Our Financial Policy:
Linda S. Falconio, M.D., Inc.

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

1. Payment is due at the time of service unless previous arrangements have been made with our billing staff or your services are covered by a contract with the insurance carriers with whom we contract. We accept Visa, MasterCard, checks and cash. It is your responsibility to be aware of your deductibles and co-pay amounts. There is an information number on the back of your insurance card.
2. We do bill and participate in most insurance plans, including Medicare, but keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim if you agree to have your insurance company to pay the doctor directly. If your insurance company does not pay the practice within 45 days of billing, we will have to look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you. You will need to provide a copy of your current insurance card at the time of each visit to make sure we have your proper billing information or payment will be expected at the time of service. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. All non covered services will be your responsibility and payment is due at the time you receive your statement.
3. All co-pays and deductibles are due at time of service.
4. Accounts over 90 days past due will be turned over to a collection agency, unless a payment schedule has been previously arranged and followed. You will be notified by mail and will have 2 weeks to clear up your account. If your account still remains unpaid, you will be discharged from the practice and given 30 days to find alternative medical care. During that time, only emergency care will be provided.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

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Signature of patient (or responsible party, if minor) Date

Please print Patient Name

ADULT MEDICAL HISTORY

Name:
Date:

(Please check below that apply to you)

PAST SURGERIES: LIST APPROPRIATE YEAR

Tonsils ☐	Adenoids ☐	Hernia ☐
Hysterectomy ☐	Prostate ☐	C-Section (why?) ☐
Cataracts ☐	Joint (Knee, Shoulder, Hip,Other) ☐	D+C ☐
Vasectomy ☐	Hemorrhoids ☐	Gall Bladder ☐
Breast ☐	Tubal Ligation ☐	Urethral Dilation ☐
Tubal Pregnancy ☐	Ovarian ☐	Laparoscopy ☐
Disc (Cervical, Lumbar) ☐	Other ☐	

HOSPITAL ADMISSIONS:NONE? (LIST APPROPRIATE YEAR)

Heart Attack ☐	Nervous Breakdown ☐	Cancer ☐	Depression ☐
Pneumonia ☐	Accidents ☐	Stroke ☐	Others (beside surgery) ☐

PAST/PRSENT MEDICAL ILLNESS: PLEASE CIRCLE OR LIST OTHERS:
HYPERTENSION☐, HIGH CHOLESTEROL☐, MIGRAINES☐, DEPRESSION☐, HEART DISEASE☐, OTHER☐

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CHILDHOOD ILLNESSESS: (PLEASE CHECK): Chicken Pox☐, Mumps☐. Measles☐, German Measles☐, Rheumatic Fever☐, Meningitis☐, Polio☐, Other:

INJURIES: None☐
Fractures or Broken Bones: Yes☐ or No☐? Which Bones?
Concussions: Yes☐ or No☐?
Blood Transfusions: Yes☐ or No☐?

INJECTIONS/VACCINATIONS: (Please list year done)

Tetanus	TB Skin test (+ OR -)	Pneumococcol	Hepatitis B
Hepatitis A	HPV	Shingles	Other:

PROCEDURES: (PLEASE LIST YEAR DONE AND RESULTS IF KNOWN)

MAMMOGRAM	BONE DENSITY	CHEST XRAY	EKG	COLONOSCOPY
TREADMILL STRESS TEST	CT SCAN (WHICH PART?)	ULTRASOUND (WHICH PART?)	MRI (WHICH PART?)	OTHER

PATIENT INFORMATION SHEET

Patient ID#:	
Patient Name: MI:	Date of Birth: Age:
Home Address:	Do you have insurance?
City, State, Zip:	Name of insurance company:
Home Phone: Cell Phone:	Holder of insurance:
Business Phone:	Who referred you to us?
Email Address:	Pharmacy of choice (Name and Location):
Place of employment:	Driver License#:
Business Address:	Occupation:

BRIEF MEDICAL HISTORY: (PLEASE CHECK OR LIST THOSE THAT APPLY TO YOU)
Allergies☐ Penicillin ☐ Codeine☐ Sulfa☐ Bee Stings☐ Erythromycin☐ Iodine☐ Food☐
Other:
Current Medications:

FAMILY MEMBERS & THEIR AGES:

	NAME	AGE	WORK PHONE (IF APPLICABLE)
SPOUSE:			
PARENTS:			
CHILDREN: (NAME & AGES)			
BROTHERS: (NAME & AGES)			
SISTERS: (NAME & AGES)			

