Medved ENT, SC
Peter Medved, MD
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Franklin, WI 53132

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Billing policy disclaimer at Medved ENT, S.C.

Please be aware that tests and procedures are additional charges and may be billed under surgical codes. Diagnostic tests **not** covered by an office appointment include: endoscopic laryngoscopy (examining the vocal folds), endoscopic nasal exam (evaluation of the interior of the nasal cavity), nasal cauterization (treatment of nose bleeds), ear tube insertion (to drain middle ear fluid), audiogram (to check hearing), biopsies, and injections.

Dr. Medved has no financial interest in surgery centers, diagnostic imaging, or dispensing medication. He **does** have a financial interest in selling hearing aids. There is no facility fee for office visits or procedures. We make an effort to keep costs reasonable and to provide good service and value to our patients.

Please complete your paperwork as instructed. Accurate medical information is the standard of care.

Peter Medved MD

Initial:_____ Date:_____

Policy date: 01/2015

MEDVED ENT, S.C.
Patient Registration

PATIENT _____ DOB _____

AGE _____ SEX _____ MARITAL STATUS: M S W D SP

ADDRESS _____ PHONE: _____

CITY _____ ZIP _____ SS# _____

EMPLOYER _____ WORK PHONE: _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

email:

SPOUSE/GUARDIAN _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMPLOYER _____ PHONE: _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PRIMARY INSURANCE _____ PHONE: _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

POLICYHOLDER'S NAME _____ RELATIONSHIP _____

POLICYHOLDER'S SS#: _____ POLICYHOLDER'S DOB _____

SECONDARY INSURANCE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

POLICYHOLDER'S NAME _____ RELATIONSHIP _____

POLICYHOLDER'S SS#: _____ POLICYHOLDER'S DOB _____

WORKMEN'S COMPENSATION _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE _____ TREATMENT AUTHORIZED BY _____

EMERGENCY CONTACT _____ RELATIONSHIP _____

HOME PHONE _____ WORK PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

REFERRING DOCTOR _____ PHONE _____

ADDRESS _____

PRIMARY DOCTOR _____ PHONE _____

ADDRESS _____

PHARMACY _____ PHONE _____

ADDRESS _____

over

MEDVED ENT, S.C.

PATIENT AUTHORIZATION STATEMENT

I hereby authorize payment of health insurance benefits directly to Medved ENT, S.C. for services rendered. I authorize the release of any medical information necessary to process my claims. I further authorize the release of medical information to other physicians and hospitals concerned in my treatment.

I understand that I am financially responsible for my deductible, co-insurance, and any amount exceeding what my insurance company pays, except where exempt by contractual agreement. I further understand that I am responsible for complying with any regulations that my insurance carrier may have regarding referrals, pre-authorizations and second opinions and agree to be personally responsible for services rendered if I have not complied with my insurance requirements.

I hereby request payment of authorized Medicare benefits be made to me or on my behalf to Medved ENT, S.C. for any services furnished to me by that provider. I authorize the release of any medical records to the Health Care Financing Administration and its agents to determine benefits and/or benefits payable. This agreement will remain in effect until revoked by me in writing. A copy of this document is considered as valid as an original.

RECEIPT OF PRIVACY NOTICE

I acknowledge that I have received from Medved ENT, S.C. a written notice of the practice's privacy practices for protected health information. I acknowledge that the written notice contains a description of how medical information about me may be used an disclosed and how I may access this information as well as a statement describing my individual rights with respect to my health information and a description of how I may exercise these rights under the federal privacy law.

_____ _____

Signature of Patient or Personal Representative Date

_____

Print Patient Name

If Personal Representative, describe relationship: _____

Welcome to Medved ENT and Hearing Services – General Health Questionnaire

Name: _____ Primary Doctor: _____
Date of Birth: _____ Age: _____ Referring Doctor: _____
Occupation(s): _____ Marital Status: _____
Race: American Indian / Alaskan Native / African American / Black / Asian / Caucasian / White / Hispanic / Other
Ethnicity: Hispanic/Latino/Not Hispanic/ Not Latino

Briefly, what is the reason that you are in the Ear, Nose and Throat office today?

_____

So that we may better understand your overall medical health, please indicate below whether you have or have had any problems regarding the listed areas. Also please list the problems, if any, in the space provided. (If you are a Parent or a Guardian, please answer for the Child.) **If answer YES to any questions: please explain on line.**

YES	NO	
( )	( )	Recent Fever, Weight Loss or Weight Gain_____
( )	( )	Heart problems, Chest pain or High Blood Pressure _____
( )	( )	Lung problems, Shortness of Breath or Asthma _____
( )	( )	Stomach or Gut problems or Heartburn _____
( )	( )	Kidney problems, Problems with Urination _____
( )	( )	Nervous System problems, Anxiety or Depression _____
( )	( )	Diabetes _____
( )	( )	Thyroid problems, Heat or Cold Intolerance _____
( )	( )	Problems with Blood, Bleeding or Easy Bruising _____
( )	( )	Dental problems or do you wear Dentures _____
( )	( )	Trauma or Major Injuries _____
( )	( )	Cancer or Tumors _____
( )	( )	Bone or Joint Problems or Pain _____
( )	( )	Eye Problems, Glaucoma _____
( )	( )	Environmental Allergies _____
( )	( )	Other Medical Problems _____
( )	( )	Hearing impairment or concerns _____
( )	( )	Do you wear hearing aids
		( ) Check box if you are you interested in hearing aid information

Please circle: Immunizations: Influenza (flu) Shingles Pneumonia Date: _____ Child – up to date: _____

YES	NO	**For "YES" answers, Please list the problems in the space provided.**
( )	( )	Allergies to Medicines? _____
( )	( )	Are you taking any Medicines? **If YES, please list with dosage:** _____
		_____
		_____
( )	( )	Have you ever had Surgery(s)? _____
( )	( )	Are there Smokers in the Home? _____
( )	( )	Tobacco use Now? What form _____ how long_____ Past Use____ What Form_____ how long _____
( )	( )	Do you use Alcoholic Beverages/Recreational/Illicit Drugs? If YES, what form? __ How much? _____

Is there anyone **(besides yourself)** in your Family with any of the following Problems?

( )	( )	Bleeding Problems? _____
( )	( )	Problems with Anesthesia? _____
( )	( )	Other Medical Problems? _____
( )	( )	If you are answering for a young child, were there any problems around the time of the child's birth?

Reviewed_____ Date_____

Welcome to Medved ENT – General Health Questionnaire

Review of Systems

Do you now or have you had any problems related to the following systems? Circle Yes or No.

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N

Other _____

Eyes

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N

Other _____

Allergic/Immunologic

Hay fever	Y	N
Drug allergies	Y	N

Other _____

Neurological

Tremors	Y	N
Dizzy spells	Y	N
Numbness/tingling	Y	N

Other _____

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N

Other _____

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N

Other _____

Cardiovascular

Chest pain	Y	N
Varicose veins	Y	N
High blood pressure	Y	N

Other _____

Integumentary

Skin rash	Y	N
Boils	Y	N
Persistent Itch	Y	N

Other _____

Musculoskeletal

Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N

Other _____

Ear/Nose/Throat/Mouth

Ear infection	Y	N
Sore throat	Y	N
Sinus infection	Y	N

Other _____

Genitourinary

Urine retention	Y	N
Painful urination	Y	N
Urinary frequency	Y	N

Other _____

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N

Other _____

Hematologic/Lymphatic

Swollen gland	Y	N
Blood clotting problem	Y	N

Other _____