Walden Ponds Medical Care LLC.

Dear Patient:

The following information is to notify you of our Financial Policy for our practice. Should you have any questions, please let the receptionist know that you wish to speak to me.

Thank you,

Practice Manager

- Co-payments must be made on the date of service. If you do not have your copay and your visit is a non-urgent, your office visit will be rescheduled. Your insurance contract states you must pay this at the time of your visit.
- There will be a $35.00 charge on all returned checks.
- There will be a $35.00 minimum charge on all NO-SHOW appointments and a $50.00 fee for NO-SHOW Complete Physicals . Please remember that other patients are waiting for appointments should you not need the appointment that we have reserved for you. Please provide 24 hour notice on cancelled or rescheduled appointments.
- There is a $25.00 service charge on all accounts over 30 days old.
- All accounts over 90 may be turned over to an outside Collection Agency. All fees attached to the account from the Collection Agency will be the responsibility of the patient. If payment arrangements must be made on accounts over $100.00, the patient agrees to pay off the account balance in 90 days (3 months).
- This office will charge an extra $25 fee for all emergency work-in appointments. This may not be covered by your insurance plan and will be patient responsibility.
- Due to a recent request from some of the insurance plans, we are asking all of our patients to provide us with a copy of a photo ID (your driver's license). This is to verify that the person presenting the insurance card is the same person with valid identification. This is not a requirement of our practice, however, it is helpful. Thank you.

Date:____

Patient /Guardian Signature:_______________________________

Walden Ponds Medical Care LLC.

Please complete this form if you would like to authorize the release of any of the following to a person other than yourself, such as a spouse, parent, child, etc. This form is optional. If any changes need to be made, please contact us.

Patient Name________________________________ Date of Birth______________

I authorize release of: (please circle below)

- All medical information
- Lab reports
- X-ray reports
- Other (please specify) ____________________________

Release to: (please print)

Name_________________________________ Relationship____________________

Release from this date: __________________ to this date:_____________________

Patient signature:________________________________ Date:_______________

CHANGE OF INFORMATION AGREEMENT

If there are any changes with insurance plans, address, or phone numbers it is the patient's responsibility to make the office aware of these changes. If the patient fails to make the office aware of such changes and charges are incurred due to incorrect information it will be the patient's responsibility to pay the accrued charges. Walden Ponds Medical Care will not resubmit charges due to patient non-compliance of office policies.

Copay is due at time of visit. COPAYS WILL NOT BE BILLED. Patients are responsible for paying balance in full within 90 days of office visit. Future appointments or office services will not be scheduled if balance is not paid, unless prior financial arrangements have been made with our billing department.

Print name: ______________________________________

Signature: ______________________________________ **Date** ______________

Walden Ponds Medical Care LLC.

5964 Golf Club Lane

Hamilton, OH 45011

(To enable us to file insurance for you, please complete the entire form)

(Mr./Mrs./Ms)____Sex: M / F
First Middle Last

Address____

City______________________________State______________Zip______________

Home Phone (______)______________Work (______)______________ext______________

Cell Phone#______________Spouse Name______________Work phone______________

Patient Birth date______________SS#______________Marital Status______________

Employer____

Emergency Contact Person______________phone______________relationship______________

If patient is a minor: Parent's Name______________ Work phone #______________

NAME OF PRIMARY INSURANCE____

Subscriber______________ Sex: M / F **DOB:**______________SS#______________
(This is the name of the person who carries the insurance) (Must have to file the insurance for you-otherwise Self –pay)

Insurance ID #______________Relationship______________

Employer:______________Effective Date______________Copay $______________

NAME OF SECOND INSURANCE____

Subscriber______________Sex: M / F DOB______________SS#______________

Insurance ID #______________Relationship______________

Employer______________Effective Date______________Copay $______________

Can confidential messages (ex: appointment reminders) be left on your answering machine/voice mail? Yes No

I give "Consent to treat" for my child who is under 18 years of age: Name______________
Relationship:______________Phone #______________

Insurance Assignment and Release: The undersigned authorizes direct payment to Family Medical Care Associates of any insurance benefits otherwise payable to or on behalf of the patient for all medical services. It is understood by the undersigned that he / she is financially responsible for the charges not covered by this assignment, and may be subject to collection/attorney fees. Authorization is also given to release any and all medical information to the insurance companies involved to allow them to process any claims for all services rendered.

______________ ______________ ______________
Patient / Parent / Guardian Relationship if not patient Date

New Patients: How did you hear about our office? (Please circle or explain) Friend / Relative / Cincinnati.MD / Other:______________

Walden Ponds Medical Care

Allergy Wellness Evaluation

Patient: ______________________________ **DOB:** __________ **Today's Date:** _________

Primary Care Provider: Dennis M. Anthony, MD

Do you experience any of these symptoms?			If, so how often per year?			
	Yes	*No*	*Occasionally*	*Over 3 times*	*Few long periods*	*Most of year*
Runny Nose						
Itchy Nose						
Stuffy Nose						
Itchy Eyes						
Watery Eyes						
Frequent Sneezing						
Itchy Mouth/Lips/Throat						
Post Nasal Drip (drainage down the back of the throat)						

Do you take prescription or over-the-counter (OTC) medications for the management of your allergy symptoms? ☐ **Yes** ☐ **No**

If yes, what was the medication & when was the last dose: ______________________________

	Please indicate below symptoms/conditions you've experienced during the past 1-2 years
	Sinus related issues (sinus pressure/pain, headaches, sinusitis, etc.)
	Re-occurring seasonal colds
	Chronic colds (lasting longer than 2 months)
	Migraine headaches
	Restless sleep, challenges sleeping through the night, snoring
	Consistent or re-occurring coughing
	Feeling of fatigue, irritability, & restlessness
	Asthma
	Skin conditions (dry and/or itchy skin, etc.)

If Patient is a minor: Guardian name and relationship to patient: ________________________

Patient/Guardian Signature:_________________________ **Patient Phone:** _____________

FOR DR. ANTHONY USE ONLY: Financial Evaluation? ☐ Yes ☐ No **Provider's Signature:**
Testing? ☐ Yes ☐ No ☐ N/A **Provider's Signature:**
FOR CAT/CAS USE ONLY: Date of last ENT Exam: