RIESBERG INSTITUTE

PATIENT INFORMATION

First Name _____ MI _____ Last Name _____

DOB _____ Age _____ Email _____

Address _____ City _____ State _____ ZIP _____

SSN _____ Marital Status _____ Sex _____

Daytime Phone _____ Evening Phone _____ Cell Phone _____

Primary Physician _____ Referred By _____

Employer _____

Employer Address _____ City _____ State _____ ZIP _____

Person Responsible for Account _____ SSN _____ DOB _____ Age _____

Responsible Person's Employer _____ Phone _____

Child's Caretaker *(if not above)* _____ Relationship _____

Spouse of Parent's Name *(if applicable)* _____

THE RIESBERG INSTITUTE FINANCIAL POLICY

OUR FINANCIAL POLICY: The Riesberg Institute is very concerned about the cost of your healthcare and has spent considerable time in setting our fees. We want to assure that the charges accurately reflect the complexity of care rendered and the skill and expertise required for your case.

INSURANCE USUAL AND CUSTOMARY: If an insurance company indicated that our fees are above the "usual and customary", please understand that most fees are above the rate which insurance companies choose to pay. We use many sources to determine the appropriateness of our fees. We cannot allow the payment or allowance of insurance companies to set the amount that we charges for services.

OUR POLICY: Our policy requires payment of co-payments and any deductibles at the time of service. If there is any balance owed after all insurance companies have made their payments, we will bill you for the remaining amount. All insurance information must be given to the office no later than 15 days after appointment or you could be responsible for the entire amount for the office visit and/or procedures.

PATIENT RESPONSIBILITIES: 1.) I understand that my insurance coverage is based on a legal contract between myself and my insurance company. 2.) I understand that I (as patient) am responsible for understanding and reading the conditions, coverage, terms, and limitations of my insurance policy. 3.) I understand that the legal contract of my insurance policy requires me to be responsible for payment of valid and legitimate fees and charges as follows: All outstanding deductibles, co-payments, non-covered procedures and services that are performed, and outstanding valid charges and fees after insurance companies have made their payments.

HMO AND PPO MEMBERS: If you are a member of an HMO or PPO in which we participate, your deductible or co-payment is required at the time of service. You are also responsible to see that we have a current referral on hand if your insurance carrier requires one. If we do not have this referral at the time of the visit, your insurance company may hold you responsible for all charges. You may also be sent back to your primary care physician prior to being treated to obtain a current referral. Our agreement is with YOU and NOT your insurance company. You have chosen your insurance coverage. Although we will assist you in submitting your claim to your carrier, you are ultimately responsible for the services you receive. Payment to our office is not contingent or dependant on your insurance carrier. In your interest, we are pleased to accept MasterCard and Visa for your charges. Returned checks will receive a $25 overdraft charge. A %5 monthly billing fee will be added to all account balances outstanding beyond 30 days from the date of service. A $100 fee will be applied to any rescheduled surgery. Refer to our surgical rescheduling policy for specific information. We require 24 hours advance notice to avoid a $25 appointment rescheduling fee. Please contact our billing office to make payment arrangements at (850) 476-0700.

RIESBERG INSTITUTE

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT,AND HEALTH CARE OPTIONS

- I consent to the use of disclosure of my protected health information (PHI) by The Riesberg Institute for the purpose of diagnosis or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operation of The Riesberg Institute.
- I understand that diagnosis or treatment of me by The Riesberg Institute may be conditioned upon my consent as evidenced by my signature on this document.
- I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or health care operations of the practice. The Riesberg Institute is not required to agree to the restriction that I may request, however, if The Riesberg Institute agrees to a restriction that I request, the restriction is bending on The Riesberg Institute.
- I have the right to revoke this consent in writing at any time, except to the extent that The Riesberg Institute has taken action in reliance on this consent.
- My PHI means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This PHI relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.
- I understand I have a right to review The Riesberg Institute's Notice of Privacy Practices as been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my PHI information that will occur in my treatment, payment of my bills, or in the performance of health care operation of The Riesberg Institute.
- The Notice of Privacy Practices for The Riesberg Institute is also provided at 4900 N. Davis Hwy, Pensacola, FL 32503. This Notice of Privacy Practices also describes my rights and duties of The Riesberg Institute with respect to my protected health information.
- The Riesberg Institute reserves the right to change the Privacy Practices. You can get a copy by calling the office and requesting a revised copy to be sent in the mail, or by asking for one at the time of your next appointment.
- Signing below, I state that I also understand that I have the right to revoke this consent, provided that I do so in writing, except to the extent that The Riesberg Institute has already used or disclosed the information in reliance on this consent.

