Please provide the following information to the best of you ability:

Patient Name: _____
Date of birth: _____
Date of Appointment: _____

What problem(s) are you here for today? _____

_____

Past Medical History:

1) Please check 'Yes' or 'No' to indicate if you have/had any of the following illnesses. For 'Yes' answer please explain:

	Yes	No			Yes	No	
Diabetes	___	___	_____	Kidney problems	___	___	_____
High blood pressure	___	___	_____	Neurological problems	___	___	_____
Heart disease	___	___	_____	Cancer	___	___	_____
Bleeding disorder	___	___	_____	Depression/Anxiety	___	___	_____
Lung (Asthma, COPD)	___	___	_____	Allergy problems/Therapy	___	___	_____
Liver problems	___	___	_____	Other(s)	_____		

_____

_____

2) Please list any surgeries (and dates) you have ever had (including tonsils and adenoids)

Surgeries	Year	Surgeries	Year
_____		_____	
_____		_____	
_____		_____	

Anesthesia Problems: ___ No ___Yes, explain_____

3) Do you have any allergies to medications? : ___ No ___Yes, please list medication and reaction :

_____

Please list all current medications

Medication	**Dose**	**Frequency (How many times per day)**

Family History

1) Please check 'Yes' or 'No' to indicate whether any relatives have any of the following illnesses/problems
2) For 'Yes' please indicate which relative(s) has/have the problem and explain

	Yes	No	
Hearing Loss	___	___	_____
Bleeding disorder	___	___	_____
Cancer	___	___	_____
Anesthesia problems	___	___	_____

Turn Over

Turn Over

Social History

1) Do you use tobacco?

___ Yes, I smoke ___ pack(s) of cigarettes per day for ___ years
___ Yes, I smoke cigarettes occasionally, but not daily
___ No, I quit smoking ___ years ago. At the time I was smoking ___ pack(s) per day for ___ years
___ No, I have never smoked
___ Yes, I smoke cigars or a pipe
___ Yes, I chew tobacco

2) Do you drink alcohol?

___ Yes, Daily
___ Yes, 1 or more times per week
___ Yes, 1 or more time per month
___ No, but I have previously
___ No, never (or rarely)

3) Do you use recreational drugs?

___ Yes, presently: type and frequency_____
___ No, but I have previously: type and frequency_____
___ No

4) How many cups or cans of caffeine do you drink per day? _____

Pharmacy Name and location_____

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Financial Policy

(Revised 07/2013)

Dear Patient,

Thank you for choosing The Ohio State University Wexner Medical Center for your health care. The location you are being seen is part of Ohio State's Wexner Medical Center. We want to make your visit as easy as possible by providing information that will help you with our billing and payment procedures.

Be sure to bring these items with you to each visit:

- Valid Driver's License or State Issued ID
- Insurance Card(s)
- Payment such as cash, check or credit card
- Test results, x-rays and any other materials, if asked to provide those

We may not be able to see you if you do not bring these items.

If you need to reschedule or cancel an appointment, contact our office at least 24 hours in advance. Phone numbers are provided below. If you miss an appointment without notice, a rescheduled appointment cannot be guaranteed. Repeated failure to keep your appointment may result in you being dismissed as a patient.

Payments

- At the time of your visit, you are responsible to pay any deductible, copayment, coinsurance, or outstanding balance as specified by your insurance company.
- Any medical services not covered by your insurance company must be paid in full at the time of the visit unless you have made arrangements with us before the appointment.
- If you do not have insurance, you will be expected to pay a deposit at the time of service unless other arrangements have been made with us.
- You need to be sure that any needed referrals and authorizations for treatment are provided to us before the visit. Your visit may be rescheduled, or you may have to pay the full amount for the services, if you do not provide the needed referral or authorization.
- Financial aid is available for qualified patients. A check of your credit status may be run to help determine if you qualify. If you feel that you may qualify, please contact the Patient Financial Services Unit. Phone numbers are provided at the end of this document. You may have to wait for your visit to be scheduled until your financial aid has been approved.
- Payment can be made with cash, check or credit card. Visa, MasterCard, American Express and Discover are accepted by our offices. There is a $30 fee for any check returned by the bank for any reason. If you have any questions or concerns, please contact the billing customer service phone number provided below.

Care of Children

- In the event of a divorce, both parents will be considered equally responsible for payment. It will be up to the parent(s) to resolve divorce decree differences.

- With few exceptions, non-emergent treatment will be denied for any child unless the parent or guardian is present. If you cannot attend an appointment with your child, call the office in advance to see if arrangements can be made. Payment arrangements must be made prior to the appointment.

