



Patient Information Form

MRN#: _____

Last Name: _____ First Name: _____ MI: _____
Date of Birth: _____ Sex: _____ Marital Status: S M D W
Language: English, Bosnian, French, German, Mandarin, Spanish, Vietnamese, Italian, Decline
Race: African American, American Indian, Caucasian, Chinese, Filipino, Hispanic, Japanese, Multiracial, Native American, Declined
Ethnicity: Hispanic or Latino, Non-Hispanic or Latino, Declined
Home Number: _____ Work Number: _____ Mobile Number: _____
Preferred Phone Contact: Home, Work, Mobile Ok to Receive Text Messages: Yes or No
Email Address: _____
Home Address: _____
City: _____ State: _____ Zip Code: _____
Preferred Local Pharmacy: _____ Phone Number: _____
Referring Physician: _____ Primary Care Physician: _____
How did you hear about us: Flyer, Insurance, Radio, Facebook, Patient, Other _____

Guarantor Information (Person bringing in minor)

Last Name: _____ First Name: _____ MI: _____
Date of Birth: _____ Sex: _____ Relationship to Patient: _____
Billing Address(if different from above): _____
Home Number: _____ Mobile Number: _____

Insurance Information

Primary Insurance: _____ Subscriber/Policy Number: _____
Last Name: _____ First Name: _____ MI: _____
Date of Birth: _____ Sex: _____ Relationship to Patient: _____
Billing Address(if different from above): _____
Home Number: _____ Mobile Number: _____

Secondary Insurance: _____ Subscriber/Policy Number: _____
Last Name: _____ First Name: _____ MI: _____
Date of Birth: _____ Sex: _____ Relationship to Patient: _____
Billing Address(if different from above): _____
Home Number: _____ Mobile Number: _____

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes to the above information. I authorize the release of any medical information necessary to process an insurance claim and request payment of benefits be made to the physician unless my account has been paid in full. I have received Sound Health Services, P.C. notice of privacy practice.

Responsible Party Signature: _____ Initials: _____ Date: _____
In Lieu of Signature Option, if not available, please type name and initial



FINANCIAL AGREEMENT

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. WE WILL REQUEST A COPY OF YOUR INSURANCE CARD AND A PHOTO I.D. FOR YOUR FILE.

- **APPOINTMENTS-** 24 hours notice must be provided in the event you cannot keep an appointment. Should you not provide this notice, a cancellation fee of \$35 may then be added to your account. Cancellations on Ancillary Service will have a higher fee.
- **REFERRALS-** If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral, YOU WILL BE REQUIRED TO SIGN A FINANCIAL WAIVER to be set up as a "Self-Pay" patient. It is then your responsibility to provide us with the referral within 48 hours or you will personally be responsible for that day's services.
- **CO-PAYMENTS-** By law we MUST collect your carrier designated copay. This payment is expected at the time of service. Please be prepared to pay the copay at each visit. Should you not pay at the time of service, and we subsequently send you a statement, an administrative fee of \$5 may be added to your account. Any procedure performed in this office could be deemed surgical by your insurance company and all copays and deductibles will apply.
- **FMLA and/or WORKMAN COMP-** There is a \$25.00 charge for completion of FMLA or Workman Comp forms.
- **SURGERY DEPOSITS-** If you and your physician determine that your course of care requires surgery, a surgical deposit will be collected at the time of scheduling. Our scheduling coordinators will work with you to determine the estimated insurance payment and estimated patient responsibility.
- **OUT of NETWORK PLANS-** You will be responsible for any balance your plan indicates as due to their explanation of benefit form. We will adjust the charges to coincide with your plan's UCR (Usual, Customary and Reasonable) charges. All patients will be responsible for their co-insurance and deductible. If we do not "participate" with your plan, we will send a courtesy bill to that carrier on your behalf. However should they not pay your claim within 45 days, you will be responsible for the full amount. Should you receive payment from your insurance carrier, please forward it to the physician's office.

Private Insurance Authorization of Benefits/Information Release. I, the undersigned, authorize payment of medical benefits to Sound Health Services, P.C. for any service furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize any holder of information about me to release to my insurance company (or the agent) information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

- **SELF-PAY PATIENTS** Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.
- **MEDICARE-** We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one.

Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits to be made on my behalf to Sound Health Services, P.C. for any services furnished to me. I authorize any holder of medical information about me to release to the CMS (and its agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluation and administering claims of benefits.

- **DIVORCED/SEPARATED PARENT of MINOR PATIENTS-** The parent who consents to the treatment of a minor child is responsible for payment of services rendered. Sound Health Services, P.C. will not be involved with separation or divorce disputes.
- **INSUFFICIENT FUND CHECKS-** A \$25.00 fee will be charged to a patient's account for checks returned due to on sufficient funds.
- You are responsible for the timely payment on your account. Should it become necessary for us to use an outside agency to collect payment from you, you will be obligated to pay us, to cover the costs of using a collection agency and an additional 30% of your total unpaid balance at the time a collection agency is brought in to collect your account. WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, AMERICAN EXPRESS, DISCOVER OR CARE CREDIT. THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share with us special concerns.

Patient's Name: _____ Date of Birth: _____

Responsible Party Signature: _____ Initials: _____ Date: _____

In Lieu of Signature Option, if not available, please type name and initial



AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____

Date of Birth: _____

I understand that Sound Health Services, P.C. (the "Practice") has certain rights and obligations with regard to my protected health information (information regarding my health and treatment that the Practice may have in its possession). I also understand that I have certain rights with regard to my protected health information.

