M. BOYD HERNDON, D.O.
HEALTH QUESTIONAIRE

DATE: _____
PATIENT: _____AGE: _____REFERRING DR:_____

PLEASE PUT A CHECK BY ALL SYMPTOMS THAT APPLY:

EARS
____Pain (____Left____Right)
____Drainage (____Left____Right)
____Pressure (____Left____Right)
____Decrease in Hearing
____Family History of Hearing Loss
____History of Noise Expsure
____Ringing in Ears
____Dizziness
____Fainting Spell
____Frequent Ear Infections
____Hearing Aids
____History of Head Trauma

NOSE
____Runny Nose / PND
____Difficulty Breathing Through Nose
____Headaches
____Nosebleeds
____Asthma / Wheezing

THROAT
____Sore Throat
____Difficulty Swallowing
____Thyroid Disease
____Difficulty Sleeping / Snoring

ALLERGIES
____Previously tested for allergies?
____History of Sinus Infection
____Hay Fever / Allergies
____Food Cravings
____ Rosy Cheeks, Blemishes, Acne
____Hoarseness (prolonged)
____Rashes / Hives
____Psoriasis
____Eczema

SOCIAL HISTORY
____Alcohol (____Amount per week)
____Smoking (____cig/day ____#yrs ____yrs quit)
____Coffee / Tea (____cups per day)

CONSTITUTIONAL
____Fatigue (Sluggish, Tired)
____Hyperactive (Nervous energy)
____Restless (can't relax / sit still)
____Sleepiness During Day
____Insomnia at Night

RESPIRATORY
____Pneumonia
____Bronchitis / Chronic Cough
____Shortness of Breath

DIGESTIVE
____Heartburn / Esophageal Reflux

PLEASE ANSWER ALL QUESTIONS BELOW – WRITE N/A IF IT DOES NOT APPLY

Do you take the following: _____Aspirin _____Tylenol _____Ibuprofen

Medical History: _____

Surgical History: _____

Present Medications: _____

_____

Allergies to Medications: _____

M. BOYD HERNDON, D.O., P.A.

886 Sierra Drive / Port Neches, Texas 77651 / (409) 729-6401

SS#:_____

DOB:_____

PLEASE PRINT, SIGN AND DATE THIS CONSENT/ASSIGNMENT **AGE:** _____ **Male or Female**

Patient Information: **Referring Phys:**_____

Name: _____ **Preferred name:** _____

Last First **Middle** **Marital Status:** _____

Address:_____ **City, State Zip** _____

Home Phone ( ) _____ **Cell Phone** ( ) _____ **Email:**_____

Employer name and address: _____

PRIMARY INSURANCE

NAME INSURANCE CO #1 _____ **POLICY#** _____ **GROUP#**_____

INSURED NAME: _____ **INSURED DOB:** _____

RELATIONSHIP TO PATENT: _____

SECONDARY INSURANCE

NAME INSURANCE CO #2_____ **POLICY#**_____ **GROUP#**_____

INSURED NAME: _____ **INSURED DOB:** _____

RELATIONSHIP TO PATIENT: _____

EMERGANCY CONTACT

NAME: _____ **RELATIONSHIP:** _____

CELL PHONE: _____ **WORK PHONE:** _____

M. BOYD HERNDON, D.O., P.A.
FINANCIAL POLICY

Dr. Herndon believes that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy.

PAYMENT is expected at the time of your visit. We will accept check, cash, debit, or credit card. **Please be advised that there will be a 3.50% service fee on all cards used**. Payment will include deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. All past due balances are due at time of check-in unless previous arrangements have been made with our business office.

INSURANCE is a contract between you, your employer and the insurance company. **We are not a party to that contract.** It is very important that you understand the provisions of your policy. It is your responsibility to verify that we are an in-network provider on your specific plan. Insurance plans vary considerably, and we cannot predict or guarantee what part of our services will or will not be covered. It is the responsibility of the patient to provide ***accurate*** and ***timely*** insurance information. Therefore, we ask you to ***bring your current insurance card and driver's license to each visit.*** Inaccurate or untimely information given to the staff that results in denial or non-coverage by your insurance company will result in the guarantor being responsible for payment.

If you have insurance coverage under a plan with which we do not have a contract, or if you are un-insured, you will be required to pay ***in full*** at the time of service for all office visits and/or procedures. You may be given a same-day discount for most services when full payment is received. Some exclusions may apply due to cost of medications, etc.

The parents(s) or guardian(s) accompanying a minor are responsible for providing current insurance information for the minor as well as the payment in full for services provided.

Initial: _____

BILLING: Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. You should call your insurance company for any questions regarding how they processed your claim(s). You may call the billing office for any other questions regarding your bill or to discuss payment options.

RETURNED CHECKS: A $30.00 fee will be charged for any checks returned for insufficient funds. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the $30.00 service charge.

Initial: _____

I have read and understand the above financial policy of M. Boyd Herndon, D.O., P.A. and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice at any time without prior notification to the guarantor.

_____	_____	_____
Patient Signature	Printed Name	Date

M. BOYD HERNDON, D.O., P.A.

886 Sierra Dr/ Port Neches, Texas/ 77651/ (409) 729-6401

Assignment of Benefits/ Consent for Treatment

I hereby agree to pay in full for medical services unless otherwise contractually or statutorily prohibited. I understand that I will be financially responsible for any charges not paid by my insurer. I also agree that any payment due from me will be made at the time services are rendered or promptly upon billing. I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the result or outcome of treatments, examinations, or testing by Dr. Herndon.

I authorize and request payments of medical benefits directly to M. Boyd Herndon, D.O., P.A. I further authorize M. Boyd Herndon, D.O., P.A. to release to my insurance company(s) any and all medical information (including that of confidential nature) necessary to process my insurance claims, and to any healthcare provider for continuation of my healthcare.

Sign:_____ Date: _____

Consent for Release of Protected Medical & Billing Information

_____ I will allow ALL results including ABNORMAL results to be released to the following:

_____ _____

Name Relation

_____ _____

Name Relation

_____ I will allow INSURANCE AND BILLING or information to be discussed regarding my ACCOUNT with the following:

_____ _____

Name Relation

_____ _____

Name Relation

_____I will allow SCHEDULING APPOINTMENTS to be discussed with the following:

_____ _____

Name Relation

_____ _____

Name Relation

___May leave message on (circle one or all): voice mail / answering machine / text

_____

Printed name of patient Date

_____

Signature of patient Date

****This content will expire one year from date above