

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ Home Tel: (\_\_\_\_) \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_ Wk Tel: (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

Referring Physician: \_\_\_\_\_ SS# \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

Pharmacy \_\_\_\_\_ Telephone: \_\_\_\_\_

How did you hear about Dr. Marcus? \_\_\_\_\_

Have you been to our website? \_\_\_\_\_ was our website helpful? No Yes If No, pls. list reason:

\_\_\_\_\_

What is the reason for your visit today? \_\_\_\_\_

Please describe why you are interested in having the procedure(s) listed above: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you consulted with other physicians about procedure(s) indicated above: No Yes

If yes, please describe your understanding of the procedure(s) \_\_\_\_\_

Is this procedure a revision from a previous surgery? No Yes

If yes, how many previous surgeries? \_\_\_\_\_

What is your "ideal time frame" for procedure(s) completion \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Marital Status \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Emergency Contact Phone Number: \_\_\_\_\_

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### INSURANCE INFORMATION

Primary Insurance Co. \_\_\_\_\_ Policy # \_\_\_\_\_

Group # \_\_\_\_\_ Name of person insured \_\_\_\_\_ SS# \_\_\_\_\_

Providers Phone # \_\_\_\_\_ Copay \_\_\_\_\_

Secondary Insurance Co. \_\_\_\_\_ Policy # \_\_\_\_\_

Group # \_\_\_\_\_ Name of person insured \_\_\_\_\_ SS# \_\_\_\_\_

Providers Phone # \_\_\_\_\_ Copay \_\_\_\_\_

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### HEALTH INFORMATION

Personal Past History:

Do you have any chronic medical problems? (Circle all that apply)

- |                     |                       |                  |
|---------------------|-----------------------|------------------|
| High Blood Pressure | Diabetes              | Cancer           |
| Heart Disease       | Kidney Disease        | HIV or AIDS      |
| Heart Failure       | Psychiatric Diagnosis | Stroke           |
| Seizures            | Bleeding Problems     | Hepatitis        |
| Heart Attack        | Liver Disease         | Emphysema        |
| Chest Pain          | Gastric Reflux        | Stomach Problems |
|                     | Asthma                | Other _____      |

Is there a personal or family history of anesthetic complications? No Yes

If yes, please explain \_\_\_\_\_

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Family History:

Do you have a family history of any medical problems? Circle all that apply. Please indicate family member.

- |                     |                       |                  |
|---------------------|-----------------------|------------------|
| High Blood Pressure | Diabetes              | Cancer           |
| Heart Disease       | Kidney Disease        | HIV or AIDS      |
| Heart Failure       | Psychiatric Diagnosis | Stroke           |
| Seizures            | Bleeding Problems     | Hepatitis        |
| Heart Attack        | Liver Disease         | Emphysema        |
| Chest Pain          | Gastric Reflux        | Stomach Problems |
|                     | Asthma                | Other _____      |

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Please list all prior operations:

Date

List any complications

- |          |       |       |
|----------|-------|-------|
| 1. _____ | _____ | _____ |
| 2. _____ | _____ | _____ |
| 3. _____ | _____ | _____ |
| 4. _____ | _____ | _____ |
| 5. _____ | _____ | _____ |

Please list all prior hospitalizations:

Date

List any complications

- |          |       |       |
|----------|-------|-------|
| 1. _____ | _____ | _____ |
| 2. _____ | _____ | _____ |
| 3. _____ | _____ | _____ |
| 4. _____ | _____ | _____ |
| 5. _____ | _____ | _____ |
- 
- 

Please list ALL medications and/or dietary supplements including:

**(Prescriptions, Over the Counter Medicines, Aspirin, Vitamins and Herbal Supplements such as Fish Oil, Saw Palmetto, Flax Seed Oil and St. John's Wort)**

- |          |           |
|----------|-----------|
| 1. _____ | 6. _____  |
| 2. _____ | 7. _____  |
| 3. _____ | 8. _____  |
| 4. _____ | 9. _____  |
| 5. _____ | 10. _____ |
- 
- 

Please list ALL allergies and describe reactions: (i.e. Shellfish, Latex, Penicillin, etc).

