

Dr. Nina Lee-Tall, M.D.
1200 South Pacific Coast Highway, Suite C, Redondo Beach, CA 90277

PATIENT'S INFORMATION

LAST NAME: _____ FIRST NAME: _____ MI: _____ SEX: M/F
BIRTH DATE: / / MARITAL STATUS: _____ DL#: _____ SS#: _____
ADDRESS: _____ CITY: _____ ZIP CODE: _____
PHONE (H): _____ (C): _____ (WK): _____
EMAIL: _____ PHARMACY NAME: _____ PHARMACY #: _____
Which is the best number to call you during business hours? _____ OCCUPATION: _____
EMPLOYER: _____ (PARENT) IF UNDER AGE 18: _____
PRIMARY CARE PHYSICIAN: _____ PHONE: _____
REFERRING PHYSICIAN: _____ PHONE: _____

DO WE HAVE PERMISSION TO:

Leave a message on your answering machine?
Leave a message on your cell phone?
Leave a message at work?
Discuss your medical condition with anyone?

Yes/No (Circle)
Yes/No (Circle)
Yes/No (Circle)
Yes/No (Circle)

If yes, please give name(s): _____

BILLING INFORMATION

PRIMARY INSURANCE: _____ SECONDARY INSURANCE: _____
SUBSCRIBER'S NAME: _____ SUBSCRIBER'S BIRTH DATE: / /
RELATION TO SUBSCRIBER (CIRCLE): SELF/SPOUSE/CHILD/OTHER

ASSIGNMENT OF INSURANCE BENEFITS

I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for the services provided. I also authorized Dr. Nina Lee-Tall, M.D., or my insurance company to release any information required to process my claim.

MEDICARE

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf. If I only have Medicare, I will be responsible for whatever Medicare does not cover.

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

MEDICAL HISTORY FORM

Patient Name: _____ Date: _____

Past Medical History: (please note all that apply)

<input type="checkbox"/> Seizure	<input type="checkbox"/> Asthma	<input type="checkbox"/> Major trauma (type): _____
<input type="checkbox"/> Heart attack	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Cancer (type): _____
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Stroke	<input type="checkbox"/> Lung disease (type): _____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Heart disease (type): _____
<input type="checkbox"/> Autoimmune disease	<input type="checkbox"/> Liver disease	<input type="checkbox"/> Thyroid disease (type): _____
<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Severe allergies (type): _____

Other Medical Problems (not listed above):

Past Surgical History:

Current Medications:

Allergies to Medications:

Family History of Medical Problems:

Smoking History: (please mark one)

<input type="checkbox"/> Current EVERY day smoker	<input type="checkbox"/> Current SOME day smoker	<input type="checkbox"/> Former smoker
<input type="checkbox"/> Never smoker	<input type="checkbox"/> Smoking status unknown	

Patient/Guardian Signature: _____

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To improve efficiency in the office and to better serve patients, the following policies are instituted:

- ____ It is your responsibility to inform the staff of any insurance changes. The staff will make every effort to verify insurance eligibility and coverage at the time of your visit, but if we are unable to do so, you will be required to pay for your visit at the time of service. You will be responsible for billing your insurance for that date of service, should you wish to be reimbursed by your insurance.
- ____ It is imperative that the staff has your current address and phone number(s). Please notify us of any changes.
- ____ Insurance Co-Payments are due at the time of service. There is a \$5 service charge for non-payment of the insurance Co-Payment at the time of service.
- ____ There is a \$20 charge for all returned checks. Repeat occurrences will result in a "cash only" policy for the patient.
- ____ Statements are sent monthly. If your account is delinquent, you will be seen on a "cash only" basis. You will also be required to pay our balance prior to future medical services.
- ____ As a courtesy, the staff will call to remind you of your office visit one day in advance. If you fail to show up for your appointment (NO SHOW), you will be charged \$50. This charge is not billable to your insurance company. Patients with multiple late cancellations (cancelled on the day of appointment) will also be charged \$50 at the third late cancellation and every occurrence thereafter.
- ____ Patients arriving 20 minutes or more past their scheduled appointment time, will need to be rescheduled for a different time.
- ____ In accordance with the laws of the State of California, Dr. Lee-Tall does NOT treat or prescribe medication for patients over the phone. A visit must be scheduled.
- ____ Three "NO SHOW" appointments will result in our office asking you to transfer your medical care to another physician.

Patient's Name: _____

I have read, understand, and agree to the above stated policies.

Patient/Parent Signature: _____

Date: _____

Nina Lee-Tall, M.D.

Adult and Pediatric Otolaryngology



PATIENT NAME: _____

DATE OF BIRTH: _____

Please be aware that certain procedures performed in our office are not included in the standard office visit. These procedures will be billed separately and in addition to office visit charges. Please note that some insurance carriers classify these procedures as "surgery," which may result in the charges being applied to a higher deductible. In such cases, insurance may cover the office visit but not the procedure, leaving the patient responsible for the procedure's payment. Please be assured that we are following standard billing and coding guidelines and that all procedures are performed in the best interest of patient care.

Examples of in-office procedures include:

- **FLEXIBLE LARYNGOSCOPY:** This procedure involves passing a thin, flexible fiberoptic scope through the nasal cavity and into the throat. The fiber optic scope enables the physician to visualize areas of the throat, base of tongue, larynx and hypopharynx.
- **NASAL ENDOSCOPY:** This procedure involves utilizing a flexible or rigid scope attached to a light source to view the nasal cavities. The scope enables the physician to visualize areas of the nose not easily seen using the standard nasal speculum and head mirror.
- **NASAL ENDOSCOPY WITH DEBRIDEMENT OR BIOPSY:** This procedure uses the technique described above, with the removal of excess debris, crusting, or blood clots as needed.

Please speak with my nurse if you have any questions.

Patient's signature

Date

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