

History Form

Name: _____ DOB: _____ Date: _____
 Address: _____ Phone: _____
 Age: _____ (M S W D) Occupation: _____ Referred: _____

ALLERGIES: _____

Please list all the medications you are taking:

FAMILY HISTORY	FATHER	MOTHER	FATHER'S PARENTS	MOTHER'S PARENTS	SIBLINGS	CHILDREN
Cancer						
Diabetes						
Blood Pressure						
Stroke						
Heart Disease						
Cholesterol						
Mental Illness						
Kidney						

HOSPITALIZATIONS	YEAR	SURGERIES	YEAR

Are you experiencing any of the following?

Y N

- ☐ ☐ Hearing problems
- ☐ ☐ Dizziness
- ☐ ☐ Vision problems
- ☐ ☐ Nose bleeds
- ☐ ☐ Sore throat
- ☐ ☐ Hoarseness
- ☐ ☐ Shortness of breath
- ☐ ☐ Chest Pain
- ☐ ☐ Swelling in the legs
- ☐ ☐ Leg Pain
- ☐ ☐ Appetite changes
- ☐ ☐ Heartburn
- ☐ ☐ Abdominal pain
- ☐ ☐ Diarrhea
- ☐ ☐ Vomiting
- ☐ ☐ Constipation
- ☐ ☐ Urinary problems
- ☐ ☐ Nighttime urination
- ☐ ☐ Weight changes.
- ☐ ☐ Fatigue
- ☐ ☐ Easy bruising
- ☐ ☐ Rash
- ☐ ☐ Depression
- ☐ ☐ Headaches
- ☐ ☐ Sleep problems
- ☐ ☐ Sexual problems

Have you ever been diagnosed with any of the following?

Y N

- ☐ ☐ Allergies
- ☐ ☐ Pneumonia
- ☐ ☐ COPD
- ☐ ☐ Asthma
- ☐ ☐ Anemia
- ☐ ☐ High blood pressure
- ☐ ☐ Heart murmur
- ☐ ☐ Ulcer
- ☐ ☐ Acid reflux
- ☐ ☐ Diverticulosis
- ☐ ☐ Kidney stones
- ☐ ☐ Frequent urine infections
- ☐ ☐ Cancer (Type _____)
- ☐ ☐ Diabetes
- ☐ ☐ Thyroid disease
- ☐ ☐ Arthritis
- ☐ ☐ Gout
- ☐ ☐ Seizures
- ☐ ☐ Depression
- ☐ ☐ Anxiety

Other history

Smoking

How much? _____
 How long? _____
 When did you quit? _____

Alcohol

How much? _____
 What kind? _____

Drug Use

What kind? _____
 How often? _____

Exercise

How often? _____
 What kind? _____

Coffee/Tea/Colas

cups per week? _____

FEMALE PATIENTS

Last period? _____

Last Pap? _____

Last mammo? _____

pregnancies? _____

children? _____

Joshua Z. Steiner, D.O., P.A.

PATIENT INFORMATION SHEET

Date Completed: ____/____/____

NAME: _____ SEX: _____ MARITAL STATUS: S M W D

BIRTHDATE: ____/____/____ RELIGION: _____ PRIMARY LANGUAGE: _____

REFERRED BY: _____

ADDRESS: _____

CITY _____ STATE _____ ZIP _____

HOME PHONE: _____ CELL PHONE: _____

EMAIL: _____

EMPLOYER/SCHOOL: _____

TITLE: _____ WORK PHONE: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

SPOUSE/PARTNER: _____ BIRTHDATE: _____

SPOUSE EMPLOYER/SCHOOL: _____ CITY/STATE: _____

SPOUSE PHONE: _____

RACE/ETHNICITY: Caucasian African American Native American Asian Hispanic Latino Other _____ Refuse to Answer

SOMEONE TO CONTACT LOCALLY IN CASE OF EMERGENCY *OTHER THAN SOMEONE LIVING WITH YOU:*

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

PRIMARY INSURANCE: _____ ID #: _____

SECONDARY INSURANCE: _____ ID #: _____

Joshua Z. Steiner, D.O., P.A.

PATIENT INSURANCE RESPONSIBILITY

I hereby authorize my insurance company to make payments directly to my physician and further permit a copy of this authorization to be used in place of the original. This authorization applies to all claims submitted by my physician. I hereby authorize my physician to release any information required in the course of examination and treatment. I further authorize my physician to release any of medical records to any insurance company that may request them. This includes all information of HIV, drug use, psychiatric treatment, or other problems. I understand that my physician will comply with all applicable HIPAA regulations. There is no time limit on this record release.

I understand that a physical exam, school exam, or pre-operative exam including lab and diagnostic testing may not be a covered benefit under my insurance. I will be held responsible for any payment due. I understand that I should check before any lab work, diagnostic tests, or specialist visit that the provider is still affiliated with my insurance company as these can and do change frequently. My physician will not be held responsible for the fees of any lab, diagnostic facility, or specialist that is not covered by my insurance for any reason. If I find that a service will not be covered. I should call the office for a new referral.

A 1.5% late payment charge may be added to all unpaid balances not paid within 30 days of request. In addition, if this account is delinquent and is forwarded to a collection agency or attorney, I agree to pay any and all costs.

