require payment in full for services rendered for each patient being treated for a MVA/other accident-related injury. We will file claim(s) with the motor vehicle or third party insurance company that you designate, provided we receive all necessary information with which to bill. If the claims are denied, or a protracted lawsuit is involved, the patient is responsible to pay the account balance in full. We will bill your private health for balance left after your personal injury protection (PIP) exhausted.

Form Fees

Forms and letters requested by our patients will be assessed a fee as listed below. This list is not meant to be all inclusive but is merely representative of the items that may incur a charge. This fee covers our administrative expenses related to physician/staff time, photocopying, mailing, etc.

Work Excuses	\$30.00 each	Letters of Medical Necessity	\$30.00 each
Disability forms	\$30.00 each	Family Medical Leave Act Forms	\$30.00 each
Workers Comp	\$30.00 each	MVA Forms	\$30.00 each

I acknowledge that I have received a copy of this financial policy. I agree to read this document and comply with the terms set forth for services rendered by Michael E. Villano, MD, LLC.

Patient Signature (Guarantor)

Date