I authorize the Practice to provide informational reminders regarding upcoming appointments I may have to me or anyone who may answer the telephone, or to leave such reminders on any telephone answering device or service, at the telephone number(s) I have provided the Practice as telephone numbers at which I may be contacted (other than the telephone number of my place of employment) or an at of the following telephone numbers

_____.

I authorize Sound to report any test results on any telephone answering devices or service which may answer the telephone number I inserted in the preceding paragraph.

I authorize the Practice to disclose my protected health information to any of the following persons (state name of person and relationship to you):

I understand that I may revoke any authorization granted above by written notice signed by me delivered to the Practice's Privacy Official at the address stated below. My authorization remains valid until revoked by me in writing.

I acknowledge receipt of the Practice's Privacy Practices Notice effective September 23, 2013 regarding the Practice's rights and obligations and my rights regarding Protected Health Information. I acknowledge that I understand that I have the right to request and receive clarifications, explanations or further information with regards to the Practice's Privacy Practices through written request signed by me addressed to the Practice's Privacy Official.

Sound Health Services, P.C.

Attn: Privacy Official

1010 Old Des Peres Road

St. Louis, MO 63131

Signature of Patient/Patient's Representative _____ Initials: _____ Date: _____

In Lieu of Signature Option, if not available, please type name and initial

Basis of representative's authority to act for patient: _____



Pediatric Medical History Form

Patient Name: _____ Patient Date of Birth _____ Today's Date: _____

Patient Address: _____ Phone #: _____

Parent/Child – Place of Employment: _____

Name and Title of Legal Guardian: _____

Is the above named responsible for 100% of Medical Decision Making ___ YES ___ NO ___ OTHER

Child resides with: ___ Both Parents ___ Mom ___ Dad ___ Grandparents ___ Foster Family ___ Other family/relatives

Parents are: ___ Married ___ Not Married ___ Separated ___ Divorced

Does your child attend: ___ Daycare ___ Preschool ___ Current Grade in school? _____

Number of brother(s)/Sister(s) _____ Pets in the home? ___ Yes ___ No ___ Dog ___ Cat. If other please list _____

What is the main reason for your child's visit today? _____

How long has this problem Existed? _____ Current Height _____ Current Weight _____

Current Concerns: Please check all that apply:

Ear Problems- Ear infection ___ # in 6 months ___ # in 12 months, Prolonged fluid in middle ear, Ea Ear Pain, Ear Wax, Ear Drainage, Failed Hearing Test, Hearing Loss, Other _____

Nose Problem- Nasal Blockage, Nasal Drainage, Headache, Repeated Sinus infections, Nosebleeds, M Mouth breathing, Throat-Clearing/Cough, Other _____

Throat/Mouth/Neck Problems- Sore Throat ___ # in 12 months, Hoarseness/voice problems, Speech Speech Delay, Tongue Tie, Swallowing Problems/Poor Feeding, Cough, Snoring, Noisy Breathing, Mass in Neck, Croup, Sleep Apnea, Other _____

Past Medical Problems/Hospitalizations. Please Include dates of Admission: _____

Past ENT Medical History. If possible, please include dates: _____

Past Surgical History. Please list procedure, dates and surgeon: _____

Past ENT Surgeries (ie: tonsils, tubes etc.) _____

Medications--Please check if your child is now, or has in the past 6 months, been on any of the following:

A Amoxicillin, Augmentin, Bactrim, Biaxin, Ceclor, Cedax, Cefdin, Cefzil, Clindamycin, Er Erythromycin, Omnicef, Pedazole, Rocephin, Sepira, Surpax, Vantin, Zithromax

If you checked any of the above, please list Name, Date, Strength and frequency:

Current Medications: _____

Allergies to Medications: List drug name and reactions (rash, swelling, shock) _____



Pediatric Medical History Form

Patient Name: _____

DOB _____

Social History

Smokers in the house? (include even if they do not smoke inside) ___ YES ___ NO

Family History: Has any immediate family (Father, Mother, Brother Sister, Grandparents) been diagnosed with any of the following: If yes please specify relation

Problems with Anesthesia: _____

Problems with Bleeding: _____

Seizures: _____

Heart Disease: _____

Kidney Disease: _____

Allergies: _____

Asthma: _____

Hearing Loss: _____

Sudden Death: _____

Review of System:

- Fever ___ YES ___ NO Weight Loss ___ YES ___ NO Eye Drainage ___ YES ___ NO
Headaches ___ YES ___ NO Dental Problems ___ YES ___ NO Heart Murmur ___ YES ___ NO
Wheeze ___ YES ___ NO Indigestion ___ YES ___ NO Rash ___ YES ___ NO
Anxiety ___ YES ___ NO Depression ___ YES ___ NO Bleeding Problems ___ YES ___ NO
Bed Wetting ___ YES ___ NO Sleep Apnea ___ YES ___ NO Thyroid Problem ___ YES ___ NO
Broken Bones ___ YES ___ NO Diabetes T1 ___ YES ___ NO Diabetes T2 ___ YES ___ NO
Food Allergies ___ YES ___ NO Seasonal Allergies ___ YES ___ NO Increased Infection ___ YES ___ NO

Alerts: Please check YES or NO for the following

- Allergy to Iodine YES NO
Allergy to Latex YES NO
Allergy to Adhesive YES NO

Other Medical Problems not listed above: _____

Has your child received a recent flu vaccine? ___ YES ___ NO

Signature of Legal Guardian

Date

FOR OFFICE USE ONLY: Reviewed by _____