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |
- 
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**SOCIAL HISTORY:**

**Tobacco Use:**  Never  Former use  Yes, current every day use  Yes, current some day use

If yes, for how long? \_\_\_\_\_ How much? \_\_\_\_\_

Which tobacco product(s) have you used? \_\_\_\_\_

If you are a former smoker, state the year you stopped: \_\_\_\_\_

Past or current use of Nicotine Gum, Patch, or any other type of stop-smoking aid: No Yes

If yes, please list:

\_\_\_\_\_

**E-Cigarette Use:**  Never  Former use  Yes, current everyday use  Yes, current someday use

If using, for how long? \_\_\_\_\_ How much? (i.e cartridges/day) \_\_\_\_\_

If you are a former user, state the year you stopped: \_\_\_\_\_

**Drug Use:**  Never  Former use  Yes, current everyday use  Yes, current someday use

Which types?:  Cocaine  Heroin  IV  Marijuana  Methamphetamines  Opioids  Other (See comments)

Comments: \_\_\_\_\_

If you are a former user, state the year you stopped: \_\_\_\_\_

**Alcohol Consumption:** \_\_\_\_\_ Never (Do not consume alcohol) \_\_\_\_\_ Rare (1-2 drinks a week)

\_\_\_\_\_ Moderate (7-10 drinks a week) \_\_\_\_\_ Heavy (more than 10 drinks a wk)

Did you ever drink heavily in the past? No Yes

Are you feeling hopeless about the present/future? No Yes

Do you currently have thoughts of harming yourself? No Yes

Review of Systems:

Please answer the following Yes or No questions to the best of your ability. Do you have any of the following conditions, illnesses or symptoms?

CARDIOVASCULAR

High Blood Pressure Y \_\_\_ N \_\_\_  
Heart Attack Y \_\_\_ N \_\_\_  
Angina/chest pain Y \_\_\_ N \_\_\_  
Heart bypass surgery Y \_\_\_ N \_\_\_  
Pacemaker Y \_\_\_ N \_\_\_

Heart Failure Y \_\_\_ N \_\_\_  
Irregular Heartbeat Y \_\_\_ N \_\_\_  
Heart Murmur Y \_\_\_ N \_\_\_  
Do you exercise? Y \_\_\_ N \_\_\_  
Comments: \_\_\_\_\_

NEUROLOGICAL

Stroke Y \_\_\_ N \_\_\_  
Seizures Y \_\_\_ N \_\_\_  
Fainting Y \_\_\_ N \_\_\_  
Dizziness Y \_\_\_ N \_\_\_  
Headache Y \_\_\_ N \_\_\_  
Double Vision Y \_\_\_ N \_\_\_

RESPIRATORY

Abnormal Chest X-ray Y \_\_\_ N \_\_\_  
Asthma Y \_\_\_ N \_\_\_  
Bronchitis Y \_\_\_ N \_\_\_  
Emphysema Y \_\_\_ N \_\_\_  
Recent Chest Infection Y \_\_\_ N \_\_\_  
Shortness of Breath Y \_\_\_ N \_\_\_  
Shortness of Breath at night Y \_\_\_ N \_\_\_  
Shortness of Breath on exertion Y \_\_\_ N \_\_\_  
Cough Y \_\_\_ N \_\_\_  
Cough with Sputum Y \_\_\_ N \_\_\_  
Sleep Apnea Y \_\_\_ N \_\_\_  
-Use a C-PAP Machine Y \_\_\_ N \_\_\_

PSYCHIATRIC

Depression Y \_\_\_ N \_\_\_  
Anxiety Y \_\_\_ N \_\_\_  
Psychiatric Care Y \_\_\_ N \_\_\_  
Obsessive Compulsive Disorder Y \_\_\_ N \_\_\_

MUSCULOSKELETAL

Sciatica Y \_\_\_ N \_\_\_  
Herniated disc Y \_\_\_ N \_\_\_  
Arthritis Y \_\_\_ N \_\_\_  
Rheumatoid Y \_\_\_ N \_\_\_  
Neck, Back, Arm, Leg Prob Y \_\_\_ N \_\_\_