Signature of Patient of Personal Representative	Date
Printed Name of Patient or Personal Representative	Description of Personal Representative's Authority

ACKNOWLEDGEMENT OF REVISED NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received the revised Notice of Privacy Practices statement dated January 01, 2012 of the Riesberg Institute.

Signature	Date

4900 N. Davis Hwy | Pensacola, FL 32503 | Phone 850.476.0700 | Fax 850.476.4300

RIESBERG INSTITUTE

PATIENT MEDICAL HISTORY

Patient Name_____ Date of Visit _____

What are we seeing you for today? _____

_____

List any allergies or reactions to medication/anesthetics: _____

_____

List any previous ear, nose, or throat surgeries, and date performed: _____

_____

List any hospitalization or other surgery and date: _____

_____

PERSONAL/SOCIAL HABITS

Do you smoke or have you ever smoked? ☐ Yes ☐ No

If so, how much and how long? _____ Year stopped? _____

Do you now or have you ever used smokeless tobacco? ☐ Yes ☐ No

If so, how much and how long? _____ Year stopped? _____

Do you drink Alcohol? ☐ Yes ☐ No How much per day? _____

Do you or have you used any recreational drugs? ☐ Yes ☐ No

If so, what type? _____

Do you take blood thinners other than aspirin? ☐ Yes ☐ No

If so, what type? _____

Type of work? _____ Retired ☐ Yes ☐ No Disabled ☐ Yes ☐ No

Are you a student? ☐ Yes ☐ No Grade in School? _____

RIESBERG INSTITUTE

MEDICAL QUESTIONNAIRE

Patient Name_____ Date of Visit _____

PLEASE CIRCLE ALL THAT APPLY

Ears	Decreased Hearing: YES NO Dizziness: YES NO Frequent Ear Infections: YES NO Ringing in Ear: YES NO
Nose	Snoring/Sleep Apnea: YES NO Difficulty Breathing Through Nose: YES NO Sinus Pressure: YES NO
Throat	Recurrent Sore Throats: YES NO Difficulty Swallowing: YES NO Hoarseness: YES NO Difficulty with Singing Voice: YES NO
Allergy	History of allergies: YES NO Allergy Shots: YES NO
Endocrine	Diabetes: YES NO Thyroid Trouble: YES NO
Cardiovascular	Irregular Pulse: YES NO High Blood Pressure: YES NO Previous Heart Attack: YES NO
Hematological	Previous Transfusion: YES NO Easy Bruising: YES NO HIV+: YES NO
Gastrointestinal	Heartburn/Reflux: YES NO Vomiting Blood: YES NO Ulcer: YES NO History of Hepatitis: YES NO
Respiratory	Frequent Cough: YES NO Asthma: YES NO Emphysema: YES NO Coughing Blood: YES NO
Neurological	Previous Head Injury: YES NO Previous Stroke: YES NO Migraines: YES NO Seizures: YES NO
Psychiatric	Anxiety: YES NO Depression: YES NO
Other	History of Cancer: YES NO Weight Loss: YES NO Frequent Fever: YES NO Are You Pregnant: YES NO

Other Conditions/Family History *(please list)* Use back if necessary:

4900 N. Davis Hwy | Pensacola, FL 32503 | Phone 850.476.0700 | Fax 850.476.4300

RIESBERG INSTITUTE

CONSENT FOR VERBAL RELEASE OF INFORMATION

Please list below the name(s) of any person(s) that you give us permission to discuss your health care or billing with. This is only a release for us to verbally speak with someone regarding you and your health care or billing questions. This is not a release for us to physically give or send any documentation out of your chart. The things that are typically discussed are test results or outstanding balances with the office.

