GLENN P. MATNEY, M.D.

ASSIGNMENT OF BENEFITS

I hereby certify that I, _____ am the
(PRINT YOUR FULL NAME HERE)

financially responsible party for patient _____;
(PRINT PATIENT'S FULL NAME HERE)

and I hereby authorize the release of all information necessary to process insurance claims for reimbursement for all services rendered and/or items dispensed to this patient; and I assign all benefits and insurance payments to Glenn P. Matney, M.D.; and I direct that all insurance payments be made directly to Glenn P. Matney, M.D.; and I understand that I remain fully financially responsible for all charges, whether or not paid in full by insurance; and I authorize the use of this signature on all insurance submissions and correspondence.

SIGNED_____ **DATE**_____

Glenn P. Matney M.D

12402 Industrial Blvd Ste B-1

Victorville, CA 92395

Privacy Officer: Terri 760-245-9363

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

Signed:_____ Date:_____

Print name:_____Telephone:_____

If not signed by the patient, please indicate relationship:

(Circle one only)

Parent of guardian of minor patient

Guardian or conservator on an incompetent patient

Name and Address of Patient _____

_____

Statement of Financial Responsibility & Consent for Courtesy Billing & Assignment of Benefits

Patient's Name:_____

Patient's Date of Birth:_____

By my signature below, I hereby certify that I am the financially responsible party for the patient named above, and I request that all payments of insurance benefits be made on my behalf directly to **Glenn P. Matney, MD** for all services provided to this patient; and I hereby authorize release of all relevant medical information to my insurance carrier needed to determine my payable benefits; and I understand that I am financially responsible for all deductibles, co-insurance, and any non-covered service; and I understand this authorization can only be revoked in writing.

Financial Arrangements and Medical Insurance:
As a courtesy to you, if the patient named above has active medical insurance, we will submit the claim for you on your behalf. **It is your sole responsibility** to notify our office immediately of any changes to your insurance coverage, and to keep your mailing address and phone number up to date with us at all times. Payment for all office services are due at the time of the visit, unless payment arrangements have been pre-approved in advance. We accept cash, checks, Visa, MasterCard, American Express, and Discover. There is a $30 charge for all returned checks for insufficient funds. If this account is referred to a collection agency, the undersigned agrees to pay all collection expenses. We do not accept checks for circumcision services.

It is important that you understand the following:
"Accepting Assignment" does not mean we will not bill you for amounts that are deemed to be the patient's responsibility, such as: deductibles, co-insurance, co-pays and any non-covered services. If we are participating with your insurance carrier, or the network your insurance carrier utilizes, we have a negotiated contract with the carrier, and have agreed to accept their fee schedule; and they will pay us directly. Any balance still remaining beyond our negotiated rate is still your sole responsibility. Depending on your plan, it may be a co-insurance amount, a co-pay amount, a deductible, or a combination of thereof.

Depending on your insurance policy, certain medical services may require a pre-authorization. It is your responsibility to obtain the appropriate authorization, if required, for your visit. The office will help you with your request for an authorization, but it still remains your personal responsibility.

There may be times when your insurance carrier requests patient information from you directly that we cannot provide. It is extremely important that you provide this information to your carrier, otherwise they may deny the claim for payment, and then you will owe the entire balance due.

Print your full legal name here:_____
Patient, or if a minor: Parent or Legal Guardian

Your date of birth:_____ **Your Social Security Number:**_____

By signing this form, I certify that I can read and understand English, and that I have read and understood and do agree to the terms of this form.

Date:_____

Signed:_____in Victorville, California
Patient, or if a minor: Parent or Legal Guardian

Witness:_____

CHILD HEALTH HISTORY

HISTORY OF PREGNANCY WITH THIS CHILD:

During which month of pregnancy did you first see the doctor?_____Month
How long was your pregnancy? _____Months
Where was baby born? _____
If baby was born at home, were blood tests for newborn screening done? ☐ Yes ☐ No

Did you have any illnesses or problems? (including sexually transmitted or other communicable diseases)	YES	NO	Did you use any non-prescribed drugs? (tobacco, alcohol, *street drugs:, over-the-counter or home remedies)	YES	NO
Did you take any medications prescribed by your doctor?	YES	NO	Did the baby go home with you from the hospital?	YES	NO
Did you have a difficulty/abnormal delivery/C-section?	YES	NO	Was more than one baby born?	YES	NO
Did the baby have any problems during the 1st week of life?	YES	NO	Did baby receive any shots for Hepatitis B?	YES	NO

CHILD'S HISTORY: ☐ Male ☐ Female Is this child adopted? ☐ YES ☐ NO Birth Weight: _____pounds _____ounces Length: _____ inches

Has your child ever had (Please circle Yes or No):

Measles, Chickenpox, Mumps, Rubella	YES	NO	Vomiting after eating, refusal to eat	YES	NO
Tuberculosis or positive TB Test	YES	NO	Muscle, joint or bone problems	YES	NO
Tonsillitis/Sore Throat	YES	NO	Skin problems	YES	NO
Problems with eyes or vision	YES	NO	Headaches or dizziness	YES	NO
Problems with ears or hearing	YES	NO	Convulsions, seizures, epilepsy	YES	NO
Difficulty breathing/snoring at night	YES	NO	Diabetes	YES	NO
Heart problems	YES	NO	Thyroid problems	YES	NO
Asthma, bronchitis, or pneumonia	YES	NO	Allergies	YES	NO
Anemia, bleeding problems, blood transfusions	YES	NO	Problems with development of school performance	YES	NO
Stomachaches	YES	NO	Serious illness or accident	YES	NO
Diarrhea, Soiling self with stool	YES	NO	Surgery or hospitalization	YES	NO
Bladder Kidney Problems, Wetting self or bed	YES	NO	(GIRLS) Has she stared her periods?	YES	NO
Constipation	YES	NO	(GIRLS) Are there problems with her periods?	YES	NO