Insurance Benefits and Forms

- Ohio State's Wexner Medical Center contracts with many insurance companies. If you have insurance with of one of these companies, our billing offices will submit a claim for payment of services for you unless you instruct us not to. All needed insurance information, including special forms, must be completed by you before you leave your appointment.
- If the Ohio State's Wexner Medical Center does not contract with your insurance company, you will be responsible for any balance not paid by your insurance. While our billing offices will file a claim on your behalf to your insurance company, you may be required to pay Ohio State's Wexner Medical Center before receiving services. If payment is received from your insurance company after processing your claim, you will be refunded any extra amount after all charges have been covered.
- If you have questions about your specific insurance coverage, you need to call your insurance company. Their telephone number should be printed on your insurance card.
- Our staff is happy to help with insurance questions relating to how a claim was filed. We will also provide any additional information your insurance company might need to process your claim.

Care as part of Clinical Research Study

- Many studies involve routine services that would be done even if you were not part of the study. If a service provided is not considered part of the research study, Ohio State's Wexner Medical Center will bill you or your insurance for that service.
- You are responsible to know what services will be billed to you or your insurance and what will be paid for by the study. If you have questions about what services should be paid for by the study, contact your study doctor or coordinator at the number on the study consent form.

Financial Policy Acknowledgement

I have read or someone has read the form to me and I received a copy of the above Financial Policy. I agree to follow the policy.

_____ _____

Printed Patient or Responsible Party Name *Date*

_____

Signature for Patient or Responsible Party

Ohio State's Wexner Medical Center Phone Numbers	
Hospital Billing Inquiries: (614) 293-2100 or (800) 678-8037	Physician Billing Inquiries: (614) 255-1000 or (888) 886-8446
Appointment or General Information inquiries: (614) 293-5123	

Please complete if you have any form of Medicare, if you are on disability, OR if you are 65 years of age or older.

Medicare Secondary Payer Questionnaire - Standard Form

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Medicare law mandates that we determine if your medical services might be covered by another insurer. As a Medicare provider, we are required to ask you the following questions:

1) Is the patient a member of a Medicare HMO?

☐ **NO**, Medicare HIC#: _____ ☐ **YES**, You are finished. You do not have to complete the remainder of this form.

Please answer **ALL** questions below and **FOR EACH YES** indicated, complete the section as directed.

2) Is the patient and/or spouse working?

☐ **NO**, Retirement date: _____ ☐ **YES**, Complete **SECTION I**

☐ **NO**, Never Employed

3) Is the patient under 65 and disabled?

☐ **NO** ☐ **YES**, Complete **SECTION II**

4) Is the patient under 65 has End State Renal Disease (ESRD)?

☐ **NO** ☐ **YES**, Complete **SECTION III**

5) Is the patient covered by any other Federal Program?

☐ **NO** ☐ **YES**, Complete **SECTION IV**

6) Is the patient's injury/illness or condition job-related?

☐ **NO** ☐ **YES**, Complete **SECTION V**

7) Is the patient's injury/illness due to a non work-related accident?

☐ **NO** ☐ **YES**, Complete **SECTION VI**

SECTION I - Working Aged Patient or Spouse

1) Is the patient 65 or older?

☐ **NO,** This section is complete. ☐ **YES**

2) Is the patient employed?

☐ Retirement date: _____ ☐ Full Time

☐ Part Time ☐ Never Employed

3) Is the spouse employed?

☐ Retirement date: _____ ☐ Full Time

☐ Part Time ☐ Never Employed

SECTION II - Disability

1) Is the patient under 65 and entitled to Medicare by reason of disability?

☐ **NO,** This section is complete. ☐ **YES**

2) Does the patient have a group health plan (GHP) coverage based on the patient's or a family member's current employment?

☐ **NO,** This section is complete. ☐ **YES**

3) Does the employer that sponsors your GHP employ 100 or more employees?

☐ **NO,** (GHP is secondary) ☐ **YES**

SECTION III - End Stage Renal Disease (ESRD)

1) Is the patient under 65 and entitled to Medicare solely on the basis of ESRD?

☐ **NO,** This section is complete. ☐ **YES**

2) Is the patient covered by a GHP within the 30 month coordination period?

☐ **NO,** This section is complete. ☐ **YES**

3) First dialysis date: _____ **Transplant date:** _____

SECTION IV - Veteran's Administration or Other Federal

1) Are the services for this patient covered by a federal program?

☐ Public Health Services (PHS) ☐ Veteran's Administration (VA)

☐ Federal Black Lung Program (BL) ☐ Federal grant

☐ Other Federal program? If so, specify: _____

SECTION V - Worker's Compensation

1) Is the accident, injury, or condition job-related and covered by Worker's Compensation?

☐ **NO,** This section is complete. ☐ **YES**

2) Accident date: _____

SECTION VI - Auto-Medical, Auto or Other Liability

1) Accident date: _____

2) Type of non work-related accident:

☐ **Automobile**

☐ **Other** **If so, specify:** _____

3) Was another party responsible for the accident?

☐ **NO** ☐ **YES**

********Please bring any supporting documentation to your appointment for any of the given areas in this document that apply to the patient.********

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