1._____ Relationship: _____ Contact Number: _____

2._____ Relationship: _____ Contact Number: _____

3._____ Relationship: _____ Contact Number: _____

4._____ Relationship: _____ Contact Number: _____

Patient Signature	Date	Printed Name

MEDICATION REFILL POLICY

- Responses to requests for medication refills of medications may take 24–72 hours.
- You should contact us at least (3) days before your medication is due to run out. If you use a mail order company, please contact us at least (14) days before your medication is due to run out.
- We prefer you contact your pharmacy for any prescription refills. The pharmacy will then fax us the information we need to refill the prescription you have requested.
- Refills on medication can only be authorized on medications prescribed by Michael V. Riesberg, M.D.
- For all non-narcotic medications, and appointment for re-evaluation with Michael V. Riesberg will be required every 12 months.
- All narcotic/pain medicine and antibiotics require an office visit for refills.
- No medications will be refilled on Saturdays, Sundays, or holidays.
- Prescription phone-in/pick up: Monday–Friday during business hours only.
  Monday through Wednesday, 8am–4:30pm
  Thursday, 8am–3:30pm
  Friday, 8am–Noon
- Medications are for the prescribed individual's use only. It is illegal to "share" your medicine.
- Patient must pick up his/her prescription(s) in person, unless pre-authorized by staff.

I understand and accept the protocol listed above. Failure to comply may subject immediate termination of prescriptive medications.

Patient Signature	Date	Printed Name

RIESBERG INSTITUTE

CANCELLATION & NO SHOW FEE ACKNOWLEDGEMENT

Effective January 1, 2012, there will be a $25 fee charged for all **same day** appointment cancellations and no-shows.

_____ _____

Patient Signature Date

_____

Printed Name

4900 N. Davis Hwy | Pensacola, FL 32503 | Phone 850.476.0700 | Fax 850.476.4300

RIESBERG INSTITUTE

MEDICATIONS

List all Medications (including vitamins and over-the-counter): If you need more space, please use the back of the page.

PATIENT NAME:	PATIENT DOB:
PHARMACY:	PHARMACY #:

MEDICATION NAME	DOSAGE	DATE	DATE	DATE	DATE	DATE	DATE

4900 N. Davis Hwy | Pensacola, FL 32503 | Phone 850.476.0700 | Fax 850.476.4300

RIESBERG INSTITUTE

AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

Patient Name _____

Date of Birth _____ Phone Number: _____

Obtain From:

_____
Name

_____
Address

_____
City State ZIP

_____
Phone Fax

Release To:

The Riesberg Institute
4900 N. Davis Hwy
Pensacola, FL 32503
Phone: 850-476-0700 Fax: 850-476-4300

Authorization: I hereby give The Riesberg Institute permission to disclose my individually identifiable health information as listed below. I understand that once this information is disclosed, it may no longer by protected by The Riesberg Institute. I understand that this authorization is voluntary, that further treatment cannot be conditioned upon my signing this authorization, and that there may be a cost to copy the records.

INFORMATION TO BE RELEASED (CHECK ALL THAT APPLY)

Date of service/range (mm/dd/yy): From: _____ To: _____

☐ Clinic Notes ☐ Operative Report ☐ Radiology Reports ☐ Lab Reports

Other: _____

I understand that I can revoke this authorization to release my medical records at any time, except for the information that has already been released according to this authorization. I do understand that this consent will expire after 180 days from the date of my signature unless I provide notice in writing that it should be revoked. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. A copy of facsimile of this form is considered as valid as the original.

_____ _____
Signature of Patient or Legally Authorized Representative Date of Signature

_____ _____
Printed Name of Signed on Behalf of the Patient Relationship to patient, if applicable

IDENTITY AND PAYMENT PROTECTION SECURITY

I authorize Dr. Riesberg to store my credit card or debit card information in full compliance of the payment care industry (PCI) Data Security Standard and Federal Red Flag Rules to safeguard against identity theft.

I authorize Dr. Riesberg to charge this credit card or debit card for any deductible, co-payment, co-insurance, non-covered, or outstanding balances, which are all fair trade balances due for services or products I have received.

I agree to pay a $50.00 fee if charges are denied or contested, unless I pay in full within 24 hours of being notified. I agree to pay any and all fees and penalties due to denied or contested charges deemed valid, including charge back fees.

If the Riesberg Institute owes me money, I authorize Dr. Riesberg to apply the amount as a credit on to my debit card or credit card.

If I need to make financial arrangements, I can call the Riesberg Institute and they will work with me, in a sincere attempt to avoid collection agencies or liens placed on unpaid accounts. I understand that if I remain delinquent in my balance due, in spite of the good faith attempt to make a fair payment plan through my credit card or debit card, that my account at that time would be sent to a collections agency.

A collection agency may take over delinquent accounts. If your account is placed with a collection agency, you will be responsible for all costs of collection. Timely payment will prevent consequences to your credit rating.

If you have any questions about our financial policy or your insurance reimbursement, please feel free to discuss them with any staff member.

_____ _____

Patient/Responsible Party Signature Date