MATTHEW L. FINERMAN, M.D., INC.

HEAD & NECK SURGERY ~ ADULT & PEDIATRIC EAR, NOSE & THROAT
ENT ALLERGY ~ NASAL/SINUS DISORDERS ~ SNORING

WELCOME!

We are pleased that you have chosen our office to assist you with your healthcare needs. We strive to maintain the highest standards of medical care and excellence of service for all our patients and their family.

To best meet the individuality and unique needs of each or our patients, you will be asked to complete the following forms and provide the following documents upon your arrival.

- PATIENT INFORMATION
- MEDICAL HISTORY
- HIPAA *(Notice of Privacy Practices)*
- INSURANCE CARD
- DRIVERS LICENSE/PHOTO I.D.

At best navigating insurance polices and regulations can be confusing and time consuming. While we make every possible effort to assist you, it is up to the individual patient to know the terms and limits of his or her policy.

This is especially important to keep in mind if you have procedures in the office including:

- audiology
- biopsy
- CT
- cultures
- ear cleaning
- laryngeal endoscopy
- nasal endoscopy

or procedures outside the office since additional co-payments and deductibles generally apply.

We encourage questions and look forward to assisting you with any concerns.

IT IS BOTH AN HONOR AND A PLEASURE TO BE OF SERVICE TO YOU!

✓ **SIGNATURE** _____ Date ____/____/_____
MONTH DAY YEAR

2080 Century Park East #1703 ~ Los Angeles, CA 90067 (310) 201-0990 ~ Fax: (310) 201-9665

losangelessnoringandsinus.com

MATTHEW L. FINERMAN. M.D., INC.
2080 Century Park East, Suite 1703
Los Angeles, CA 90067
(310) 201-0990

~ CONSENT FOR PURPOSES OF TREATMENT PAYMENT AND HEALTHCARE OPERATIONS~

I consent to the use of disclosure of my protected health information by MATTHEW L. FINERMAN. M.D., INC. for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of MATTHEW L. FINERMAN. M.D., INC.. I understand that the diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document. I understand that 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 healthcare operations of the practice.

MATTHEW L. FINERMAN. M.D., INC. is not required to agree to the restrictions that I may request. However, if MATTHEW L. FINERMAN. M.D., INC. agrees to a restriction that I request, the restriction is binding on MATTHEW L. FINERMAN. M.D., INC. and the rendering physician. I have the right to revoke this consent, in writing at any time, except to the extent that MATTHEW L. FINERMAN. M.D., INC. has taken action in reliance on this consent. My "protected health information" means health information, including my demographics information collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health condition and identifies me or there is a reasonable basis to believe the information may identify me.

I understand that I have a right to review MATTHEW L. FINERMAN. M.D., INC.'s Notice of Privacy Practices prior to signing this document. MATTHEW L. FINERMAN. M.D., INC.'s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of MATTHEW L. FINERMAN. M.D., INC.. This Notice of Privacy Practices also describes my rights and the MATTHEW L. FINERMAN. M.D., INC.'s duties with respect to my protected health information. MATTHEW L. FINERMAN. M.D., INC.. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting in writing that a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient
Or Personal Representative: _____ Date: _____

Printed Name of Patient or Personal Representative: _____

IN COMPLIANCE WITH NEW FEDERAL AND STATE REGULATIONS, THIS IS TO CONFIRM THAT I HAVE RECEIVED THE FOLLOWING DOCUMENTS:

A. Consent for purposes of treatment, payment, and healthcare operations

B. Notice of Privacy Practices

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

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PLEASE PRINT

Patient Name _____
LAST FIRST MIDDLE

Date of Birth _____/_____/_____ Social Security Number: .#_____-_____-_____ Male____ Female____
MONTH DAY YEAR

Primary Language: _____Race: _____ Ethnicity: _____

Address_____City/State/Zip: _____

Primary Contact Number: (_____)_____ Secondary Number: (_____)_____
[ ] Cell [ ] Home [ ] Work [ ] Cell [ ] Home [ ] Work

Email Address: _____
We keep your email strictly confidential and do not share your personal information. Please check here if you do not wish to receive emails [ ]

Emergency Contact: _____Relationship: _____Telephone #: (_____)_____

** If Patient is a Minor, Name of Parent/Responsible Party:* _____

PERSONAL PHYSICIAN - Does the Patient have a Personal Physician? Yes [ ] No [ ]

If *yes*, may we send your physician a report of our findings? Yes [ ] No [ ]

Physician Name _____ Telephone Number: (_____)_____

HOW DID YOU FIND US? (check all that apply)

*Physician [ ] Dr. Name: _____ Phone: _____

*Insurance Provider [ ] *Family/Friend [ ] *Online/Google Search [ ] *Yelp [ ]

*FaceBook [ ] * Other [ ] (if other, please list)_____

AUTHORIZATION: I authorize the release of medical information to my insurance company: Yes ___ No ____

BILLING POLICY: PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED, unless your physician is contracted with your insurance carrier (including Medicare). The insurance company is hereby authorized to pay all benefits to my attending physician. If special arrangements for payment are needed, they must be made prior to services; please ask for the office manager. We do not accept Medi-cal or legal liens.