I understand the following message from my physician: To avoid any misunderstanding regarding medical insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and the patient is personally responsible for payment of fees. As a courtesy, we will prepare the necessary forms to help you obtain your benefits from your insurance company. We do not render our services on the basis that insurance companies will pay our fee, except in instances such as with specific PPO/HMO groups. If the insurance company does not cover our fee in full, the balance is due and payable by you.

Please sign below to indicate that you have reviewed the above information and give Joshua Z. Steiner, D.O., P.A. permission to treat you.

Patient Signature

Date

Patient Name (printed)

MEDICARE BENEFICIARIES ONLY

I request that payment of authorized Medicare benefits be made to my treating physician for any services rendered. I authorize any holder of medical information about me to release to the Center for Medicare Services and its agents any information needed to determine these benefits or benefits payable for related services.

Patient Signature

Date

Joshua Z. Steiner, D.O., P.A.

OFFICE FINANCIAL POLICIES

In order to better serve your needs and clarify any questions that you may have regarding your insurance, we have adopted the following financial policies. If you have any questions, please speak with one of our billing or managerial staff, and she will gladly assist you.

We will gladly file your insurance claim. Copayments, deductibles, and co-insurance amounts are collected at the time of service. We will verify your insurance coverage at each visit. All insurance changes must be given to us at the time of service. If your insurance changes and we are not notified, you will be responsible for all charges.

As a courtesy to you, insurance forms for services rendered will be completed by our office and submitted to your primary insurance carrier. We will not file the secondary insurance – unless it is secondary to Medicare.

In the event that your health insurance plan determines a service to be “not covered”, you will be responsible for the uncovered charge.

All forms and letters that we are asked to complete, including Disability forms, FMLA forms, Leave of Absence forms, jury duty excusals, letters regarding travel, and/or any requested correspondence that is not associated with reimbursement of a claim will incur a \$25.00 fee to the patient.

NON-CANCELLATION OF APPOINTMENTS

There is a \$25.00 charge to patients for a missed appointment without prior notice. Please call us no later than 9:00 AM on the day of your appointment to notify us of your cancellation.

RETURNED CHECK FEE

There is a charge of \$50.00 in the event a check is returned for insufficient funds.

STATEMENT PROCEDURE

We will mail a statement to the address you have provided once we receive payment from your insurance carrier. If we do not have payment from you within 90 days, we will make every effort to notify you that the account is being turned over to our collection agency and may impact your credit rating.

MEDICAL RECORDS REQUEST

Any patient requesting records must submit a signed records release form and there will be a clerical fee of \$1.00 per page to process.

I AGREE TO MY FINANCIAL RESPONSIBILITIES. I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL POLICIES

Patient Signature

Date

Patient Name (printed)

Joshua Z. Steiner, D.O., P.A.

ALTERNATIVE COMMUNICATION RELEASE FORM

Patient Name: _____ Date of Birth _____

I authorize Joshua Z. Steiner, D.O., P. A. in regards to my protected health information (PHI):

(check as many as you wish)

- ☐ To call me at work
- ☐ To call me at home
- ☐ To call my cell phone
- ☐ To speak with anyone on the Right To Share Information list below
- ☐ To speak only with me
- ☐ To fax information to me at this secured number _____
- ☐ Other _____

RIGHT TO SHARE INFORMATION WITH FAMILY AND FRIENDS

Joshua Z. Steiner, D.O., P.A. reserves the right to communicate PHI with family or friends when it is deemed in the best interest of the patient as described in the Notice of Privacy. In order to have your PHI shared in other circumstances with members of your family or friends, please list below those individuals to whom we are authorized to release information.

Signature of Patient _____ Date _____

Joshua Z. Steiner, D.O., P.A.

4410 Sheridan St.

Hollywood, FL 33021

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGMENT

I, _____, have reviewed and read this office's Notice of Privacy Practices. I also give my authorization for this office to disclose any of my personal health information as necessary for treatment, payment, or other healthcare operations as detailed in this office's Notice of Privacy Practices.

Patient's signature

Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

Individual refused to sign this form (initial____)

Communication barriers prohibited obtaining the acknowledgment (initial____)

An emergency situation prevented us from obtaining the acknowledgment (initial____)

Joshua Z. Steiner, D.O., P.A.

MEDICAL STUDENT RELEASE

Dr. Steiner is proud to have been appointed a Clinical Assistant Professor at Florida International University College of Medicine and Adjunct Professor of Nova Southeastern University College of Osteopathic Medicine. From time to time, medical students spend time with all of the providers in this office to gain additional knowledge and hone their skills in the practice of medicine. These medical students may enter the exam room with the provider at the time of your exam.

All medical students adhere to the strictest rules of ethics and HIPAA confidentiality adhered to by all providers and staff in this office.

YOU WILL ALWAYS BE GIVEN THE OPPURTUNITY TO REQUEST THAT A MEDICAL STUDENT NOT BE PRESENT IN THE ROOM DURING YOUR EXAM. IF, AT ANY TIME DURING YOUR EXAM, YOU WOULD LIKE THE MEDICAL STUDENT TO LEAVE, YOU MAY REQUEST IT.

Today's medical students will be your children's and grandchildren's doctors tomorrow. Your help in assisting us to teach them benefits us all.

Thank you!

Dr Steiner and associates

I have reviewed this notice and understand my rights as entailed herein

Signature

Date