ENDOCRINE

Diabetes Y \_\_\_ N \_\_\_  
Thyroid Disease Y \_\_\_ N \_\_\_  
Taken Steroids Y \_\_\_ N \_\_\_

INFECTIOUS

GASTROINTESTINAL  
Jaundice Y \_\_\_ N \_\_\_  
Hepatitis Y \_\_\_ N \_\_\_  
Ulcers Y \_\_\_ N \_\_\_  
Hiatal Hernia Y \_\_\_ N \_\_\_  
Heartburn Y \_\_\_ N \_\_\_

HEMATOLOGIC/ONCOLOGIC

Bleeding Tendency Y \_\_\_ N \_\_\_  
Easy Bruising Y \_\_\_ N \_\_\_  
Anemia Y \_\_\_ N \_\_\_  
Sickle Cell Disease Y \_\_\_ N \_\_\_  
Blood clots in legs Y \_\_\_ N \_\_\_  
Blood clots in lungs Y \_\_\_ N \_\_\_  
Radiation Therapy Y \_\_\_ N \_\_\_

SKIN

Basal cell skin cancer Y \_\_\_ N \_\_\_  
Melanoma Y \_\_\_ N \_\_\_  
Staph Infection Y \_\_\_ N \_\_\_

URINARY/REPRODUCTIVE

Kidney Disease Y \_\_\_ N \_\_\_  
Urinary Disease Y \_\_\_ N \_\_\_  
Dialysis Y \_\_\_ N \_\_\_  
If female, could you be preg? Y \_\_\_ N \_\_\_  
Number of live births \_\_\_\_\_  
Number of pregnancies \_\_\_\_\_  
Date of last mammogram \_\_\_\_\_  
Date of last menses (period) \_\_\_\_\_

EYES

Cataracts Y \_\_\_ N \_\_\_  
Glaucoma Y \_\_\_ N \_\_\_

**ASSIGNMENT AND RELEASE**

I, the undersigned, have insurance coverage with \_\_\_\_\_ and assign directly to Daniel Marcus, M.D., Professional Corporation, all Medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. If the nature of the disability be such that it is not covered by insurance, I will be responsible to the doctor for payment of the entire bill. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

\_\_\_\_\_  
Signature of Insured/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

## **PATIENT FINANCIAL POLICY AGREEMENT**

We would like to take this opportunity to welcome you to our practice and thank you for choosing Dr. Daniel R. Marcus to provide your surgical care. We appreciate your trust and look forward to keeping you happy and healthy.

As part of our services, we try to contain the rising cost of healthcare. In an effort to do this, we have implemented this Financial Policy which we ask you to read carefully and sign. An original copy of this agreement will be in your medical chart. You may receive a copy of your records if you so desire.

### **INSURANCE BENEFITS AND COVERAGE**

As a courtesy to you our billing service **M&D Capital Premier Billing, LLC** will submit your insurance claim(s) for treatment/procedure(s) rendered at this office or by Dr. Marcus. Please be advised that your insurance policy is a contract **between you and your insurance company**. We are not a party to that contract. If you ever have any questions regarding your coverage and or benefits, please contact your insurance company directly. Ultimately, you are responsible for all costs incurred during treatment with the exception of insurance contracted adjustments. These adjustments are determined by the contract the doctor has with the individual insurance company.

### **COPAYMENTS, DEDUCTIBLES AND COINSURANCE**

We require payment of any co-payments due at the time of service. **We accept cash, check and credit and/or debit cards**. If you have any deductible or coinsurance amounts that need to be met, you will be billed once your insurance has processed and paid their portion of the claim.

### **UNINSURED PATIENTS AND NON-COVERED BENEFITS**

Full payment is due at the time of service. **We accept cash, check and credit and or/debit cards**. In some instances may be made for some patients on a case by case basis with our billing service **M&D Capital Premier Billing, LLC**. While we try to accommodate all of our patients our billing service does maintain strict guidelines regarding payment plans.

