

**MARSHALL D. NATHAN, M.D., P.A.**

Medical Center Tower 1, 7950 Floyd Curl Dr., Ste. 1002

San Antonio, TX 78229-3926

Phone: (210) 614-3939 – Fax: (210) 614-4747

**PATIENT HISTORY QUESTIONNAIRE**

All Information is Strictly Confidential and will be Released Only with Your Written Permission

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

**Have you Had? (Circle Y or N)**

Asthma	Y	N	Hearing Loss	Y	N
Anemia	Y	N	Hepatitis (A / B / C)	Y	N
Arthritis	Y	N	Migraine Headaches	Y	N
Sinus Disease	Y	N	Exposed to HIV/AIDS	Y	N
Birth Defects	Y	N	Stroke	Y	N
Cancer (Type: _____)	Y	N	Thyroid Disease	Y	N
Tuberculosis	Y	N	Goiter	Y	N
Emphysema	Y	N	Ulcers	Y	N
Ear Disease	Y	N	Vertigo	Y	N
Epilepsy or Seizures	Y	N	High Blood Pressure	Y	N
Diabetes	Y	N	Cholesterol	Y	N
Heart Problems	Y	N	Type/Date: _____		

Allergies: (List Below) None: \_\_\_\_\_

Name of Drug/Item:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medications**

Currently Taken:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**OB/GYN History**

Date of Last Menstrual Period: \_\_\_\_\_ N/A \_\_\_\_\_

Are you Pregnant Y N N/A

Hysterectomy Y N N/A

If yes, please provide date: \_\_\_\_\_

**Surgical History**

Name of Operation	Date	Complications
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_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever had a Blood Transfusion? Y N Date: \_\_\_\_\_

Were there any complications during surgery? Y N

Name: \_\_\_\_\_

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



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If yes, please list number of children and age(s)?

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**Current Health Status:** \_\_\_\_\_

What is the primary reason for this visit? \_\_\_\_\_

Date symptoms first occurred or injury happened? \_\_\_\_\_

If injury, where did the accident occur? \_\_\_\_\_

What symptoms are you having? (swelling, pain, etc.) \_\_\_\_\_

Have you been treated by another doctor for this problem? \_\_\_\_\_

Did you treat yourself? (Advil, aspirin, Ibuprofen, etc.) \_\_\_\_\_

What kind of treatment was received? \_\_\_\_\_

Have you injured this area before? \_\_\_\_\_

**Other Problems Not Listed:**

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**Signature of Patient or Legal Representative:**

\_\_\_\_\_  
(Print Name of Patient/Legal Guardian)

\_\_\_\_\_  
(Relationship to Patient)

\_\_\_\_/\_\_\_\_/\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Patient/Legal Guardian)

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**ASSIGNMENT OF BENEFITS TO PHYSICIAN**

I hereby assign, transfer, and set over to **Marshall D. Nathan, M.D., P.A.**, all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy with \_\_\_\_\_ insurance company. I further understand that benefits are based upon a percentage of those charges, which my insurance company considers “reasonable and customary” and may not be based upon a percentage of the physician’s charges. I also agree to pay for all charges not covered by my insurance policy or policies.

**PATIENTS RECEIVING AUDIOMETRIC EVALUATION**

Your insurance company determines the services for which they will reimburse you. If an audiometric study is desired by you or ordered by a physician, your insurance company will determine after the claim has been filed whether they will cover this service. Your insurance company makes the determination based on the diagnosis for which the service was performed. However, the diagnosis cannot be made until the completion of the testing. Therefore, your insurance company may at its discretion, not cover audiometric services.

\_\_\_\_\_  
Signature of Insured or Authorized Person

\_\_\_\_\_  
Date

I authorize the release of any medical information necessary to process claims.

\_\_\_\_\_  
Signature of Insured or Authorized Person

\_\_\_\_\_  
Date

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**AUTHORIZATIONS**

**PERMISSION TO TREAT MINORS**

Should my minor child ever need immediate medical attention and I am unable to be present, I give my consent for treatment. This signed statement will serve as my authorization for Dr. Marshall D. Nathan to proceed with whatever medical care deemed advisable until I can be reached.

\_\_\_\_\_  
(Signature of Parent or Legal Guardian)

\_\_\_\_\_  
(Date)

**HEALTH INSURANCE**

According to the Texas Department of Insurance, we must be informed of any other health insurance, (secondary insurance), that you might have. Please be sure to list them on the Patient Information Form. Please let us know if you change insurance companies or if you later obtain a secondary insurance. If you do not have a secondary insurance, please sign the following statement:

At this time I do not have any other health insurance other than the one I have informed the office of Dr. Marshall D. Nathan of today. If I obtain another health insurance, (secondary), or if I change insurance companies, I will inform the office immediately.