I have read the above policy and understand my financial responsibility.

✓ **SIGNATURE OF RESPONSIBLE PARTY:** _____ Date _____/_____/_____
MONTH DAY YEAR

2080 Century Park East #1703, Los Angeles, CA 90067 (310) 201-0990 ~ Fax: (310) 201-9665 ~ drfinerman.com

MATTHEW L. FINERMAN, M.D., INC.
Century City Medical Plaza ~ 2080 Century Park East, Suite 1703, Los Angeles, CA 90067 ~ (310)201-0990 Fax (310)201-9665

PATIENT'S NAME:_____ **DATE OF VISIT:** ____/____/____
DATE OF BIRTH: ____/_____/_____ **OCCUPATION** _____

REASON FOR VISIT: _____

CURRENT MEDICINES/DOSES: 1. _____ **ALLERGIES TO MEDICINES:**

2. _____ 5. _____ 1. _____

3. _____ 6. _____ 2. _____

4. _____ 7. _____

PLEASE LIST ALL PRIOR MAJOR ILLNESSES/SURGERIES (with years)

Illnesses/Injuries 1. _____ 2. _____ 3. _____

Hospitalizations 1. _____ 2. _____ 3. _____

Operations 1. _____ 2. _____ 3. _____

FAMILY HISTORY (please check) ___Heart Disease ___Diabetes ___ Cancer ___ Other _____

Which family member? _____

Do you drink soda/coffee/tea? __ No, *never* __ No, *but I used to* __ Yes ~ Cups/Drinks per day? _____
Do you drink alcohol? __ No, *never* __ No, *but I used to* __ Yes ~ How many drinks? _____/day or wk?
Do you smoke? __ No, *never* __ No, *but I used to* __ Yes ~ Packs per day? _____x_____ years
Do you use illicit drugs? __ No, *never* __ No, *but I used to* __ Yes ~ Which? _____

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (circle Y or N)

CONSTITUTIONAL			**CARDIOVASCULAR**			**GENITOURINARY**		
weight gain/loss(>15lbs)	Y	N	heart attack	Y	N	frequent urination	Y	N
constant night sweats	Y	N	high blood pressure	Y	N	prostate problems n/a	Y	N
			heart murmur	Y	N			
EYES			**GASTROINTESTINAL**			**SKIN**		
double vision	Y	N	diarrhea	Y	N	past skin cancer	Y	N
glaucoma	Y	N	heartburn	Y	N	past radiation therapy	Y	N
EAR/NOSE/THROAT			**ENDOCRINE**			**MUSCULOSKELETAL**		
hearing loss	Y	N	diabetes	Y	N	arthritis	Y	N
ear pain	Y	N	thyroid disease	Y	N	back pain	Y	N
ringing in ears	Y	N	autoimmune disease	Y	N	**RESPIRATORY**		
balance problems	Y	N	**NEUROLOGIC**			asthma/emphysema	Y	N
hearing aid	Y	N	headaches	Y	N	chronic cough	Y	N
difficulty breathing	Y	N	seizures	Y	N	Tuberculosis	Y	N
nosebleeds	Y	N	stroke	Y	N	**PSYCHIATRIC**		
nasal drainage	Y	N	**HEMATOLOGY**			anxiety	Y	N
sinus problems	Y	N	bruise easily	Y	N	depression	Y	N
snoring	Y	N	anemia	Y	N	sleep problems	Y	N
voice changes	Y	N	cancer	Y	N			

OTHER _____

If YES to any of the above, please explain: _____

_____

Reviewed by: _____ M.D.

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In an effort to extend a pro-active level of customer service to our patients and decrease the amount of "No Show Patients" our office has instituted a No Show Policy.

Any patient who fails to show up for a scheduled appointment and does not give sufficient notification (within 24 hours of the scheduled appointment) will be designated as a **No Show** and will be charged a No Show Fee.

No Shows will incur a fee of $100.00.

After two (2) consecutive No Shows the doctor will be consulted as to the future status of the patient's appointments, and it may be decided to make no further appointments for the patient.

Any questions may be addressed to Henry Ruiz at (310) 201-0990 ext.212

Patient Name: _____

Date: _____