### **BALANCE AND STATEMENT**

You will receive a statement once a month, if you have a balance owing monies. Failure to pay a balance by the third billing statement will result in your account being turned over to the collection process. If you have made a payment agreement and fail to make two consecutive monthly payments, your account will be turned over to the collection process. **Please note there is a fee of \$25.00 plus balance owed for all returned checks.**

### **AGREEMENT TO ENDORSE CHECK PAYMENT RECEIVED FROM YOUR INSURANCE COMPANY**

I understand that Daniel R. Marcus, MD is a non-participating provider with my insurance company and that reimbursement for claims that he submits to my insurance company on my behalf might be paid directly to the patient or the subscriber of my policy.

I agree to endorse to Daniel R. Marcus, MD any check payment I receive from my insurance company for services he rendered by affixing my signature on the back of the check and immediately forwarding it to his office. I also agree to enclose a copy of the explanation of benefits (EOB) to allow for the proper processing of the payment and crediting to my account. If I fail to do so, the collection process will start immediately and possible legal action.

In order to refrain from raising our fees, we must control our costs and maintain efficiency in the business aspect of our practice. We are dedicated to providing you and your family with the best possible care available. We will also attempt to accommodate you whenever possible. If you have any questions, please contact our office and we will be happy to discuss them with you. Thank you for your understanding. We look forward to providing your care.

**I have read the Patient Financial Policy; I understand it and agree to its terms.**

Patient: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**FINANCIAL POLICY/ASSIGNMENT OF BENEFITS**

Thank you for choosing Dr. Daniel Marcus for your medical provider. Dr. Marcus is not a participating provider with any insurance plan; by choosing him for your treatment, you are willfully going out of your insurance network.

We require pre-payment in advance of the surgery. Please note that the deposit paid at the time of scheduling is not considered payment in full. The deposit and payment from the insurance carrier will be considered payment in full. In the instance that your claim is processed through the Multiplan Shared Savings Plan, you will be responsible for the amount applied to the out of network deductible and out-of-pocket cost.

Dr. Marcus will file a claim with your insurance company for your procedure. Your signature below indicates that you are assigning benefits to Dr. Marcus so that he may be paid directly by your insurance carrier. In the event that your insurance submits the payment directly to you, your signature indicates that you will forward the full payment received promptly to Dr. Daniel Marcus.

While in some instance pre-certification is required for services, satisfying this requirement is not a guarantee of payment from your insurance carrier. In cases where payment is denied, we may request that you become engaged in assisting our billing department to appeal the payer's decision of non-payment.

Patient: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## **NOTICE OF PATIENT INFORMATION PRIVACY PRACTICES**

This notice describes how medical information about you may be used or disclosed and how you can get access to information. Please review it carefully.

### **LEGAL DUTY**

We are required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

### **USES AND DISCLOSURE OF HEALTH INFORMATION**

We use your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities and evaluating the quality of care what we provide. For example, we may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health benefits that could be of interest of you.

We may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, our policy is to obtain your written authorization before disclosing your personal health information. If you provide us with written authorization to release information, for any reason, you may later revoke that authorization, in writing, to stop future disclosures at any time.

### **PATIENT'S INDIVIDUAL RIGHTS**

You have the right to review or obtain a copy of our personal health information at any time upon signing a release. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

### **CONCERNS AND COMPLAINTS**

If you are concerned that we may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager. You may also send a written complaint to the US department of Health and Human Services. For further information on our health information practices or if you have a complaint, please contact our office manager or Dr. Marcus.

I have acknowledged that I have reviewed/ received Daniel R. Marcus, M.D.'s Medical Practice Notice of Privacy Practices.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

## Miscellaneous Fees

We are happy to provide you with the following services for a small convenience fee.

- \$35 for the completion of State Disability paperwork
- \$25 To extend State Disability paperwork
- \$35 for the completion of FMLA or Short-term disability paperwork
- \$25 Medical Clearance Letter or Certification of Disability

Please allow 5-10 business days for forms to be completed.

I, the patient / patient's legal representative, understand and agree to abide the miscellaneous fees set forth.

Date \_\_\_\_\_

Patient Name \_\_\_\_\_

Patient Signature \_\_\_\_\_