David W. Price, M.D. P.A.
Ear, Nose, and Throat
2210 San Jacinto Blvd, Ste 3
Denton, TX 76205
940-566-6747 Fax 940-565-9162
www.dpricemd.com

For Office Use: Setup Date: _____

Account #: _____

Patient's Name (First, Middle, Last): _____

Address: _____

City: _____ State: _____ Zip Code: _____ Email: _____

Main Contact#: _____ Alternate #: _____ Work #: _____

Date of Birth: _____/_____/_____ Sex: Male Female Social Security #: _____

Marital Status: Single Married Divorced Widowed Occupation: _____

Spouse Name: _____ Spouse Date of Birth: _____/_____/_____

Spouse Main Contact#: _____ Spouse Alternate #: _____

Emergency Contact: _____ Relationship: _____ Phone#: _____

Primary Care Physician: _____ Phone#: _____

Referring Physician: _____ Phone#: _____

Preferred Pharmacy: _____ Phone#: _____

Other Patient Information:----------

Which Racial Category does the patient most closely identify with?

African American Asian Caucasian Hispanic Native American Native Hawaiian

Other : _____ (Please Specify)

Ethnicity: What is the patient's ethnicity? Hispanic or Latino Not Hispanic or Latino

What is the patient's language of preference? English Spanish Other : _____ (Please Specify)

Insurance Information ----------

Primary Insurance: _____

Name of Policy Holder: _____ DOB: _____/_____/_____ SS# _____

Employer: _____ Employer Address: _____

City: _____ State: _____ Zip Code: _____ Work#: _____

Secondary Insurance: _____

Name of Policy Holder: _____ DOB: _____/_____/_____ SS# _____

Employer: _____ Employer Address: _____

City: _____ State: _____ Zip Code: _____ Work#: _____

Complete –Only if Patient is a Minor----------

Father's/Guardian Name: _____ Phone#: _____

Mother's/Guardian Name: _____ Phone#: _____

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Assignment to Pay Insurance Benefits

I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, private insurance and any other health plans to David W. Price. This assignment is for services rendered to me by David W. Price. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure this payment. I understand that failure to notify David W. Price of any changes or insurance coverage will result in the financial obligation to rest fully on myself regardless of any contract between the insurance company and David W. Price.

Signature: _____ Date: _____

Patient/Guardian

Consent for Treatment

By signing this consent, I am authorizing David W. Price and/or other individuals he deems appropriate to perform and/or order exams, test, procedures, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical conditions. This consent is valid for each visit I make to David. W. Price unless revoked by me in writing.

Signature: _____ Date: _____

Relationship to Patient: _____

HIPPA Disclosure

I understand that, under the Health Insurance Portability & Accountability Act of 1996, as amended and supplemented (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). PHI may originate in your medical record David W. Price (DP), or may be received from outside health entities and filed in your medical record. I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that DP, has the right to change its Notice of Privacy Practices from time to time and that I may obtain a current copy of the Notice of Privacy Practices from his office. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I understand that I may revoke this consent in writing at any time.
Name or class of person(s) authorized by this form to use and disclose the patients PHI. (Spouse, parent, doctor)_____

_____

_____

Signature: _____ Date: _____ Relationship to Patient: _____

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FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bills is considered part of your treatment.

- **PAYMENT: Payment is expected at the time of service.** If your deductible has not been met, or a percentage is your responsibility, we expect payment when services are rendered. **Even though insurance will be filed, you are responsible for any balance after insurance processes your claim.** All charges for treatment become due and payable forty five (45) days after the date of service. These periods allow sufficient time to process insurance and make payment in full of any remaining balance. There will be a $30.00 charge for returned checks. If not paid within 45 days, David W. Price will begin various collection activities including, but not limited by submitting the past due account to a collection agency.

- **SELF PAYMENT (PRIVATE, CASH PAYMENT):** If you have no insurance coverage we require payment for professional services rendered at time services are received.

- **MANAGED CARE: All managed care (PPO, etc.) co-payment amounts are due at the time of service.** If your insurance plan requires a referral authorization from a primary care physician please present this at your initial visit. If you request an office visit or surgery without a referral authorization your insurance plan may deem this as **"out of network" or "non covered" treatment**, and you will be responsible for all of the charges. By signing below, patient acknowledges that it is the patient responsibility to be aware of what services are covered and agrees to pay for any service deemed to be non covered or not authorized by the plan. Before receiving services, you must verify that we are participating providers for your insurance company. It is also necessary that a primary care physician be listed with your insurance company, if required by your contract.

- **MEDICARE:** David W. Price is a participating provider with the Medicare program and accepts as payment, the Medicare allowable, patient deductible and/or 20% co-insurance. If you have supplemental insurance (Medigap) to cover the portion of the charges that Medicare does not pay, please provide us with a copy of your insurance card and any forms your insurance company may require. Medicare or secondary carriers do not cover some procedures and supplies. Please make certain you understand which aspects of your treatment are covered before proceeding. In this rare case you may be asked to sign a waiver form, which states that you understand that you will be responsible for these charges. We are not a Medicaid/QMB provider and will not file a claim to Medicaid for services rendered.

- **CHILDREN OF DIVORCED PARENTS:** Responsibility for payment for treatment of minor children, whose parents are divorced, rests with the parent who seeks the treatment. Any court ordered responsibility judgment must be determined between the individuals involved, without the inclusion of David W. Price MD.

- We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance, it is your responsibility to contact our office within 30-days after receipt of the initial statement.

- In the event you submit payment by check and the bank returns the check unpaid for any reason, we will add $30 to your original balance. In addition, we may seek all additional legal remedies provided to us under Texas law.

Failure to keep your account balance current may require us to cancel or reschedule your appointment.

Patient Name (please print): _____ DOB: _____

Signature (insured/guardian): _____ Date: _____

Medical History Form

Patient Name (first, mi, last): _____DOB:____/___/___

Allergies: (include medications, foods, and x-ray dyes) or circle **NONE KNOWN**:

Name of Allergen	Type of reaction	Approximate Date

CURRENT MEDICATIONS :(include prescription, OTC medications).Attach extra sheet if needed. Or circle **NONE**

Name of Medication	Dose(mg)	How often taken	Reason for taking	Physician Prescribing

Previous Hospitalizations(all non surgical hospitalizations. Attach extra sheet if necessary) or circle **NONE**

Reason for Stay	Date	Hospital

Surgeries: list or circle **NONE**

Type of Surgery	Date	Hospital

TOBACCO HISTORY:

Are you an active Cigarette smoker: yes no

If yes, I smoke an average of _____packs/day for _____years.

Have you ever been a cigarette smoker: yes no I quit in _____.

If yes, I smoked an average of _____packs/day for _____years.

Do you use other forms of tobacco? _____Please specify what type: _____

If yes, I use _____a day for _____years.

ALCOHOL AND DRUG HISTORY:

Do you currently drink alcohol regularly? Yes no seldom

If yes approximately how many drinks per week? _____

Have you ever used drugs? Yes No

FAMILY HISTORY (has a relative had a history of any of the following)

	Yes	No	Affected Relative
Cancer			
Thyroid Disease			
High Blood Pressure			
Stroke			
Diabetes			
Other Significant disease			