FAMILY HISTORY: Does mother (M), father (F), brother (B), sister (S), aunt (A), uncle (U), or grandparent (GP) have:

			Which Family Member?				Which Family Member?
YES	NO	Diabetes		YES	NO	High blood pressure	
YES	NO	Epilepsy or convulsions		YES	NO	Bleeding disorder	
YES	NO	Mental retardation		YES	NO	Tuberculosis	
YES	NO	Heart disease		YES	NO	Allergy	
YES	NO	Cancer		YES	NO	Lung or breathing problems	
YES	NO	Kidney or urinary disease		YES	NO	Eye disorder	
YES	NO	Bone or joint problems		YES	NO	Ear disorder	

PARENT INFORMATION:

	Mother:	Father:
Age:	_____	_____
Height:	_____	_____
Occupation:	_____	_____

HOUSEHOLD INFORMATION: Number of people in home _____
Are both parents living in the home? ☐ Yes ☐ No
Does anyone in the home smoke, or use drugs or alcohol? ☐ Yes ☐ No
Language spoken in the home: _____
Do you live in a: ☐ House ☐ Apartment ☐ Mobile Home ☐ Shelter ☐ Homeless

Patient Identification:

Signature: _____ Date: _____

Relationship to Child: _____

Reviewer's
Signature: _____ Date: _____

UNIVERSAL CONSENT FOR VACCINATION

MY SIGNATURE BELOW INDICATES THAT I HAVE, TO MY SATISFACTION, READ THE "WHAT YOU NEED TO KNOW" VACCINE(S) SHEET(S) PROVIDED. OR HAVE HAD EXPLAINED TO ME INFORMATION ABOUT THE VACCINE(S) LISTED BELOW AND THE DISEASE(S) MEANT TO BE PREVENTED. I BELIEVE THAT I UNDERSTAND BOTH THE RISKS AND BENEFITS OF THE VACCINE(S) LISTED BELOW AND GIVE MY CONSENT FOR ANY VACCINE(S) THAT MY CHILD MAY NEED OR THE PERSON NAMED BELOW FOR WHOM I AM, LEGALLY AUTHORIZED MAY NEED.

A RECORD WILL BE KEPT IN PATIENTS MEDICAL FILE RECORDING WHAT VACCINE WAS GIVEN, THE MANUFACTURER'S NAME, LOT NUMBER OF THE VACCINE, AND THE SIGNATURE OF THE PERSON WHO HAS GIVEN THE VACCINE(S).

STANDARD VACCINES

HEPATITIS B (HBV)
HEPATITIS A (HAV)
IPV (Injectable Polio)
HIB (Hemophilus Influenza Type B)
MMR (Measles, Mumps, Rubella)
MENACTRA (Meningococcal)
ROTATEQ (Rotavirus)
GARDASIL (Quadrivalent Human Papillomavirus)
TDAP (Tetanus, Diphtheria, Pertussis)
PREVNAR (Pneumoccal Conjugate)
VARIVAX (Chickenpox)
DTAP (Diphteria, Tetanus & Pertussis)
TB skin test
INFLUENZA (Inactivated)
FLUMIST/INFLUENZA (Live Intranasal)

NAME OF PERSON TO RECEIVE VACCINATION

LAST_____FIRST_____MI___
BIRTHDAY_____AGE_____
STREET_____
CITY_____STATE_____ZIP_____

SIGNATURE OF PERSON AUTHORIZED TO GIVE CONSENT

NAME_____
SIGNATURE_____DATE_____
WITNESS_____DATE_____

GLENN P. MATNEY M.D
REGISTRATION SHEET(Patient's Info Goes Here)

Last:_____First:_____M.I._____
Date of Birth:_____ Age:_____ Sex: M F
Address:_____City:_____State:_____Zip:_____
Home Phone: ( )_____Message Phone: ( )_____

PERSON RESPONSIBLE FOR PATIENTS EXPENSE

Last:_____First:_____M.I._____
Address:_____City:_____State:_____Zip:_____
Relationship to Patient:_____ Social Security No:_____
Date of Birth:_____

PERSON RESPONSIBLE'S EMPLOYER

Name:_____ Address:_____
City:_____ State:_____ Zip:_____ Phone: ( )_____
Occupation:_____

SPOUSE OF PERSON RESPONSIBLE

Last:_____First:_____M.I.:_____
Address:_____City:_____State:_____Zip:_____
Relationship to Patient: _____ Social Security No: _____
Date of Birth: _____

SPOUSE'S EMPLOYER

Name:_____ Address:_____
City:_____ State:_____ Zip:_____ Phone: ( )_____
Occupation:_____

INSURANCE INFORMATION

Primary Insurance Name: _____
Subscriber's Name: _____ Date of Birth: _____
Insured Id Number: _____

Secondary Insurance Name: _____
Subscriber's Name: _____Date of Birth: _____
Insured Id Number: _____

EMERGENCY CONTACT

Name: _____Phone No: ( ) _____Relationship:_____
Name: _____Phone No: ( ) _____Relationship:_____

Signature of Responsible Person _____**Date:**_____