WHOM SHOULD WE NOTIFY IN CASE OF EMERGENCY? (BESIDES PARENTS OR SPOUSE)

NAME:	PHONE WORK:	HOME:
NAME:	PHONE WORK:	HOME:

OPTIONAL INFORMATION:
MARITAL STATUS: YEARS OF EDUCATION: PLACE OF BIRTH:
RELIGION: HOW LONG AT PRESENT JOB:

BILLING POLICY:
Payment at time of service is expected unless other arrangements are made in advance. You may pay with cash, check or credit card (MasterCard or Visa). Bills not paid at the time of service are subject to a $15 billing charge. We do bill most insurance plans. Please check with our receptionists. You may bill those insurance plans not billed by our office by attaching a copy of your receipt to your completed insurance form.
Your signature below demonstrate that you understand our billing policy, agree to allow the doctor to bill your insurance company (when appropriate) and release necessary medical information to the insurance company. Your signature also gives you consent for medical treatment.
I understand that I am financially responsible for all charges incurred by me, whether my insurance company pays or not. I further agree that in the event of non payment, I will bear the cost of collections and/or court cost and reasonable legal fees should such court action be required. I agree that a photo copy of this authorization shall be valid as the original.

SIGNATURE: DATE:

RELATIONSHIP IF MINOR:

LABORATORY: (PLEASE LIST WHEN LAST LABS WERE DONE)

Routine Labs (CBC, CHEMISTRIES):
Cholesterol:
Thyroid Tests:
PSA:
Testosterone:
Estradiol:
Hemoglobin AIC:

SOCIAL HISTORY: (PLEASE CHECK AND LIST AS INDICATED)
Marital Status: Married ☐ Single ☐ Divorced ☐ Widowed ☐ Significant Other/Partner ☐
Occupation:
Nutrition: Good ☐ Bad ☐ Ugly ☐ Too much Fast Food? ☐ Too many Sweets? ☐
Exercise: Regular ☐ Occasionally ☐ Sedentary ☐ Type: ☐
Sexual Activity: Long term Monogamous ☐ Dating ☐ Abstain ☐ Same Sex ☐
Contraception:
Tobacco History: Yes ☐ No ☐ How many packs per day? Age you began?
Age you quit?
Cigarettes ☐ Chewing Tobacco ☐ Cigars ☐ Marijuana ☐
Illicit Drugs: Yes ☐ No ☐ Types:
Alcohol: Yes ☐ No ☐ Types: Beer ☐ Wine ☐ Liquor ☐ How often?
Religious preference:

FAMILY HISTORY: (PLEASE CHECK THOSE THAT APPLY TO YOUR FAMILY)

High Blood Pressure☐	Heart Disease☐	Stroke☐
Diabetes☐	Ulcers☐	Thyroid☐
Seizures☐	Tuberculosis☐	Emphysema/COPD☐
Migraines☐	Depression/Anxiety☐	Mental Illness☐
Glaucoma☐	Asthma☐	Alcoholism☐
Arthritis☐	Obesity☐	Alzheimer's Dementia☐
Osteoporosis☐	HIV☐	Cancer☐
Other☐		

REVIEW OF SYSTEMS: (DO YOU HAVE TROUBLE WITH THE FOLLOWING? PLEASE CHECK)

Headaches☐	Breasts☐	Hernia☐	Sexual Abuse☐
Ears☐	Heart☐	Hemorrhoids☐	Physical Abuse☐
Eyes☐	Lungs☐	Joints☐	Marriage/Family☐
Nose/Throat☐	Stomach☐	Circulation☐	Job Stress☐
Mouth/Teeth☐	Bowels☐	Weight (Loss or Gain) ☐	Nerves☐
Neck/Back☐	Arms /Legs☐	Fainting☐	Alcohol/Drugs☐
Skin☐	Testes/Penis☐	Sleep/Fatigue☐	Depression☐

Other:

WOMEN ONLY:
Last Period: Date of last Pap Smear: Abnormal Pap?
From of birth control: Pill ☐ IUD ☐ Condoms ☐ Diaphragm ☐ Rhythm ☐ Other ☐
None ☐ Patch ☐ Ring ☐
Number of: Pregnancies Abortions Miscarriages Stillborn

Do you have trouble with the following? (Please Check)

Irregular Periods ☐	Painful Periods ☐	Vaginal Infections ☐	Vaginal Discharge ☐	Urine Infections ☐
Losing Urine☐	Hot Flashes☐	Vaginal Dryness ☐	Painful Sex☐	PMS☐