\_\_\_\_\_  
(Signature of Patient or Legal Representative)

\_\_\_\_\_  
(Date)

**PAYMENT POLICY**

Payment for services rendered is expected at the time of service. This is to include all HMO/PPO co-payments required by the members contract. HMO/PPO patients will be billed for “patient share/insured’s responsibility” amounts due after payment from the Insurance Company has been received. **THE BALANCE DUE ON YOUR ACCOUNTS IS REQUIRED TO BE PAID UPON RECEIPT OF STATEMENT.** I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance due on my account for any professional services rendered. I have read all the information provided and have completed it to the best of my knowledge. I will notify you of any changes with regards to how and who will provide and or change my insurance coverage.

A \$25.00 charge for returned checks along with any recovery fees incurred will be billed to your account. The Balance Due is expected upon receipt of statements and or notification. If you are unable to keep your appointment, a 24-hour notice is required to cancel/reschedule that appointment or you will receive a \$25.00 charge. Only under special circumstances can this fee be waived.

\_\_\_\_\_  
(Signature of Patient or Legal Representative)

\_\_\_\_\_  
(Date)

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**FINANCIAL POLICY**

The doctors and staff of Dr. Marshall D. Nathan are dedicated to giving the best possible medical care that can be provided. We want to serve you in a friendly and caring manner. You are important to us. With this in mind, we would like to explain our payment policy to you.

- I. If you have insurance coverage, we will file a completed insurance claim form with your insurance company.
  - 1. You will be expected to pay any co-pay, unfulfilled deductible, co-insurance or out-of-pocket expense, as your policy dictates, at the time of your visit to our office and before surgery is performed.
  - 2. We automatically file all Medicare/Medicaid, Blue Cross/Blue Shield PPO and HMO claims.

- II. If you do not have insurance coverage, we ask that you pay for your office visit and any procedures at the time of service.

There are three ways in which you may pay:

- 1. Cash
- 2. Check
- 3. Credit/Debit Cards: (V, MC, AMEX, DISC, DINER'S CLUB)

- III. Should you need surgery, you will be asked to speak with one of our Patient Representatives to make payment arrangements.

- IV. If for any reason your account is not paid in a timely manner and has to be turned over to an outside agency for collection, all collection expenses charged by that agency will be added to the balance of your account. (We feel this action can be avoided by proper communication and understanding of our financial policy)

\_\_\_\_\_  
(Signature of Patient/Responsible Party)

\_\_\_\_\_  
(Date)

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**CONFIDENTIALITY OF PATIENT INFORMATION  
POLICIES AND PROCEDURES**

Dr. Marshall D. Nathan is committed to full compliance with Health Insurance Portability and Accountability Act (HIPAA) Laws and regulations protecting patient privacy and confidentiality of patient information.

**PROCEDURE**

- I. Many federal disclosure restrictions require “unconditional compliance,” meaning violations are prosecuted even if the holder of the information believed disclosure was lawful.
  1. Dr. Nathan’s office must ensure that information from our copies of patient records are released only to authorized individuals.
  2. Dr. Nathan’s office must ensure that unauthorized individuals cannot gain access to or alter patient records.
  3. Dr. Nathan’s office should establish a chain of authority for referral of outside information requests, with final accountability for confidentiality in one officer acting as custodian of records and information.
  4. Employees faced with any request for patient records or information, whether in writing, over the phone, or in person by someone who looks official and tells a convincing story, must refer all such requests up the established chain of authority or to corporate legal counsel for consideration.
  
- II. Dr. Nathan’s designated information and records custodian should have familiarity with all laws, regulations, and rules relating to disclosure of patient information.
  1. Regular contact should be maintained with legal counsel
  2. The custodian or his/her subordinates should be readily available to patient treatment wards and outpatient departments that receive requests for patient information.
  3. Requests for patient information often comes from outside healthcare providers or their staff members who may be treating the same patient in common on a referral or other basis and may need, for treatment purposes, information contained in Dr. Nathan’s records.
  4. All requests should be referred to the appropriate Department Leader before any information is released to any outside party.
  5. Both the identity of the requestor and patient’s authorization for release of information to that party must be carefully verified before any information is released.
  
- III. Dr. Nathan has certain orientation and education programs in place to reinforce the need for vigilance in the area of patient confidentiality, both for new and existing employees.
  1. The custodian of information or a member of his/her department, or another high-ranking officer with Dr. Nathan’s office conducts these educational programs, in order to instill an understanding of our office commitment to compliance with HIPPA laws and regulations.

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- IV. Violations of Dr. Nathan’s policies and procedures concerning patient confidentiality occasionally occur, perhaps inadvertently.**
- 1. Dr. Nathan ensures firm but even-handed discipline of such violations and effectively corrects them before they are repeated.**
  - 2. Employees are often reminded that they are each vital individual links in the compliance chain.**
  - 3. Employees have a duty, subject to disciplinary procedures, to report suspected or potential violations of patient confidentiality.**

\_\_\_\_\_  
(Signature of patient/legal representative)

\_\_\_\_\_  
(Date)